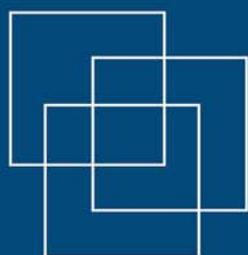




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The state of social protection in ASEAN at the dawn of integration



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The state of social protection in ASEAN at the dawn of integration

Cheng Boon Ong and Céline Peyron Bista

Foreword

The Association of Southeast Asian Nations (ASEAN) Economic Community (AEC) will become a reality at the end of 2015. The AEC will affect 600 million men and women. It has the potential to drive innovation, create new jobs, increase productivity and thus accelerate growth. This accelerated growth will necessitate changes in skills and jobs. To smooth this transition, ensure that no vulnerable people are left behind, and that the majority of men and women benefit from these changes, effective social protection must be a priority.

At the 23rd ASEAN Summit in Brunei Darussalam in October 2013, the ten ASEAN leaders adopted a Declaration on Strengthening Social Protection, which reaffirmed their commitment to building an ASEAN community that is “socially responsible and people-oriented” (ASEAN Member States, Cambodia, 2012), through the establishment of nationally-defined social protection floors (SPFs) for all.

The Declaration channels a growing consensus in the region that the establishment of SPFs is fundamental for reducing poverty and inequality and promoting inclusive and sustainable growth. Despite differing levels of coverage and speeds of change most countries are now moving towards establishing sound policy and institutional frameworks to deliver social protection effectively and efficiently.

Based on the principle of universal protection, SPFs are an investment with both immediate and long-term effects on millions of lives, enhancing political stability and social cohesion. Social protection and SPFs also contribute to economic growth by supporting household incomes and thus domestic consumption. They also enhance human capital and productivity and empower people to find decent jobs. Consequently, they are a critical policy tool for supporting transformational national and regional development and the formalization of economies.

This report comes at a historic moment. Social Protection is increasingly recognized as a key component of the new global development agenda, gaining a prominent space in the recently approved United Nations Sustainable Development Goals (SDGs). This is exemplified by the use of social protection systems and measures, including floors, as an indicator for Goal No. 1, on ending poverty in all its forms everywhere. Substantial coverage of the poor and vulnerable sections of the population should be achieved by 2030.

Within ASEAN, the extension of social protection should be done in ways that will provide an adequate level of protection to its people. Risk pooling and social solidarity principles should be encouraged, and in some countries strengthened, to ensure that the increases in economic growth and social protection reach everyone, including those in temporary and vulnerable employment. To achieve universal social protection, ASEAN countries will need to boost their efforts to expand both their effective population coverage and level of protection, through both the establishment of new and the improvement of existing social insurance and tax-funded schemes.

The International Labour Organization has traditionally been a close partner of the ASEAN Member States and the ASEAN Secretariat in the promotion of social protection in the region. Since 2011, the ILO Regional Office for Asia and the Pacific, with the support of the ILO/Japan Multi-bilateral Programme and in collaboration with the ASEAN Secretariat, has implemented the project, *Promoting and building social protection in ASEAN*. The present report is a product of this project.

The study provides an overview of the social protection situation in each of the ten ASEAN Member States, using the framework of the four Guarantees adopted in 2012 under the ILO's Social Protection Floors Recommendation (No. 202). The report documents country experiences that can inspire ASEAN Member States in their work to develop effective social protection systems. The study also offers recommendations for practical strategies and policy options for extending social protection coverage in the region and provides baseline information against which to measure progress.

I trust that the report will provide an important resource that will enrich the continuing social protection-related discussions among ASEAN Member States and inspire policymakers at national and regional levels. Finally, I hope that the study will help to advance the realization of social protection floors for all and thus social progress in ASEAN.



Tomoko Nishimoto
Assistant-Director General and
Regional Director
ILO Regional Office for Asia and the Pacific

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Executive summary

Social protection is unequivocally a universal human right. Its schemes are key instruments for poverty eradication and equality advancement. At the aggregate level, social protection contributes to inclusive economic growth by raising labour productivity and enhancing socio-political stability. The crucial role of social protection was proven during the global financial and economic crises of 1997–98 and 2008–09 as it was utilized to mitigate the adverse social and economic impacts (ILO, 2011a). Social Protection has also gained a new prominence in the global development agenda with the approval of the Sustainable Development Goals (SDGs) in September 2015. The SDGs propose the implementation of nationally appropriate social protection systems for all, including social protection floors.

The Association of Southeast Asian Nations (ASEAN) has expressed commitment towards ensuring social protection for all its peoples, the most notable being the ASEAN Declaration on Strengthening Social Protection signed in 2013. The Declaration echoes the adoption of the International Labour Organization (ILO) Social Protection Floors Recommendation, 2012 (No. 202) by the Ministries of Labour, and employers' and workers' organizations of the 184 ILO members states, which include all ten ASEAN Member States. The assessment of

social protection in this report, shortly before the establishment of the ASEAN Community, is aimed at determining the present “baseline” state of social protection in the region and to facilitate the ensuing monitoring of relevant policies' design and implementation. It is partly based on the results of the assessment based national dialogue (ABND) on social protection conducted in several ASEAN Member States and a comprehensive desk review used to compile social protection information on the other Member States as well as to update the ABND assessments. It also relies on the inputs from separate consultations among workers' and employers' organizations of the ASEAN Member States between August and November 2014, the ILO-ASEAN seminar on strengthening social protection that took place in Bangkok, 17–18 November 2014, and the ASEAN multi-sectoral consultation on social protection in Siem Reap, 8–9 December 2014 with representation from the ILO, Food and Agriculture Organization (FAO), United Nations Development Programme (UNDP), United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) and the United Nations Children's Fund (UNICEF).

The report looks at the existing social protection schemes in the ASEAN Member States from the angle of the four guarantees of the social

protection floor, that are: health care for all and income security for children (including access to necessary goods and services), those in working age, and the elderly. Following a lifelong approach, the ILO instruments particularly, the ILO Social Security (Minimum Standards) Convention, 1952 (No.102), have organized the provision of social protection along nine contingencies: medical care, sickness, maternity, old-age, work injury, invalidity, survivors, family allowances, and unemployment.

The state of social protection in ASEAN is very diverse: five countries have statutory schemes covering at least six social security policy areas while several are still in the process of developing their social protection systems.

Overall, the state of social protection in the ASEAN region can be characterized as diverse. Table A provides an overview of the national social security system in the ten Member States

based on the existence of statutory programmes anchored in national legislation, across the nine social security policy areas. Thailand is the only Member State with a comprehensive scope of social security legal coverage with at least one statutory programme in each social security policy area. Viet Nam has legal coverage for eight out of nine contingencies, lacking statutory programmes offering family allowances. The Lao People's Democratic Republic and the Philippines have in place statutory schemes for seven social protection policy areas, excluding family and unemployment benefits. Singapore offers protection in six policy areas while the remaining ASEAN countries possess a more limited scope in legal coverage with statutory programmes in fewer than six social security policy areas. Nonetheless, legal coverage is only one of the important elements used to analyse the provision of social protection. Country differences become more pronounced when observed in detail.

Table A. Overview of national social security systems in ASEAN

Country	Existence of statutory programme								
	Medical care	Sickness (cash)	Maternity (cash)	Old-age	Work injury	Invalidity	Survivors	Family allowances	Unemployment
Brunei Darussalam	Ω	Σ	Σ	✓	✓	✓	✓	None	None
Cambodia	⊠	None	Σ	⊠	✓	⊠	⊠	None	Σ
Indonesia	✓	Σ	Σ	✓	✓	✓	✓	None	Σ
Lao PDR	✓	✓	✓	✓	✓	✓	✓	None	⊠
Malaysia	Ω	Σ	Σ	✓	✓	✓	✓	None	Σ
Myanmar	✓	✓	✓	⊠	✓	⊠	⊠	⊠	⊠
Philippines	✓	✓	✓	✓	✓	✓	✓	None	Σ
Singapore	✓	Σ	Σ	✓	✓	✓	✓	✓	None
Thailand	✓	✓	✓	✓	✓	✓	✓	✓	✓
Viet Nam	✓	✓	✓	✓	✓	✓	✓	None	✓

None: No statutory programme anchored in national legislation.

✓ At least one programme anchored in national legislation.

Ω Medical benefit in kind without statutory programme anchored in national legislation.

Σ Limited provisions via employer's liability under national labour code (includes company sick leave and severance pay provisions).

⊠ Programme has yet to be implemented.

Sources: Brunei Darussalam: Employment Order 2009, Workmen's Compensation Act 1957 (Revised 1984), Tabung Amanah Pekerja Act, Old age, Disability Pensions Act 1955; Cambodia: Law on Social Security 2002, Labour Law 1997; Indonesia: Law on the National Social Security System 2004, Law on Social Security Providers 2011, Manpower Act 2003, Presidential Regulation No. 12/2013 on Health Insurance; Lao PDR: Law on Health Care 2005, Decree on National Health Insurance 2012, Law on Social Security 2013, Labour Law 2006; Malaysia: Employment Act 1955, Employment (Amendment) Act 2012, Employees Social Security Act 1969, Employee Provident Fund Act 1991, Workmen's Compensation Act 1952; Myanmar: Social Security Law 2012, Workmen's Compensation Act 1923; Philippines: National Health Insurance Act of 1995, National Health Insurance Act of 2013, Social Security Act 1997, Labour Code 1974; Singapore: Medical and Elderly Care Endowment Schemes Act 2000 (Revised 2001), Central Provident Fund Act 1955 (Revised 2013), Employment Act 1968 (Revised 2009), Child Development Co-Savings Act 2001 (Revised 2002); Thailand: National Health Security Act, B.E. 2545 (2002), Social Security Act B.E. 2533 (1990), Workmen's Compensation Act B.E. 2537 (1994); Viet Nam: Law on Health Insurance 2008, Law on Social Insurance 2014, Law on Employment 2013, Labour Code 1994.

Towards universal health coverage

All ASEAN Member States have committed to achieve universal health care through the establishment of tax-funded health care system and the extension of social health insurance. Efforts to improve equity, access, and quality are still necessary.

The regional review of access to health care in Chapter 2 has brought to light a common “ASEAN social protection guarantee” in the form of universal health coverage. It is seen as a crucial factor in poverty reduction and the provision of access to essential health care. At least four ASEAN Member States have achieved (near) universal health coverage through a predominantly general tax-financed national health care system (Brunei Darussalam, Malaysia, and Thailand) and mandatory contribution-based health care system with a social assistance component for those in need (Singapore). Other ASEAN Member States have set specific targets for achieving universal coverage: Viet Nam (by 2014), the Philippines (2016), Indonesia (2019), the Lao People’s Democratic Republic (2020), and Myanmar (2030).

Seven ASEAN countries (Indonesia, the Lao People’s Democratic Republic, Myanmar, the Philippines, Singapore, Thailand, and Viet Nam) have in place contributory-based social health insurance for formal economy employees. Some have achieved success in extending social health insurance coverage to the poor and socially disadvantaged through premium subsidization and simplified enrolment procedures (for example, Indonesia, the Philippines, and Viet Nam). Their continual success on a voluntary-basis beyond the poor and to the larger informal economy is unclear. In the example of Thailand, universal health coverage was eventually achieved by switching from the pure contributory system approach to a mixed approach with tax revenues used to extend health care coverage to the large informal economy.

Even with “nominal” health coverage, the lack of access to quality and affordable services can result

in low service utilization among the poor and vulnerable, and/or high out-of-pocket health expenditure. Out-of-pocket health payments as a percentage of total health expenditure range from 8 per cent for Brunei Darussalam to 71 per cent for Myanmar. Physical barriers to health care access still afflict many ASEAN communities living in remote, difficult-to-access areas. Equally important next to monetary cost coverage are supply-side provisions and regulatory mechanisms such as accessible health services in rural areas, the training of medical staff, and price control of services and drugs.

Social protection for children

Every ASEAN Member State provides virtually free primary education. Complementary benefits such as nutrition, child care, and income support programmes are still limited to the very poor households.

Universal primary education is another potential “ASEAN social protection guarantee” revealed in Chapter 3 with every ASEAN Member State providing virtually free primary education which helps sustain high gross enrolment rates (more than 90 per cent) at the start of primary school. The regional average primary school completion rate within the region (excluding Thailand due to lack of data availability) is high at 85.7 per cent. At the same time, there are large differences in socioeconomic factors, school quality, and other barriers which affect a child’s probability of completing primary school and obtaining the necessary literacy skills. Disproportionately affected are children in rural areas (in particular those of ethnic minority background) and/or from poor families.

Nutrition and income shocks can have long-term irreversible effects on child health and education outcomes. Healthy and well-educated children grow up to be labour productive and collectively drive a country’s socioeconomic development. Among ASEAN countries, the proportion of children under five years being underweight ranges widely from 3 per cent in Singapore to 29 per cent in Cambodia with the regional

average at 18.4 per cent. All ASEAN Member States have some form of school feeding programme for school-age children and cash benefit schemes to assist households in reducing the negative effects of chronic low income and income shock on children.

Cash benefit schemes targeting families with children can indirectly support children's nutritional outcomes while school feeding programmes directly contribute to school-age children's nutrition. All ASEAN Member States have such schemes, most of which are means-tested social assistance. Some of the cash benefit programmes are tied to obligations such as ensuring school attendance, immunization, and/or health check-ups. Childcare is still primarily perceived to be a responsibility of the child's family in ASEAN countries (with the exception of Singapore), therefore policies and schemes aimed at supporting childcare are very much limited. Although every Member State has established early child care and education (ECCE)-specific national legislation and/or policies, major gaps exist in public funding, coverage especially among marginalized communities and the very young (age 0 to 3 years), and training for teachers and caregivers.

Ensuring income security and access to decent work

Social protection for the working population is mainly limited to the formal economy. Employers' liability, with its shortcomings, remains the predominant practice in case of maternity, sickness, and loss of employment, while social insurance schemes for occupational injury and diseases are typical across ASEAN.

Chapter 4 focuses on the income security of the working age population – in particular for the contingencies of occupational injury and diseases, sickness, maternity, and unemployment – and active labour market policies as complementing instruments. Unlike the former two social protection floor guarantees related to health and children, social protection for this subgroup is

largely mixed in terms of outcomes such as level of coverage and financing mechanisms like employer's liability versus social insurance systems.

Legal coverage rates of work injury schemes – most of which are social insurance-based – range from a low 6.7 per cent in the Lao People's Democratic Republic to a high 88.0 per cent in Brunei Darussalam, with the ASEAN regional average (excluding Myanmar) at 46.2 per cent. The low legal coverage rates in low- and medium-income countries of ASEAN are partly due to the exclusion of self-employed and informal economy workers who make up the majority of workers – as of 2014, 58.8 per cent of the ASEAN workforce is in “vulnerable employment”. Other exceptions to statutory insurance coverage involve employees working under short contracts (defined as less than three months duration in Viet Nam), small firms (with fewer than eight employees in Cambodia or fewer than five employees in Myanmar), or non-manual work above a salary threshold (monthly earnings above 3,000 ringgit (MYR) in Malaysia and at least 1,600 Singapore dollars (SGD) in Singapore). Furthermore, effective coverage rates are even lower without government-enforced compliance and for voluntary schemes.

Paid sickness and maternity leaves are provided to varying extents in ASEAN countries with two dominant scheme types: employer's liability and social insurance. Both are considered employer's liabilities under the related labour laws of Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Singapore, and Thailand. For maternity benefit provision, an employer's liability system can be a source of workplace discrimination through hiring and dismissal policies against women of childbearing age. Employers may prefer to evade the costs of maternity allowances and temporary staff replacement. And like most employer-liability provisions without a strong compliance enforcement system, it is subject to the risk of non-payments. The employer-liability system also undermines the principles of solidarity and social redistribution across enterprises, economic

sectors, social and income classes, and geographical regions.

In the ASEAN region, two countries – Thailand and Viet Nam – have introduced unemployment or employment insurance schemes. Unemployment benefit is part of the national social security legislations of the Lao People’s Democratic Republic and Myanmar but awaits further implementation plans. Public works programmes and active labour market policies such as skills training and rehabilitation are relatively new in the ASEAN region with limited coverage.

Preparing for old-age

Most ASEAN countries have in place some form of pension scheme, however, the bulk of populations do not possess sufficient income security for their old-age.

Despite increasing old-age dependency ratios, Chapter 5 shows that the bulk of ASEAN populations do not possess adequate, if at all, pension benefits or savings for the present and the future. The regional average coverage rate of pensionable persons receiving monthly pension (excluding Myanmar) is 29.9 per cent. In addition, the elderly and their families are left unprotected from the high costs of health care and long-term care services, leaving them vulnerable to poverty.

In Brunei Darussalam and Thailand, every older person has access to at least a minimum pension either through contributory or tax-financed schemes. In Indonesia, Malaysia, the Philippines, Singapore and Viet Nam, around half of the working populations are currently contributing for their old-age pension or provident funds, with some of these five countries providing a minimum pension to narrow age- or means-targeted groups. The Lao People’s Democratic Republic’s pension scheme covers a small group of formal workers while Cambodia and Myanmar have yet to implement national pension schemes for the private sector although legal provisions are already in place.

Non-contributory pension schemes are popular as a last resort measure for ensuring income security among the elderly, particularly women, and they can be means-tested (Indonesia, Malaysia, Philippines, and Viet Nam), pension-tested (Thailand and Viet Nam), or universal (Brunei Darussalam). Social pension schemes that currently exist in six ASEAN countries disburse monthly benefits ranging from 44 to 729 per cent of the US\$1.25 poverty line or in aggregate, 5 to 10 per cent of the respective country’s gross domestic product (GDP) per capita. Social pensions that aim for universal coverage in Brunei Darussalam and Thailand appear to be most successful in terms of ensuring full legal coverage and very high (more than 80 per cent) effective coverage.

Apart from providing income security and reducing the incidence of old-age poverty, the secondary function of pension is to maintain one’s living standards by smoothing consumption, that is, redistributing income over one’s lifetime. Mandatory provident fund schemes (found in Indonesia, Malaysia, and Singapore) tend to exhibit on average lower replacement rates compared to social insurance pension schemes (implemented in the Lao People’s Democratic Republic, the Philippines, Thailand, and Viet Nam) and do not allow for redistribution across gender, generation, enterprises, economic sectors, social and income classes, and geographical regions. Three ASEAN Member States – Malaysia, Singapore, and Thailand – have introduced voluntary “third pillar” saving schemes to increase the adequacy of existing pension schemes. Other important factors to encourage old-age income security include the periodic disbursement of income benefits instead of lump sum withdrawals, preferably with indexation to price inflation and wage growth. Regular actuarial evaluations of retirement funds are important to assist the financial sustainability of pension systems.

In the ASEAN region, family-based provision of income and care for the elderly is still prevalent with the majority of elderly co-residing with their children. For this reason, government provision

of long-term care for the elderly is meagre in ASEAN countries and the public residential care homes considered only as a contingency measure for the underprivileged or “abandoned” minority.

Cross-cutting issues influencing the effectiveness of social protection

Effective social protection in ASEAN still requires improvements in coordination among ministries and agencies at the design and implementation levels.

Despite the diversity found across ASEAN countries, the study reveals several prevailing cross-cutting issues in social protection in Chapter 6. They include: (i) inter-agency coordination at various levels; (ii) the persistent gender gap in social protection coverage; (iii) coverage of migrant workers in social protection schemes; and (iv) common threats in the form of natural disasters and climate change.

ASEAN Member States have attempted to improve inter-agency coordination at various levels in the design and implementation of social protection schemes through: (i) the adoption of a national social protection strategy or policy; (ii) the consolidation of existing schemes into a national system; (iii) a central coordination agency for social protection programmes; (iv) the establishment of centralized database of (prospective) beneficiaries; and (v) ASEAN-level coordination. Coordination and consolidation help improve complementariness and reduce duplication among fragmented social protection-related programmes, agencies (line ministries, local implementers, development partners, and so forth), and sources of funding (such as insurance premiums, general tax revenues, and donor aid). At the same time, progress has been made at the regional-level in terms of developing normative frameworks for extending social protection in the region, the most significant achievement being the 2013 ASEAN Declaration on Strengthening Social Protection.

Many women are engaged in informal work that affects their access to social protection. Non-contributory schemes are more gender-inclusive.

Across ASEAN Member States, the gender gap in labour market participation rate varies widely – the largest gap of 33 per cent in Indonesia is more than ten times that of the smallest gap of 3 per cent in the Lao People’s Democratic Republic. Even so, women are overrepresented on informal work such as domestic and care giving work that is typically beyond the remit of national labour laws thus affecting their labour rights and income security. Non-participation in the labour market, the formal economy in particular, effectively limits these women’s rights to social security benefits to that of dependents or survivors (in the event of the death of breadwinner). This is an extremely precarious position in countries that lack non-contributory benefit schemes.

Within the ASEAN region, intraregional migration has increased fourfold between 1990 and 2013. However, most migrant workers do not have adequate, if at all, access to social protection.

Within the ASEAN region, intraregional migration increased fourfold between 1990 and 2013. Six Member States – Indonesia, Malaysia, Myanmar, the Philippines, Thailand, and Singapore – have ratified the ILO Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19), that provides occupational injury protection for non-national workers. Yet, conditions are far from equal. First, many migrant workers are undocumented. Second, even for the documented migrant workers in the formal economy, they are excluded from various social protection policies and schemes. In recent years, the main receiving ASEAN countries – Brunei Darussalam, Malaysia, Singapore, and Thailand – have lowered public subsidization of non-nationals at

public health facilities by reducing hospital subsidies for non-nationals or obliging mandatory take-up of private insurance.

ASEAN is one of the most vulnerable regions to natural hazards; several Member States have started integrating social protection as part of the disaster response.

The ASEAN region is also one that is most vulnerable to natural hazards. With the confluence of several factors – geophysical characteristics, high population density, poverty, and ill-equipped infrastructure – the region suffers high costs in terms of human mortality, physical destruction, and economic loss. For some Member States, social protection schemes are increasingly integrated into the broader natural disaster response framework. Examples include: (i) disbursement of social assistance cash benefit to the affected; (ii) increase in cash benefit via the modification of parameters within the existing social security system; (iii) subsidization of private sector employment; and (iv) public works programmes that provide income, skills training and access to social protection and workplace safety.

Way forward

For a people-centred ASEAN community, Member States need to speed up the implementation of national social protection floors.

Chapter 7 details a few key recommendations aimed at fortifying the implementation process of the ASEAN Declaration on Strengthening Social Protection based on the comprehensive assessment of the state of social protection. These recommendations are also inspired by the international standards on social security, in particular the ILO Social Security (Minimum Standards) Convention, 1952 (No.102) and the Social Protection Floors Recommendation, 2012 (No. 202).

Several ASEAN countries have implemented legal and policy reforms to expand mandatory and voluntary coverage in order to widen the population coverage of social protection schemes. For example, legal coverage of some social protection schemes has been extended to self-employed and/or informal economy workers in eight out of ten Member States. However, most of the participation is offered on a voluntary basis so ASEAN countries will need additional measures such as simplified enrolment and subsidized contributions to improve effective coverage among this neglected group. Another factor contributing to the extension of social insurance coverage is the formalization of employment, most commonly with a labour contract, as seen in the examples of domestic workers in Viet Nam and the Philippines. Other methods for the extension of social coverage to the informal economy have been outlined in the new ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204).

Risk pooling and social solidarity aspects of social protection systems are crucial and can be achieved through social insurance and tax-funded schemes.

A national social protection system with full coverage based on general taxation and social insurance principles can allow for risk pooling and redistribution of risks across demographic and socioeconomic groups and geographical regions. Besides the rationale of social justice, risk pooling can contribute to fund sustainability, particularly for social health insurance funds. In the case of pension savings, the lack of risk pooling in provident fund schemes exposes one to longevity risks (that is, outliving one's retirement savings) or changes in purchasing power that occur over time.

Better coordination of social protection interventions will increase outreach and efficient use of resources.

Concrete tools and processes can be developed to reduce the overlapping functions of different programmes and inefficient use of resources, and to exploit possible synergies (for example, combining benefit packages to simultaneously address the various dimensions of poverty). These tools include: (i) a coordination mechanism; (ii) an inter-agency registry of beneficiaries; and (iii) implementation of shared delivery facilities. In the context of administrative decentralization reforms taking place in some Member States (Indonesia and Cambodia), subnational authorities have increased responsibilities to deliver social services though many still lack administrative capacity, resources (trained staff in particular), and clear guidance from the higher administrative level(s). Maintaining the present momentum in coordination and harmonization alongside increasing administrative capacity would be key ingredients to the effective implementation of social protection.

Success of social protection schemes relies heavily on the participation of social partners in their design, implementation, and evaluation.

Engagement of social partners at all regional, national, and subnational levels has several positive effects, among others: to raise awareness of social protection programmes among workers and employers; to secure their compliance and financial commitment in contributory schemes; to improve accountability, transparency and good governance of the funds; and to assist in the successful design and monitoring of schemes. One of the main advantages of the Assessment Based National Dialogue (ABND) process is the participatory approach involving, from the very beginning, all relevant stakeholders. The consultation process aims to create a sense of ownership among all stakeholders while they are sensitized to the importance of social protection, easing the path towards a consensus on priorities for extending social protection. At the ASEAN-level, peer-to-peer learning among social partners can be encouraged through sharing of good practices, policy experiences, and innovative solutions.

Monitoring and evaluation of social protection policies is lacking at national- and ASEAN-levels. It is important to build a shared denominator across the ASEAN countries.

A system of monitoring and evaluation should be in place alongside policy design and implementation. For this, ASEAN Member States should embrace a comprehensive monitoring framework with relevant indicators across all social protection guarantees that could be populated feasibly and consistently over time. In addition to indicators, objective targets are indispensable for the evaluation of progress. Indeed, the ASEAN Declaration on Strengthening Social Protection calls for “assessment tools”, “regional statistical indicators”, and “benchmarking of social protection delivery services” to monitor and evaluate the implementation of social protection in Member States. Here again, this report acts to provide crucial baseline information in the advent of regional integration under the ASEAN Community.

Creating the fiscal space for social protection floors is a question of political will.

Most importantly, previous research and assessments have shown that even in low-income countries, national capacity exists for additional public investments in social protection. The financial impact on the national budget can be spread out over time by sequencing the implementation of further extensions of the social protection floor guarantees. In ASEAN, social protection expenditure varies widely from less than 1 per cent of GDP to 7.2 per cent of GDP. The ABND scenario cost estimates for social protection floor extensions (from the status quo social protection provisions) range from an additional 0.7 to 2.5 per cent of the GDP by the end of the projection period in 2020 for Indonesia; between 0.5 to 1.2 per cent of GDP in 2020 for Thailand; and between 2.2 and 7.2 per cent of GDP in 2024 for Myanmar. Supplementary fiscal space can be created by various means such as reallocation of public expenditures, revenues generation through contribution-based schemes, and reduction in

illicit financial flows. Social protection for all in the ASEAN region is affordable, feasible, and essential for inclusive development and social

justice, and should be unremittingly strengthened alongside deepening integration under the 2015 ASEAN Community.

Key messages

- While the need for social protection has been affirmed in the ASEAN Declaration on Strengthening Social Protection, the fundamental human right to social security remains only partially fulfilled for the large majority in the region.
- Five ASEAN countries have statutory schemes covering at least six out of nine social security risks. One Member State – Thailand – has a comprehensive legal scope with statutory programmes in every social security policy area.
- Four out of ten ASEAN Member States have achieved (near) universal health coverage with the remaining Member States committed to achieving it in the near future. However, large discrepancies persist between and within Member States in terms of out-of-pocket health expenditure, availability and accessibility of health services, quality, and financial sustainability.
- Universal primary education is another potential “ASEAN social protection guarantee” with every Member State providing virtually free primary education and the regional average primary school completion rate is high at 85.7 per cent. Additionally, every ASEAN Member States has some form of school feeding programme for school-age children and cash benefit schemes that target families with children. Conspicuously absent within the region (with the exception of Singapore) are policies and schemes aimed at supporting childcare.
- Overall, the provision of income security for the working age population is still very much left to employer’s liability in many ASEAN Member States. At least half rely on employer’s liability to provide income benefit in the event of sickness or maternity, while unemployment benefit is only provided in Thailand and Viet Nam. The drawbacks of an employer-liability system include the lack of state guarantee in provision of benefits which exposes households and small enterprises to income shocks, and in the case of maternity benefits, female workers of childbearing age may face employment discrimination.
- Legal coverage rates of work injury schemes – most of which are social insurance-based – range from a low 6.7 per cent to a high 88.0 per cent among nine ASEAN countries (excluding Myanmar) with a regional average of 46.2 per cent. Effective coverage is far lower due to lack of voluntary coverage, compliance enforcement, and exemptions in compulsory social insurance coverage that can be used as legal loopholes for employers and employees to avoid social contributions.

- The regional average coverage rate of pensionable persons receiving monthly pension (excluding Myanmar) is 29.9 per cent. Statutory pension schemes in the ASEAN region are either provident saving funds (Indonesia, Malaysia, and Singapore), social insurance schemes (the Lao People's Democratic Republic, the Philippines, Thailand, and Viet Nam), or a combination of both (Brunei Darussalam). On average, mandatory provident fund schemes tend to exhibit lower replacement rates compared to social insurance pension schemes in the region and they do not allow for social redistribution across gender, generation, and income groups. Non-contributory social pension schemes, whether means-tested or not, increase a country's level of effective pension coverage.
- In recent years, ASEAN Member States have attempted to improve inter-agency coordination at various levels in the design and implementation of social protection schemes. For some Member States, social protection schemes are increasingly integrated into the broader natural disaster response framework. Overall within ASEAN, progress with respect to the equal social protection of women and migrant workers has been piecemeal and less promising.
- Despite the regional trend towards the extension of social protection, more can and should be done, especially in light of further regional integration under the ASEAN Community by 2015. The ILO Social Protection Floors Recommendation, 2012 (No. 202), provides practical guidance for setting national social protection floors and building progressively comprehensive social security systems based on the multilateral consensus reached among governments, social partners, and other key stakeholders. Previous national experiences have shown that social protection floors in the ASEAN region are affordable, feasible, and essential for inclusive development and social justice.

Abbreviations

ABND	Assessment Based National Dialogue
ACDM	ASEAN Committee for Disasters Management
ADB	Asian Development Bank
AEC	ASEAN Economic Community
AFEED	ASEAN Framework for Equitable Economic Development
AHA	ASEAN Coordination Centre for Humanitarian Assistance
ALMP	active labour market policy
APSC	ASEAN Political Security Community
ASCC	ASEAN Socio-Cultural Community
ASEAN	Association of Southeast Asian Nations
BDT	Basis Data Terpadu
BLT	Bantuan Langsung Tunai
BNPB	National Board for Disaster Management
BPJS	Badan Penyelenggara Jaminan Sosial
BSM	Bantuan Siswa Miskin
CARD	Council for Agricultural and Rural Development
CBEP	Community-based Employment Program
CCT	conditional cash transfer
CLMV	Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam
CMHI	Compulsory Migrant Health Insurance
CPF	Central Provident Fund
CSMBS	Civil Servants Medical Benefit Scheme
DILEEP	DOLE Integrated Livelihood and Emergency Employment Program
DJSN	Dewan Jaminan Sosial Nasional
DOLE	Department of Labor and Employment
DOLISA	Departments of Labor, Invalids, and Social Affairs

ECCE	early child care and education
EFAP	Emergency Food Assistance Project
EPF	Employees Provident Fund
FAO	Food and Agriculture Organization
G20	Group of Twenty
GDP	gross domestic product
GIP	Government Internship Program
GSIS	Government Service Insurance System
GST	Goods and Services Tax
HCS	Health Card Scheme
HEF	Health Equity Funds
HIP	Health Insurance Project
IDAPE	Interim Disability Assistance Program for the Elderly
IDPoor	Identification of Poor Households Programme
ILO	International Labour Organization
Jamkesda	Jaminan Kesehatan Daerah
Jamkesmas	Jaminan Kesehatan Masyarakat
Jamsostek	Jaminan Sosial Tenaga Kerja
JHT	Jaminan Hari Tua
JKN	Jaminan Kesehatan Nasional
KiFAS	Kindergarten Fee Assistance Scheme
Lao PDR	Lao People's Democratic Republic
LMIs	labour market interventions
MDG	Millennium Development Goal
MOLISA	Ministry of Labour, Invalids, and Social Affairs
MoU	memorandum of understanding
NBDM	National Board for Disaster Management
NDRRMC	National Disaster Risk Reduction and Management Council
NGO	non-governmental organization
NHS	National Health Services
NSSF	National Social Security Fund
OECD	Organisation for Economic Co-operation and Development
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OWWA	Overseas Workers Welfare Administration
PESOs	Public Employment Service Offices
PhilHealth	Philippine Health Insurance Corporation
PKH	Program Keluarga Harapan
POEA	Philippine Overseas Employment Agency
PWD	people with disability
SASS	State Authority for Social Security
SDG	Sustainable Development Goal
SER	social expenditure ratio
SFF	Social Security Fund
SJSN	Sistem Jaminan Sosial Nasional
SLOM	Senior Labour Officials Meeting

SOMHD	Senior Officials Meeting on Health and Development
SOMSWD	Senior Officials Meeting on Social Welfare and Development
SORDPE	Senior Officials on Rural Development and Poverty Eradication
SPF	social protection floor
SPOFS	Social Protection Operational Framework and Strategy
SSO	Social Security Organization
SSS	Social Security System
TAP	Tabung Amanah Pekerja
TESDA	Technical Education and Skills Development Authority
TUPAD	Tulong Pangkabuhayan sa Ating Disadvantaged Workers
TVET	technical and vocational education and training
UCS	Universal Coverage Scheme
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VAT	value added tax
VSS	Viet Nam Social Security
WFP	World Food Programme
WHO	World Health Organization

Social protection¹ has regained worldwide importance after the last global financial and economic crisis in 2008–09 and is set to be a prevailing theme in the decades to come.

The United Nations agreed on nine joint “One-UN” initiatives in April 2009 to respond to the global financial crisis – one of these is the Social Protection Floor Initiative (UNCEB, 2009). The Social Protection Floor Initiative recalls: social security is a universal human right which is yet to be fulfilled for a large majority of the world’s population. A social protection floor comprises basic, nationally defined social protection guarantees in the areas of health care and income security for children, those of working age, and the elderly. The concept of providing minimum social guarantees as part of a more inclusive global economy has since been endorsed internationally, notably by the Group of Twenty (G20) leaders (G20, 2011) and at the 101st session of the International Labour Conference where the Social Protection Floors Recommendation, 2012 (No. 202), was adopted. More recently in June 2014, the International Labour Organization and the World Bank launched a joint plan of action

on Universal Social Protection, in line with the other commitments for implementing nationally defined social protection floors (ILO and World Bank, 2015). The critical importance of social protection systems and floors was also acknowledged in one of the five targets of the first Sustainable Development Goal, “end poverty in all its forms everywhere” (Open Working Group, 2014), among others, (see box 1).

The case for striving towards minimum standards as a first step towards higher level of social protection is particularly strong – figure 1 illustrates how a nationally defined social protection floor could fill social protection gaps with universal coverage of basic social protection. Following the extension of social protection on the “horizontal dimension” (towards universal coverage), social protection should ideally be extended along the “vertical dimension” – that is, higher level of protection whether in terms of level of benefit or number of contingencies covered – as contributory schemes expands along with the fiscal and policy space of a country (Social Protection Floor Advisory Group, 2011).

¹ “Social protection” is considered the same as “social security” and defined as “*all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from (a) lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old-age, or death of a family member; (b) lack of access or unaffordable access to health care; (c) insufficient family support, particularly for children and adult dependents; (d) general poverty and social exclusion*” (ILO 2011b). Nonetheless, we acknowledge that within the ASEAN region, “social security” tends to be associated with contributory social insurance.

Box 1

Social protection within the Post-2015 Sustainable Development Goals

In September 2015, the UN General Assembly adopted the Post-2015 Development Agenda. Social protection is represented in the Sustainable Development Goals (SDGs) and Targets as follows:

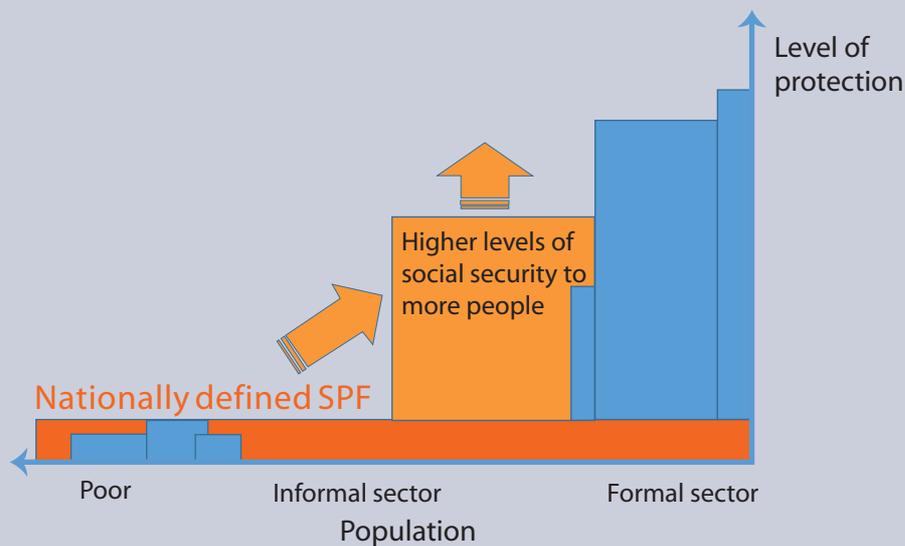
- Social protection and Social Protection Floors (SPFs) feature prominently in “Goal 1. End poverty in all its forms everywhere”. Under Target 1.3, it is proposed that countries “implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.”
- Under Goal 5, dedicated to achieving gender equality and empowerment for all women and

girls, social protection features as a strategy. Target 5.4 calls on countries to “recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies, and the promotion of shared responsibility within the household and the family as nationally appropriate”

- In order to reduce inequality within and among countries (Goal 10), Target 10.4 proposes that countries adopt “fiscal, wage, and social protection policies and progressively achieve greater equality”.

Source: Ortiz et al., 2014; Social Protection Floor Advisory Group Gateway website, www.socialprotectionfloor-gateway.org.

Figure 1. Social protection floor coverage



Source: ILO, 2012.

Social protection can protect against social risks and shocks while promoting investments in education, health, entrepreneurship, and other productive activities.² The magnitude of the

impact of social protection interventions cannot be understated – Fiszbein and colleagues (2014) estimate that between 136 and 165 million beneficiaries of social protection programmes

² Compare this to Guhan’s (1994) preventive, protective, and promotional functions of social protection and Devereux and Sabates-Wheeler’s (2004) “transformative” social protection which addresses the underlying power imbalances within a country, community, or household that create and sustain social deprivation for certain groups.

worldwide have been protected from falling into extreme poverty.³ From a macro perspective, social protection interventions can also provide short- and middle-term counter-cyclical support during economic downturns and in the long-term, transform the labour market and economic structures through investment in human capital (ILO, 2014d). Social protection can induce local demand and buffer the effects of international macroeconomic crises.

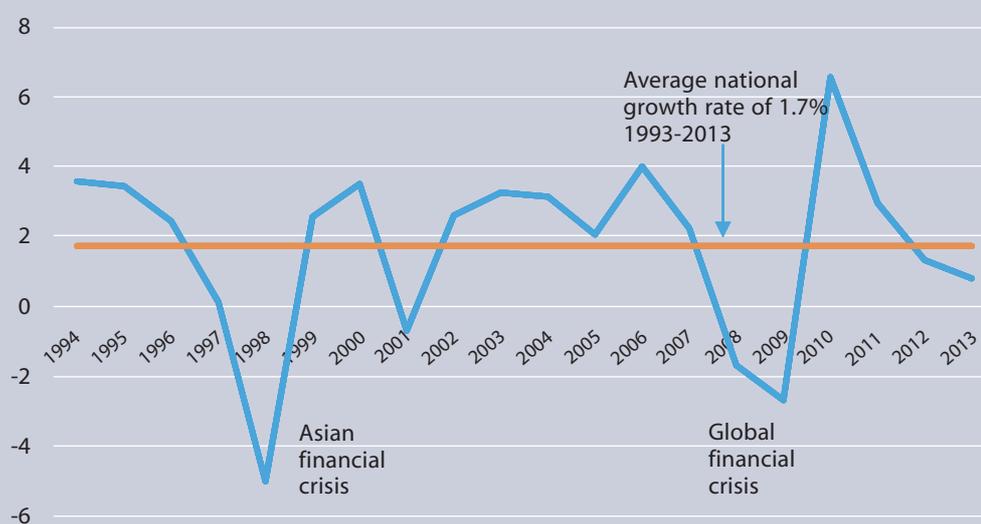
The ASEAN context

A recent ILO-ADB study (2014) estimates that 92 million in the ASEAN region do not earn sufficiently to escape poverty. Furthermore, the crisis in 2008–09 along with simultaneous food and fuel price shocks (see figure 2) have exposed the vulnerabilities of the majority of its population living below and just above the poverty line (ASEAN and World Bank, 2010).

It also highlighted the fact that the preceding economic growth period had not been accompanied with corresponding progress at the social protection front that could have helped cushion and reverse the adverse effects of the crisis. Noticeably missing were vital statistics on those affected, the severity of the crisis's effects, and information regarding effective social protection schemes and available service delivery mechanisms.

More recently, the ASEAN Economic Community will become a reality for the region's 600 million women and men by the end 2015. The unrestricted mobility of goods, services, investment capital, and skilled labour will affect the structure of ASEAN economies, stimulating innovation and productivity while at the same time, exacerbating inequality and worsening the plight of some, especially the lower skilled and migrant workers (ILO and ADB, 2014).

Figure 2. Average annual national growth rate in GDP per capita for nine ASEAN countries



Note: The average annual national growth rate in GDP per capita pertains to Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, the Philippines, Singapore, Thailand, and Viet Nam. Myanmar is excluded due to the lack of data.

Source: World Bank, International Comparison Program database.

³ In their analysis, Fiszbein et al., 2013 covered seven out of the ten ASEAN Member States: Cambodia, the Lao People's Democratic Republic, Malaysia, the Philippines, Singapore, Thailand, and Viet Nam. Under "social protection" interventions, they have included: contributory social insurance programmes (for example, pension), labour market interventions (for example, job training), and non-contributory social assistance programmes (for example, means-tested subsidies, humanitarian and disaster relief, school feeding, and labour-intensive public works).

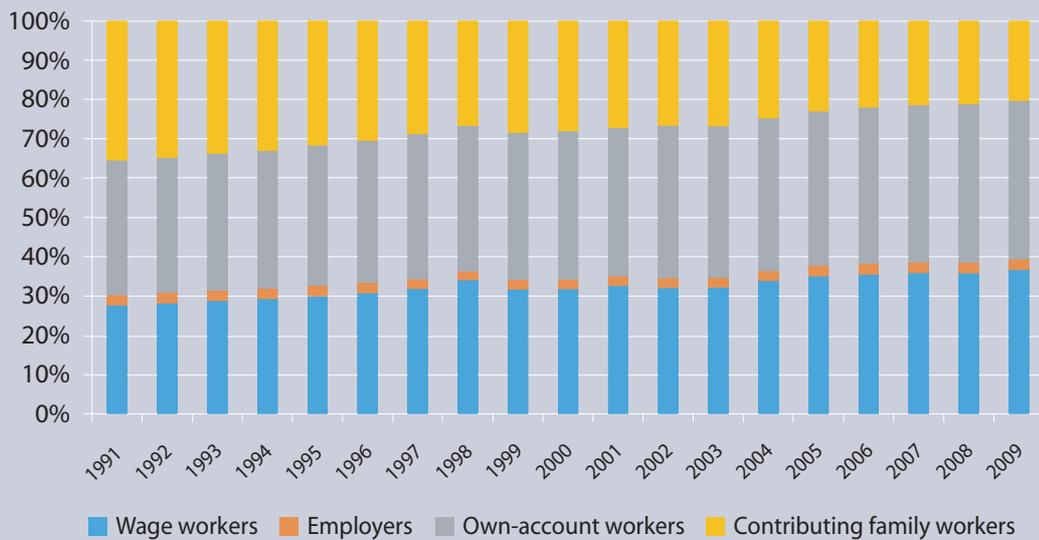
With such development ahead of ASEAN integration, social protection will play a crucial role by compensating for the short-term loss of income and facilitating access to education and skills which will improve workforce productivity and sustain economic growth in the longer term. While social protection is recognized as a key element for buffering the social impact of economic changes, the capacity for ASEAN countries to maintain and extend adequate social protection to all is of concern, especially with the new challenges posed by regional integration.

For the majority of the ASEAN Member States, social protection coverage still excludes large shares of populations, specifically those who are not formally employed and enrolled in social insurance schemes and are not recipients of social assistance. A major explanatory factor is the nature of social protection in the region. Social protection is primarily linked to formal economy employment and subject to legal coverage criteria such as the definition of “employees” who are covered under national labour codes and social security laws, and effective coverage issues such

as compliance and awareness of entitlements and schemes. The ASEAN workforce is still, on aggregate, dominated by own-account workers and contributing family workers who are considered to be in “vulnerable employment”⁴ because they are less likely to benefit from decent employment conditions, social protection coverage, and effective representation. The proportion of wage and salary workers in the ASEAN region has been growing slowly at the expense of contributing family workers and to a lesser extent, own-account workers (see figure 3). More recent estimates show that as many as 179 million or 58.8 per cent of the ASEAN workforce are vulnerably employed (ILO and ADB, 2014). It is crucial that the next steps in extending social protection address these neglected segments of the labour force and the challenges they face in relation to a contribution-based system.

With the social protection shortfalls exposed during the crisis in 2008–09 and the related advocacy efforts at the regional level, progress has been made in terms of developing normative frameworks for strengthening social protection in

Figure 3. Employment status in ASEAN countries, 1991 to 2009



Source: Data from ILO, 2015b.

⁴ Though a minority within the ASEAN workforce, small and micro enterprises are also susceptible to shocks and confront high relative burden of social contributions.

the region, such as the 2009 ASEAN Socio-Cultural Community (ASCC) Blueprint and 2007 Cebu Declaration on Migrant Workers. The most significant achievement nevertheless is the ASEAN Declaration on Strengthening Social Protection adopted by the Heads of State at the 23rd ASEAN Summit in Brunei Darussalam on 9 October 2013. It reaffirms Member States' commitment to build a socially responsible and people oriented ASEAN Community by 2015, notably, by fostering social protection floors in the region. The Declaration refers to the guiding principles prescribed by the Social Security (Minimum Standards) Convention, 1952 (No. 102) and the Social Protection Floors Recommendation, 2012 (No. 202).

Moving beyond aggregated figures and normative frameworks, the ASEAN region is in fact diverse in many ways, social protection being one of them. The ten countries are spread out across all national income categories with population sizes varying from less than 0.5 million in Brunei Darussalam to 252.8 million in Indonesia. The subject of extending and strengthening social protection could mean different objectives and interventions to different stakeholders or Member States. This however was anticipated in ILO Recommendation No. 202, which defines social protection floors to be “nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion”.

Methodology

This report is partially based on the national matrices of the assessment based national dialogue (ABND) on social protection conducted in seven ASEAN Member States: Cambodia, Indonesia, the Lao People's Democratic Republic, Myanmar, the Philippines, Thailand, and Viet Nam (see box 2). A systematic desk review was performed to compile the related social

protection information for the remaining three ASEAN Member States (Brunei Darussalam, Malaysia, and Singapore) and to update the ABND information. The main sources used include the following:

- National matrices from the assessment based national dialogue (ABND) on social protection and other resources from the *Social Protection Platform*;
- *World Social Protection Report 2014/15*;
- *Social Security Programmes throughout the World* database;
- *Social Protection Index* Database;
- Websites of ministries and other government agencies;
- Regional and country reports of the 2010 ASEAN assessment on the social impact of the global financial crisis; and
- Other sources provided in the *Bibliography* under *Data Sources*.

Additionally, the report also relies on the inputs from separate consultations among workers' and employers' organizations of the ASEAN Member States between August and November 2014, the ASEAN Tripartite Seminar on Strengthening Social Protection that took place in Bangkok, from 17 to 18 November 2014 and the ASEAN multi-sectoral⁵ consultation on social protection in Siem Reap, 8–9 December 2014.

For the purpose of this report, the existing social protection schemes are clustered according to the four social protection floor (SPF) provisions or nationally defined social protection guarantees in access to essential goods and services such as health care and income security for children, those of working age, and the elderly. Following the *World Social Protection Report 2014/15* (ILO, 2014g) methodology, social protection schemes can be evaluated according to what would be covered in terms of:

⁵ These ASEAN sectoral bodies include: ASEAN Committee for Disasters Management (ACDM), Senior Labour Officials Meeting (SLOM), Senior Officials Meeting on Social Welfare and Development (SOMSWD), Senior Officials Meeting on Health and Development (SOMHD) and Senior Officials on Rural Development and Poverty Eradication (SORDPE).

- definition of the contingency (what must be covered?);
- persons protected (who must be covered?);
- type and rate of benefits (what should be provided?);
- entitlement conditions, including qualifying period (what should a person do to get the right to a benefit?); and
- duration of benefit and waiting period (how long must the benefit be paid/provided for?).

There is also no single means or way of achieving social protection floors, for example, how a country finances its health care or pension system, or if a scheme should be means-targeted or universally available. Nonetheless, some

approaches have been shown to be more effective than others in attaining social protection outcomes. One of the advantages of a cross-country comparison is to seek out best practices and key lessons from different countries. By evaluating the pros and cons, and success (or its lack of) of the various social protection schemes in ASEAN Member States, stakeholders can then make recommendations based on the Member States' respective policy experiences in achieving social protection floors.

The national assessments produced during the assessment based national dialogues (ABND) conducted in many ASEAN countries significantly contributed to this report. Box 2 delineates the ABND objectives, process, and outcomes. The centrality of “nationally defined”

Box 2

Assessment Based National Dialogue on social protection

Social security systems, as prescribed by the Social Security (Minimum Standards) Convention, 1952 (No. 102) should mirror national cultural and historical values and align with national economic and social development plans while accounting for national institutional capacities. The assessment based national dialogue (ABND) on social protection is an exercise aimed at designing the nationally defined social protection floor (SPF) for a country. There are several steps in the assessment beginning with a stocktaking of existing social protection schemes and measures, especially in terms of policy gaps and coverage. Measuring coverage rate identifies subgroups of the target population – often the socially disadvantaged and vulnerable – who are not benefiting from the respective social services and/or transfers.

More importantly, at the core of the ABND exercise is the multilateral national dialogue among representatives from the government, trade unions, employers' associations, civil society, and development partners. Engaging key stakeholders from different segments of society allows for a more holistic attempt to establish a country's social protection floor. This is an essential process for schemes that are jointly financed, for instance by the

government, workers, and/or employers. Even when co-financing is not the case, the forum makes way for discussions on the relevant direct and indirect effects of specific policy schemes on society, in particular the labour market. Based on the inventory of existing schemes, stakeholders can formulate innovative ways to fill the gaps in policy and coverage while minimizing inefficient scheme overlaps and implementation bottlenecks.

An essential step of the assessment is the cost calculation of the diverse policy options, whether they involve continuing current policy schemes, updating them with more inclusive and effective measures, or introducing new policy interventions. Quantifying the cost of policy options while simulating their respective impacts on poverty and other outcomes helps guide the multilateral dialogue in choosing desirable, feasible, and long-term sustainable policies. While deciding on policy options that will lead the country towards its social protection floor, stakeholders should collectively account for issues of main operating actors, cost and financing structure, service delivery framework, potential challenges, and sustainability. This lends the ABND policy conclusions the necessary political legitimacy and broader support.

Source: Schmitt and De, 2014.

social protection in the ABND coincides with the 2013 ASEAN Declaration on Strengthening Social Protection which aims to:

... adhere to the following principles that are applied in accordance with the domestic laws and policies of respective ASEAN Member States, nationally-defined social protection and its national priorities, and adapted to the different contexts of ASEAN Member States.

Defining “social protection”

The ASEAN Declaration on Strengthening Social Protection adopted in 2013 recognizes the key role of evidence-based national assessments and benchmarking of social protection delivery services in contributing to the “progressive implementation, effective monitoring and evaluation, as well as optimum impact of social protection”. Social protection indicators are typically used to assess the effectiveness (for example, in terms of population coverage, benefit adequacy, and risks covered), efficiency, and sustainability of existing policies and to identify possibilities for further extension (or contraction) in future policymaking.

The national assessments map existing social protection schemes with corresponding indicators that would contribute to the monitoring of social protection extension. From an ASEAN perspective, the extension of social protection can take place within the same country or across Member States. But with the heterogeneity of social protection systems in the region, an ASEAN regional assessment of social protection would require a minimum set of comparable or harmonized key indicators to monitor the regional advancement in social protection.

Determining which policies fall under “social protection schemes” is an initial challenge of this regional exercise. The Asian Development Bank’s

Social Protection Index, for instance, excludes microfinance and general infrastructure projects since they do not involve a cash or in kind transfer (ADB, 2013). A joint ASEAN-World Bank report on the social impact of the 2008 global financial crisis included microfinance initiatives but excluded infrastructure projects (unless they function as public works programmes) and disaster relief interventions (ASEAN and World Bank, 2010). The structure of this report follows the national social protection floor’s four basic social security guarantees that have been advocated under Recommendation No. 202:

- access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
- basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- basic income security, at least at a nationally defined minimum level, for older persons.

Only schemes involving official collaboration with the national government are considered in this report, particularly where donor agencies, international organizations, and/or non-governmental organizations play a significant role in social protection. This works under the assumption that these policies, if successful, would eventually be scaled up by the government to the national level, thus ensuring long-term policy sustainability and impact on social protection outcomes.

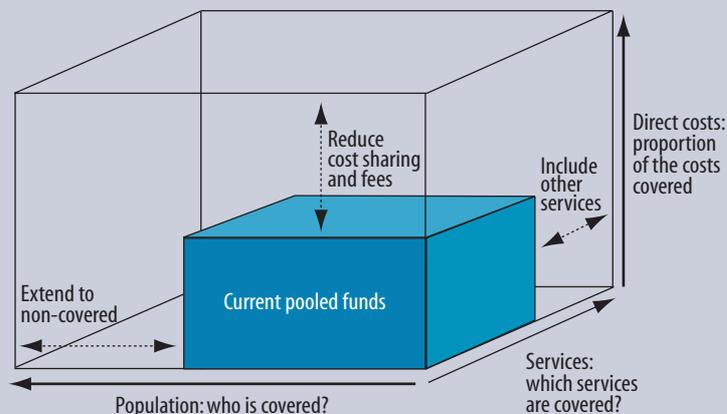
Health, in its good form, is a mental, physical, and social resource and a basic human right under the Universal Declaration of Human Rights (1948, Article 25). Three of the eight Millennium Development Goals (MDG) are health-related: reducing child mortality (MDG4), improving maternal health (MDG5), and combating HIV/AIDS, malaria, and other diseases (MDG6). Health or well-being is also one of the 17 Sustainable Development Goals (SDG) to “ensure healthy lives and promote well-being for all at all ages” (Open Working Group, 2014). Provisions for curative and preventive medical care have also been prescribed under the ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130).

The regional review of social protection has brought to light some potential for an “ASEAN social protection floor”: for instance, universal health coverage which corresponds to the first guarantee of the social protection floor under Recommendation No. 202. ASEAN and its key partners (Japan, the Republic of Korea, and China) have expressed their commitment towards universal health coverage at the 5th ASEAN+3 Health Ministers Meeting in 2012. Universal health coverage is seen as a crucial factor in poverty reduction and the provision of access to essential health care (WHO, 2013). Five ASEAN

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“The social protection floors [...] should comprise at least the following basic social security guarantees:

- (a) **access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;**
- (b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
- (c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- (d) basic income security, at least at a nationally defined minimum level, for older persons.”

Figure 4. The three dimensions of universal health coverage

Source: WHO, 2010b, p.12.

Member States have set specific targets for achieving universal coverage: Viet Nam (by 2014¹), the Philippines (2016²), Indonesia (2019), the Lao People's Democratic Republic (2020), and Myanmar (2030).³

To ensure that households receive the health care they need while being protected from the potential impoverishing effects of health care spending, the World Health Organization (WHO) offers three critical questions when assessing coverage: (i) who is covered; (ii) what services are covered; and (iii) how much of the cost is covered (see figure 4). Achieving universal health coverage would thus entail the extension of coverage and range of services, and the reduction of out-of-pocket payments, especially catastrophic expenditures.

Besides universal health coverage, the quality of health services is an equally important dimension in evaluating access to essential health care⁴ and

is prescribed by Recommendation No. 202. Examples of indirect indicators for quality of health services include per capita health expenditure and maternal mortality (Scheil-Adlung and Bonnet, 2011). Besides its effects on health outcomes, quality of services can also affect access and service utilization. One case example could be middle-income households avoiding free but poor quality public health care, preferring instead to pay for private health care. Equity between households becomes a key concern in a two-tier health care system where basic public health care is utilized primarily by the poor and marginalized who do not have alternate options, while higher quality private health care is available only for the socially advantaged.

Population coverage

Four ASEAN Member States have achieved (near) universal health coverage through general tax-financed national health care systems (Brunei

¹ This target stipulated under the Law on Health Insurance of 2008 was revised in 2012 to 70 per cent health coverage by 2015 and 80 per cent coverage by 2020 (Somanathan et al., 2014). Recent amendments to the Law on Health Insurance took effect from January 2015 and have further extended the requirement for compulsory social health insurance participation to dependents and other groups.

² The original National Health Insurance Act of 1995 had stipulated for universal and compulsory coverage within not more than fifteen years, that is, by 2010, provided that "the [Philippine Health Insurance] Corporation shall be able to ensure that members in such localities shall have reasonable access to adequate and acceptable health care services" (Congress of the Philippines, 1994). Under the National Objectives for Health 2011–16, universal health coverage or *Kalusugan Pangkalahatan* is set to be achieved by 2016 (HPDPB, 2011).

³ Indonesia's universal health coverage target is stipulated under Presidential Regulation No. 12/2013 on Health Insurance, while for the Lao People's Democratic Republic and Myanmar; their targets were included in the respective Health Strategy up to the Year 2020 and Myanmar Health Vision 2030. See also Van Minh et al. (2014).

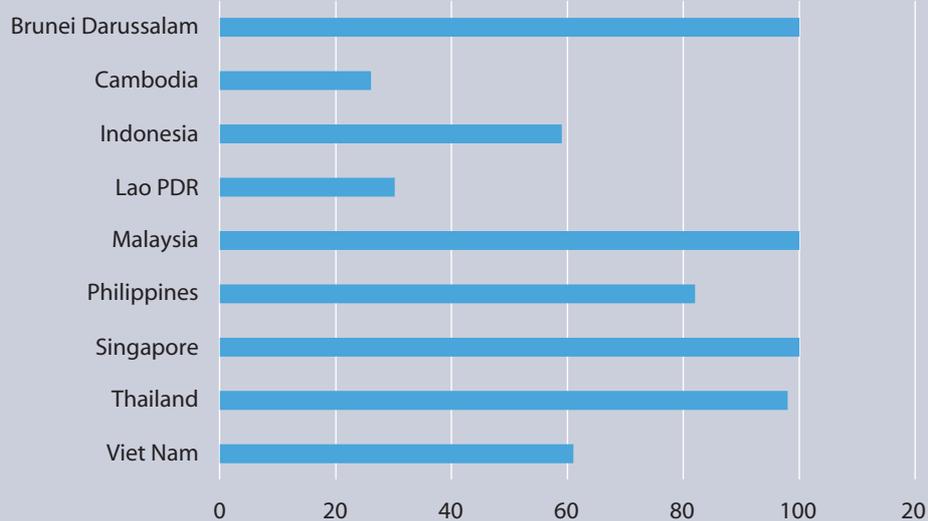
⁴ For a more comprehensive definition of access to health care by Goddard and Smith (2001): "the ability to secure a specified range of services at a specified level of quality, subject to a specified maximum level of personal inconvenience and costs, whilst in the possession of a specified level of information".

Darussalam, Malaysia, and Thailand⁵) and mandatory savings- and contribution-based health care system with a social assistance component for those in need (Singapore), (see figure 5). To extend their respective social protection floors for health, some Member States – Indonesia, the Philippines, Singapore, and Viet Nam – have introduced either mandatory or voluntary coverage for self-employed or informal economy workers. They constitute the majority in many low- and medium-income countries and yet they are excluded from risk pooling social insurances offered to formal economy employees. While Singapore has succeeded in achieving a high coverage rate with its mandatory medical savings scheme (Medisave) and opt-out social health insurance scheme (Medishield), challenges of establishing universal health coverage within a contributory social health insurance system persist for the lower income countries with a large informal economy. Voluntary coverage of social health insurance is exposed to the problem of

adverse selection – that is, people with high risks purchasing insurance while those with low risks opting out – while mandatory coverage is difficult to enforce, particularly when there is a requirement for regular payment of premiums.

Prior to the Universal Coverage Scheme (UCS) in 2001, the Thai government introduced a subsidized voluntary health insurance scheme, the Health Card Scheme (HCS) for the self-employed. Likewise, the governments of Indonesia, the Philippines, and Viet Nam have embarked on (fully) subsidizing enrolment and premiums for the poor and the socially disadvantaged into their respective national social health insurance programmes (Romualdez et al., 2011; Somanathan et al., 2013; BPJS Kesehatan, 2014). The programmes were fairly successful in terms of increasing health insurance coverage among the poor and their overall populations: for example, 97 per cent of the poor and socially disadvantaged and more than 60 per cent of the

Figure 5. Health coverage in nine ASEAN countries



Note: Myanmar is omitted due to lack of data. Depending on the health care system, health coverage is estimated by the proportion of population having free access to health care services provided by the State and/or the number of affiliated members of public health insurance as a percentage of total population.

Source: ILO, 2014g; Ministry of Labour and Social Welfare of Lao PDR (personal communication via ASEAN Secretariat, 6 October 2015).

⁵ Thailand's public health care system is pluralistic and comprise three main schemes: the Civil Servants Medical Benefit Scheme (CSMBS), the Health Branch of the Social Security Fund (SSF) for those covered under Sections 33 and 39, and the Universal Coverage Scheme that covers the rest of the Thai national population (more than 70 per cent, see Sakunphanit, 2008). There is an additional Compulsory Migrant Health Insurance (CMHI) scheme for undocumented migrant workers from Myanmar, the Lao People's Democratic Republic, and Cambodia.

population had been enrolled in the Viet Nam Social Health Insurance scheme by 2011 (Somanathan et al., 2013). Nonetheless, their continual success on extending subsidized voluntary health insurance beyond the poor and to the larger informal economy is questionable. Some scholars have argued that Thailand's universal health coverage was eventually achieved by switching from the pure contributory system approach to a mixed approach with tax revenues used to extend health care coverage to the large informal economy (Bitrán, 2014; Sakunphanit, 2008; Mongkhonvanit and Hanvoravongchai, 2014; Tangcharoensathien et al., 2013).

Despite successful health insurance enrolment, service utilization among the poor and vulnerable is still low indicating the existence of other barriers to effective health coverage such as high out-of-pocket payments (see table 1). Examples of non-monetary factors influencing under-utilization of health care among insured migrant workers and stateless or displaced persons in Thailand⁶ include: preference for self-medication, language and cultural barriers, negative perception and attitudes amongst health service providers, and the lack of information on the complex health care system (Srithamrongsawat et al., 2009). Beyond “nominal” universal health care coverage, under-utilization of health care is a major concern for individual well-being and the wider public.

Service and cost coverage

Besides population coverage, health coverage should also be assessed in terms of cost coverage and the range of goods and services offered. The two are interrelated: the range or quantity of goods and services can be limited in order to contain cost, particularly under a general tax revenue-financed system. Malaysia's general tax-financed national health system is based on

the United Kingdom's National Health Service (NHS)⁷ and similarly employs the queuing method to ration public health care services (Langenbrunner and Somanathan, 2011). The general tax-financed UCS in Thailand offers a fairly comprehensive benefit package with new services added based on economic and budget impact evaluation – as a rule-of-thumb, “one gross national income per capita for a quality-adjusted life year” to justify public investment – and the capacity to deliver services equitably (Tangcharoensathien et al., 2014). Yet not all promised services are delivered due to the lack of incentives, specialists, and/or medical devices – thus queuing within the UCS system and patients opting for private health care services instead of utilizing their UCS entitlement have been observed (Tangcharoensathien et al., 2013).

The social protection mechanism under universal health coverage is challenged if patients remain liable to high out-of-pocket spending on health services and drugs. Additional health-related expenditure include travel costs to medical facilities and can well exceed households' ability to pay, causing impoverishment (the case of Viet Nam as an example, see Van Minh et al., 2013). Financial and physical barriers in access to health care are still a reality for many communities in ASEAN countries living in remote, difficult-to-access areas due to topography and isolation, such as the mountainous terrains of the Lao People's Democratic Republic, Myanmar, Thailand, and Viet Nam, and the scattered islands of Indonesia and the Philippines. To prevent incurring high costs of health care, many households, especially the low-income and those without complementary insurance coverage, avoid pursuing medical treatment. Issues of affordability and lack of financial protection against catastrophic health spending have a two-prong effect: one limiting the access to essential health care; and the other,

⁶ Since the Universal Coverage Scheme in Thailand only covers citizens, migrants are left to be insured under the Compulsory Migrant Health Insurance while stateless or displaced persons can be insured under the Health Insurance for People with Citizenship Problems from 2010 (Suphanchaimat et al., 2014).

⁷ For details such as the 18-week maximum waiting time between general practitioner referral and specialist treatment, see the United Kingdom's National Health Service website (NHS, 2015).

jeopardizing income security that is protected under the other three social protection floor guarantees.

Since self-reported health expenditure is considered a more reliable indicator (compared to self-reported income) for household purchasing power, the World Health Organization approximates the risk of catastrophic health expenditure by the ratio of out-of-pocket payments for health to total health expenditure (WHO, 2010a). When out-of-pocket health spending is relatively high,⁸ access to other basic needs such as food and children's education is usually adversely affected by the reallocation of household expenditure. Table 1 shows that out-of-pocket health payments (as a percentage of total health expenditure) among ASEAN Member States range from 8 per cent in Brunei Darussalam to 71 per cent in Myanmar, with a regional average of 43 per cent in 2012. Households in Singapore incur relatively high out-of-pocket health spending (59 per cent in 2012) due to its unique health financing system (see box 3 and figure 6).

Service provision and quality

Deficits in health funding, infrastructure, staff and other capacities, can further hold back geographical coverage, in particular the quality level of health services (see the global evidence on inequities in rural health protection in Scheil-Adlung, 2015). For instance, the misleadingly low and declining incidence of catastrophic expenditures in the Lao People's Democratic Republic has been attributed to the underfunded and understaffed health facilities in rural areas and the consequent low service utilization among poor and rural households (Akkhavong et al., 2014). Similar inequities have been found in Viet Nam as well due to the rural and/or poor households' lower service utilization, especially for more expensive services, and the ceiling of health care providers' expenditures set based on their premium revenues (Tran Van Tien et al., 2011; Sepehri, 2013). Deficit in service availability can be indirectly measured by the number of health professionals per 10,000 population.

Table 1. Health financing system and health expenditure, 2012

Country	Main health system financing	Total health expenditure, THE (% GDP)	Out-of-pocket expenditure (% THE)
Brunei Darussalam	Tax-based national health system	2.3	8.1
Cambodia	Limited community-based health insurance coverage and social assistance	5.4	61.8
Indonesia	Social health insurance	3.0	45.3
Lao PDR	Limited social/community-based health insurance coverage and social assistance	2.9	38.2
Malaysia	Tax-based national health system	4.0	34.9
Myanmar	Limited social health insurance coverage and social assistance	1.8	71.3
Philippines	Social health insurance	4.6	52.0
Singapore	Social health insurance	4.7	58.6
Thailand	Tax-based national health system and social health insurance	3.9	13.1
Viet Nam	Social health insurance	6.6	48.9

Source: Health expenditure statistics from WHO (2014a) with own classification of main health system financing

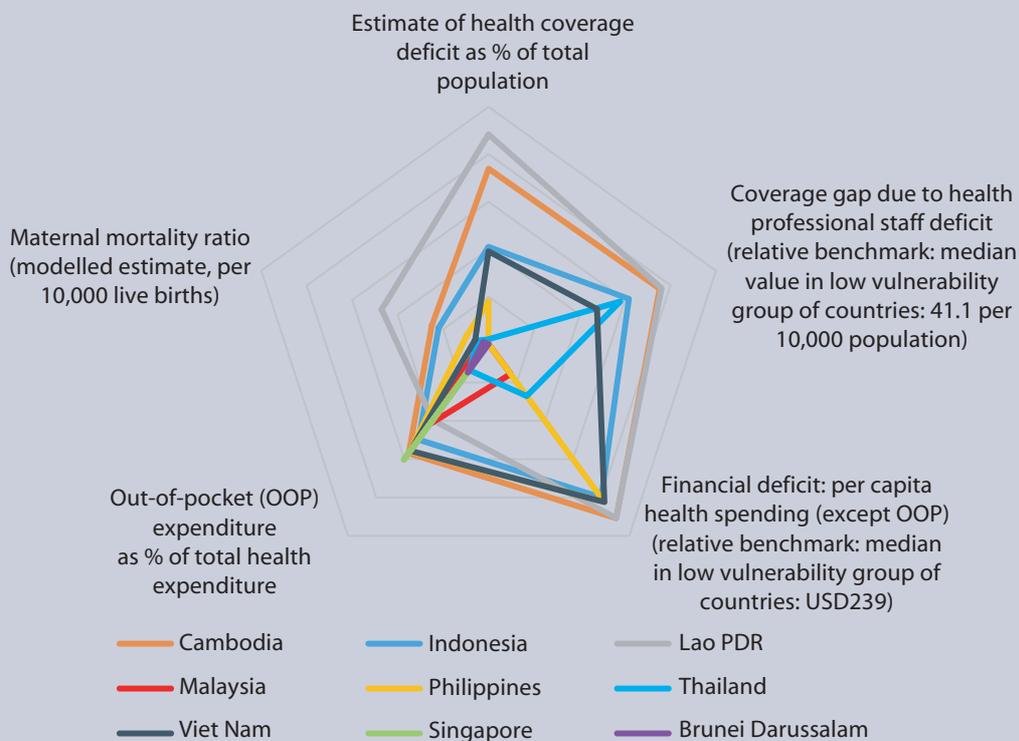
⁸ The World Health Organization defines catastrophic health expenditures as direct out-of-pocket payments that exceed 40 per cent of household income net of the cost of subsistence (WHO, 2010a).

At the same time, quality of service can be measured by proxy indicators such as health spending per capita (excluding out-of-pocket payments) and the maternal mortality ratio per 10,000 live births. The first indicator assumes a high correlation between health spending and service quality. In the same way, the overall health service quality is assumed to be reflected in the quality of obstetric service, especially in reducing the mortality rate of women due to pregnancy-related causes per 10,000 live births. As benchmarks, the number of health professionals per 10,000 population and the per capita health spending (excluding out-of-pocket payments) can be compared to the respective median values of “low vulnerability”,⁹ developed economies (for more details on the methodology, see Scheil-Adlung and Bonnet, 2011; ILO, 2014g: p. 296).

To illustrate, figure 6 compares the deficits in access to health services across five dimensions

in nine ASEAN Member States (excluding Myanmar due to data availability). The three highest income per capita ASEAN countries – Brunei Darussalam, Malaysia, and Singapore – perform relatively well (that is, with small deficits measured by the distance from the pentagon’s centre) in terms of legal coverage, service provision, and service quality (measured by per capita health spending excluding out-of-pocket payments and maternal mortality ratio). While Malaysia possesses some deficit in terms of per capita health spending (excluding out-of-pocket payments) when compared to the median value of low vulnerability countries, Brunei Darussalam and Singapore do not have deficits in terms of per capita health spending and health professionals-to-population ratio. Nonetheless, households in Malaysia and Singapore still face high out-of-pocket health payments as a percentage of total health expenditure.

Figure 6. Deficits in access to health services for nine ASEAN countries



Source: Data obtained from ILO, 2014g, pp. 290–2.

⁹ The median values in “low vulnerability” countries used as benchmarks are: 41.1 health professionals per 10,000 population and US\$239 in per capita health spending excluding out-of-pocket payments (ILO, 2014g: p. 296). Ideally, the data should be disaggregated at the provincial or lower subnational levels to determine geographical inequities.

The Thai universal health coverage system exhibits notable degrees in health coverage, service quality, and financial protection, yet it confronts a fairly large service coverage gap due to health professional staff deficit. In comparison, the Philippines has a health professionals-to-population ratio that is comparable to the average low vulnerability country but falters in both health spending indicators. Cambodia and the Lao People's Democratic Republic still face challenges in addressing deficits in access to health services over all five dimensions, particularly for legal coverage and service availability and quality. Maternal mortality ratio is highest in the Lao People's Democratic Republic with 47 deaths and lowest in Singapore with less than one death per 10,000 live births, while the regional average ratio is 14. With the exception of Viet Nam's low maternal mortality ratio (5.9), Indonesia and Viet Nam rank average across all dimensions.

Health system financing

There are trade-offs between the identified dimensions of coverage, (that is, population coverage, service coverage, and cost coverage) due to budgetary restrictions. Mediating them to a large extent is the financing mechanism of the health system, next to supply-side regulatory mechanisms such as price control of services and drugs, and the training of medical staff. Overall, the health systems of ASEAN Member States can be grouped based on their main financing mechanism(s) with their respective advantages and disadvantages (also see table 1 and table 2):

- (predominantly) tax-based national health system: Brunei Darussalam, Malaysia, Thailand;¹⁰
- national social health insurance system: Indonesia, the Philippines, Singapore, Viet Nam; and
- limited health insurance coverage supported by social assistance programmes: Cambodia¹¹, Myanmar¹², the Lao People's Democratic Republic.

The main benefits of a predominantly tax-based national health system are its (near) universal legal coverage and risk pooling for the entire population which redistributes health risks across groups. With its small population and considerable oil revenues, the health system of Brunei Darussalam may evade the usual funding constraint of tax-based national health systems. Malaysia and Thailand however tackle substantially larger populations and as discussed earlier, health care cost containment becomes a key issue. Health care costs can be contained by restricting the quantity of goods and services through rationing (that is, subject patients to queuing or waiting lists) or by limiting the range of goods and services based on economic and budget impact evaluation. For example, Thailand's "one gross national income per capita for a quality-adjusted life year" is used to justify public investment (Tangcharoensathien et al., 2014). In the scenario where socioeconomically advantaged groups seek more comprehensive and responsive alternatives in the private sector while those disadvantaged remain in the public system, equitable access to health care is threatened.

Contribution-based social health insurance systems found in Indonesia, the Philippines, Viet Nam, and Singapore allow for risk pooling among the covered segment of the population.¹³ However, coverage may be limited by a large informal economy. For Cambodia, the Lao

¹⁰ As noted previously, Thailand's public health care system also contains a small (15.6 per cent of the population in 2010) contribution-based scheme that is the Health Branch of the Social Security Fund (SSF) for those covered under Sections 33 and 39 (Schmitt et al., 2013).

¹¹ Cambodia is anticipating the launch of its new national health insurance scheme by the end of 2015.

¹² Myanmar also has a Social Security Medical Care Scheme (managed by the Social Security Board) for formal sector employees. However, its coverage rate is very low, approximately 1.4 per cent of the population in 2014 (Tessier et al., forthcoming).

¹³ The level of risk pooling allowed within a social insurance system also depends on the health care provider payment mechanism, for example, the capitation-based payment mechanism operated in many health facilities in Viet Nam reduces risk pooling by setting capitation rates separately based on provinces and type of insured – that is, formal economy workers; pensioners and other benefit recipients; poor or near-poor; children under 6 years; students; and other individuals (Somanathan et al., 2013; Tran Van Tien et al., 2011).

Table 2. Advantages and disadvantages of a health financing system

Health system	Advantages	Disadvantages
Tax-based health protection: National health systems [e.g. Brunei Darussalam, Malaysia, Thailand]	<ul style="list-style-type: none"> • Risks are pooled for the whole population • Potential for administrative efficiency and cost control • Redistributes high and low risk and high- and low income groups in the population covered 	<ul style="list-style-type: none"> • Risks of unstable funding and often underfunded due to competing public expenditure • Inefficient due to lack of incentives and effective supervision
Contribution-based social health insurance [e.g. Indonesia, Myanmar, Philippines, Singapore, Thailand, Viet Nam]	<ul style="list-style-type: none"> • Generates stable revenues • Often strong support from the population • Provides access to a broad package of services • Involvement of social partners • Redistributes between high and low risk and high- and low- income groups in the population covered 	<ul style="list-style-type: none"> • Poor are excluded unless subsidized • Complex to manage governance and accountability may be problematic • Can lead to cost escalation unless effective contracting mechanisms are in place
Premium-based community-based health insurance [e.g. the Lao People’s Democratic Republic, Cambodia]	<ul style="list-style-type: none"> • Can reach out to workers in the informal economy • Can reach the close-to-poor segments of the population 	<ul style="list-style-type: none"> • Poor may be excluded unless subsidized • May be financially vulnerable if not supported by national subsidies • Coverage usually only extended to a small percentage of the population • Strong incentive to adverse selection • May be associated with lack of professionalism in governance and administration
Premium-based private health insurance [e.g. Singapore ¹⁴]	<ul style="list-style-type: none"> • Preferable to out-of-pocket expenditure • Increases financial protection and access to health services for those able to pay • Encourages better quality and cost-efficiency 	<ul style="list-style-type: none"> • High administrative costs • Ineffective in reducing cost pressures on public health systems • Inequitable without subsidized premiums or regulated insurance content and price • Requires administrative and financial infrastructure and capacity

Source: Table based on Scheil-Adlung, 2014, p. 42.

People’s Democratic Republic, and Myanmar, relevant national legislations such as Myanmar’s Social Security Law enacted in 2012 are in place for a national social health insurance system in the (near) future. As for now, their public health care systems are characterized by limited social insurance coverage and targeted social assistance programmes such as health equity funds. Both Cambodia and the Lao People’s Democratic

Republic have voluntary Community-Based Health Insurance (CBHI) schemes with different targeting mechanisms. Cambodia’s subsidized CBHI targets the poor and near poor while the Lao People’s Democratic Republic’s CBHI targets the non-poor self-employed persons and their dependents. Like many voluntary contributory schemes, they are prone to issues of under-coverage and adverse selection (ISSA, 2012; and

¹⁴ In addition to mandatory public schemes, private insurance supplementary schemes (“Integrated Shield plans”) are common among middle and higher income households in Singapore (Ministry of Health, 2015b).

for an analysis of the CBHI scheme in Lao People's Democratic Republic, see Alkenbrack et al., 2013).

Following the path of Indonesia and its effective consolidation of various health insurance schemes under the national health insurance scheme, Jaminan Kesehatan Nasional (JKN), Cambodia and the Lao People's Democratic Republic are in the process of merging existing schemes and implementing their respective national health insurance systems. The National Social Security Fund (NSSF) of Cambodia is planning to launch its compulsory social health insurance scheme for companies with more than seven employees in

2015. It hopes to integrate the present assortment of primarily donor-funded CBHI, Health Equity Funds (HEF), and the occupation-based Health Insurance Project (HIP) for garment factory workers (Hennicot, 2012). Similarly, the 2012 adoption of the National Health Insurance Decree (No. 470/PM) in the Lao People's Democratic Republic should lead to the gradual unification of the social health insurance branches of the Social Security Organization (SSO) and the State Authority for Social Security (SASS), CBHI, HEF for the poor, and other related health programmes such as the Maternal, Neonatal and Child Health and Nutrition programme (ILO, 2013c).

Box 3

The health financing system in Singapore

Singapore has a unique mixed financing health system that is relatively low-cost (to the government at 4 per cent of GDP) for its high quality of service provision that is comparable to other developed economies. The system is described to be “anchored on the twin philosophies of individual responsibility and affordable health care for all”. The **first tier** offers basic health protection via government subsidies that include cost coverage of up to 80 per cent (based on choice of service, means-testing, and citizenship) for acute and inpatient care in lower ranked wards of public hospitals and up to 75 per cent for outpatient care in polyclinics and medical drugs. The **second tier** is provided by a mandatory savings account for health care, Medisave which is part of the Central Provident Fund and is co-funded by workers' and employers' contributions. Intra-family redistribution is permitted under the second tier as immediate family members have access to each other's Medisave accounts. To prevent overconsumption of health care and premature depletion of Medisave savings, the Ministry of Health imposes strict guidelines on the type and level of health care expenditure covered under Medisave.

The **third tier** is provided by Medishield, a social health insurance scheme against catastrophic health expenditures. Risk pooling however, is limited

by age-dependent premium rates calculated based on health risks and expected service utilization. Resident population coverage was estimated at 92 per cent with 3.5 million Medishield members in 2012. Personal responsibility is reinforced through deductibles and co-payments paid through MediSave or cash. Household out-of-pocket expenditure as a proportion of total health expenditure (netted of government health expenditure and reimbursements from health insurance) is well above the World Health Organization's threshold of 40 per cent at 58.6 per cent in 2012.

On top of the mandatory schemes, private insurance supplementary schemes (“Integrated Shield plans”) are common among middle and higher income households. There is also a last-resort, social safety net scheme, Medifund, for the most vulnerable group who do not possess further resources for their health expenditure.

By the end of 2015, Medishield will be replaced by a mandatory social health insurance scheme, Medishield Life to provide coverage to all Singaporean citizens and permanent residents. Government subsidy will ensure universal coverage, in particular those overage, low-income, and have pre-existing conditions.

Source: Ministry of Health website, 2015a, 2013; Haseltine, 2013; WHO, 2014.

According to ILO Recommendation No. 202, basic income security together with “access to nutrition, education, care and any other necessary goods and services” are all equally important when it comes to children. This is reflected in the two Millennium Development Goals (MDG) that are specifically focused on children: achieving universal primary education (MDG2) and reducing child mortality (MDG4). The new Sustainable Development Goals (SDG) and targets also reflect similar priorities for children such as ending child malnutrition (SDG2) and child mortality (SDG3), and improving their access to care and education (SDG4). Table 3 provides an indication on children’s nutrition and access to primary school education in ASEAN Member States whether via income security and/or the provision of a basket of “necessary goods and services” that is facilitated by the government.

Education

The regional review of social protection has revealed some potential for a common “ASEAN social protection floor”. Achieving universal primary education appears to be part of it. All ASEAN Member States virtually have free public primary education and benefit from high gross enrolment rates (more than 90 per cent) at the

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“The social protection floors [...] should comprise at least the following basic social security guarantees:

- (a) access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- (b) **basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;**
- (c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- (d) basic income security, at least at a nationally defined minimum level, for older persons.”

Table 3. Malnutrition and primary school completion

Country	Moderate malnutrition (% children under 5)	Year	Completion rate of primary education	Year
Brunei Darussalam	...	...	96.4	2011
Cambodia	29	2011	65.9	2011
Indonesia	20	2013	89.0	2011
Lao PDR	27	2012	69.9	2011
Malaysia	13	2006	99.2	2009
Myanmar	23	2010	74.8	2009
Philippines	20	2011	75.8	2008
Singapore	3	2000	98.7	2008
Thailand	9	2012	...	...
Viet Nam	12	2011	97.5	2011

...: data not available.

Notes: "Moderate malnutrition" is measured by the percentage of children aged under five years who are underweight, that is, weight-for-age between -3 and -2 standard deviations below the WHO Child Growth Standards median. "Completion rate of primary education" is measured by the estimated proportion of a cohort of students enrolled in the first grade of primary education in a given school year who are expected to reach a given grade, regardless of repetition.

Source: WHO, UNESCO-UIS.

start of primary school (UNESCO-IBE, 2011). In Myanmar alone, 5.2 million children (or approximately 87.7 per cent of children of primary school age) received 1,000 kyat (MMK), textbooks, and exercise books each (Tessier et al., forthcoming).

However, there remain large differences in socioeconomic and school-related factors such as quality, availability, and access which affect a child's probability of completing primary school and obtaining the necessary literacy skills. Children in rural areas (in particular those of ethnic minority background) and/or from poor families face higher pupil-to-teacher ratios and barriers to schooling in the form of long distance to school, extra-curricular costs, difference between school medium and mother tongue, and so forth (No et al., 2012; Grimes, 2009; ILISSA, 2014; Oxfam and ActionAid, 2012). Table 3 shows the significant divergence between ASEAN Member States, notably for Cambodia and the Lao People's Democratic Republic with primary education completion rates below 70 per cent while the regional average hovers at 85.7 per cent¹ (with the exception of Thailand years vary

according to most recent data availability from UNESCO-UIS).

Despite the relative "success" in primary school completion, enrolling and retaining students in schools beyond primary-level is a challenge for some Member States. One in four in the Lao People's Democratic Republic and one in five in Cambodia of lower secondary school age are not attending primary or secondary school (UNESCO-UIS). The situation is more dire in rural areas and among the ethnic minority populations. For example, in some of the mountainous areas of Viet Nam populated by its ethnic minority groups, dropout rates in upper secondary schools can be as high as 70 to 80 per cent (Oxfam and ActionAid, 2012).

Nutrition

Improving nutrition particularly during early life or the "1,000 days" of a child's life from during the mother's pregnancy up to the child's second birthday (see for instance, Save the Children, 2012), has a long-term irreversible effect on child health and education outcomes, and later their

¹ The "regional" average of primary school completion rate (excluding Thailand due to lack of data) has been weighted by the 2010 estimated national population aged between 5 and 9 years (UN DESA, 2012).

labour productivity which collectively drives a country's socioeconomic development, (see for example, the report on the cost of malnutrition in Cambodia by CARD, UNICEF, and WFP, 2013). Programmes for tackling malnutrition and hunger such as the micronutrient supplementation and nutritional education campaigns, have been found to have exceptionally high benefits compared to costs (Copenhagen Consensus, 2008). The important role of breastfeeding in ensuring a young child's nourishment is also enshrined in the Maternity Protection Convention, 2000 (No. 183) which advocates nursing breaks or reduction of working hours for breastfeeding mothers. Convention No. 183 also safeguards the health and safety rights of pregnant and breastfeeding women at the workplace and promotes medical benefits in the form of prenatal, childbirth, and postnatal care. Equally beneficial for the child's early nutrition is the provision of paid maternity benefits, recommended at two-thirds of previous income for at least 14 weeks under Convention No. 183.

Compared to the median WHO child growth standards, child malnutrition is measured by low weight-for-height (wasting) or low height-for-age (stunting) or a combination of both (see the WHO's Global Health Observatory definition). Among ASEAN countries (with the exception of Brunei Darussalam), the proportion of children under five years being underweight ranges widely from 3 per cent in Singapore to 29 per cent in Cambodia with a regional average of 18.4 per cent² (see table 3). More specifically, micronutrient deficiencies among children under five and women who are pregnant or lactating have detrimental lifelong health effects on (unborn) children. A popular intervention within the region involves the micronutrient fortification of staple foods and condiments. At present, iodine fortification of salt is done in all ASEAN countries except Brunei Darussalam and Singapore, and vitamin A fortification in various food items such as margarine and condensed milk

in Malaysia and Thailand, and in wheat flour, refined sugar, and cooking oil in the Philippines (Gayer and Smith, 2015).

For school-age children, all ASEAN Member States have some form of school feeding programme – involving either hot meals, snacks or biscuits, take-home rations, or a combination of them – that is usually means-tested. Table 4 presents school feeding programmes across ASEAN Member States in terms of their main implementing organization(s), number of beneficiaries, and coverage. For some of the ASEAN countries, the reliance on development partners can be unsustainable and precarious due to their varying priorities and funding constraints. Unlike other ASEAN countries, hot and packet drinks and snacks are offered during the morning break to all government primary school students in Brunei Darussalam (Ministry of Education Brunei Darussalam, 2014). Free breakfasts and lunches are also provided to low-income government primary and secondary school students, while government boarding school students receive full board meals. In many countries, school feeding programmes not only encourage nutrition and school attendance, they have also been found to provide income and learning support to children and their families (Bundy et al., 2009). Even so, a main shortcoming of relying mainly on school feeding programmes is that they exclude younger children below school age.

Child allowance

“Child-sensitive” social protection policies such as cash benefit or social insurance schemes that target households with children, particularly at a young age, can help improve overall child outcomes (see the ‘Joint Statement on Advancing Child-sensitive Social Protection’ by UNICEF et al., 2009). Children are particularly vulnerable to income shocks, for instance macro-level shocks in the form of the global financial crisis in 2008, or micro-level shocks in the

² The “regional” average of malnutrition rate (excluding Brunei Darussalam due to lack of data) has been weighted by the 2010 estimated national population aged below 5 years (UN DESA, 2012).

Table 4. School feeding programmes and coverage

Country	Implementer(s)	Number of beneficiaries in 2011 ('000s)*	Estimated coverage**
Brunei Darussalam	Government	27***	100
Cambodia	Development partner(s)	756	33
Indonesia	Government and development partner(s)	125	0
Lao PDR	Government and development partner(s)	177	19
Malaysia	Government	1 916*	...
Myanmar	Development partner(s)	310	6
Philippines	Government and development partner(s)****	92	1
Singapore	Government	188*	...
Thailand	Government	1 677	...
Viet Nam	Government	3 409*	...

* beneficiary numbers were estimated when not available from WFP school feeding survey or other sources.

** coverage rate estimated as proportion of primary school-attending children.

*** Number of beneficiaries estimated for Brunei Darussalam based on the assumed full coverage of the 26,819 students enrolled in government primary schools in 2012 (Ministry of Education Brunei Darussalam, 2013).

**** Updated from "Development partner(s)" to "Government and development partners". Number of beneficiaries in 2011 corresponds to original WFP State of School Feeding 2013 data based on the WFP Global School Feeding Survey field to WFP country offices in early 2012.

...: data not available.

Note: coverage is not calculated for countries of upper-middle and above income and for those with estimated beneficiaries due to low reliability (see Annex III in WFP 2013, 115–119).

Source: WFP, 2013, 2015; Bahrum Ali, 2010; Ministry of Education Brunei Darussalam, 2014; Department of Education, 2014.

form of incapacitation or death of the family breadwinner. Cash benefit schemes have been found to assist households in social investments (in education and health) and smoothing consumption, especially reducing the negative effects of poverty and income shocks on children (see the reviews by Fiszbein and Schady, 2009; Hanlon et al., 2010). The Social Security (Minimum Standards) Convention, 1952 (No. 102) covers the maintenance of children under "family benefit" where Article 42 calls for periodical payment and/or "the provision to or in respect of children, of food, clothing, housing, holidays or domestic help".

Most ASEAN Member States have in place cash benefit schemes in the form of means-tested social assistance for families with children. This is the case in Brunei Darussalam, Indonesia, Malaysia, Myanmar, the Philippines, and Viet Nam, shown in table 5. Four Member States – Malaysia, Myanmar, Singapore, and Thailand – have non-means-tested cash transfer programmes. Thailand's Child Allowance stands out for being

targeted at children below age six whose parents are or were used to be formally employed (under the Social Security Act's Articles 33 and 39) and were covered under its national social insurance scheme. It is also unique among ASEAN countries for its tripartite funding mechanism with contributions from workers, employers, and the government (Schmitt et al., 2013).

Another unique scheme is Singapore's "Baby Bonus" scheme which has two components: (i) a universal cash benefit for all children; and (ii) a dollar-to-dollar matched savings fund until the child reaches the age of 12 years to encourage parental savings (within an annual cap) for the child's health- and education-related expenditures (Ministry of Social and Family Development, 2014a). Both Myanmar and Malaysia have universal cash benefits for children attending public primary schools with Malaysia's scheme extended to those enrolled in public secondary schools too (Tessier et al., forthcoming; Bernama, 2014).

Table 5. Features of main cash benefit programmes targeted at children

Country	Scheme type	Means-test	Children as target group
Brunei Darussalam	Unconditional	Yes	Orphans and children of poor and vulnerable households
Cambodia	Conditional (pilot)	Yes	(depends on the pilot programme)
Indonesia	Conditional	Yes	Children aged below 15 years (or 18 if still in primary/middle school) of very poor households
	Conditional	Yes	Children with disability or abandoned (0–18 years), street children (6–18 years), children with criminal charges (6–16 years)
Lao PDR	Conditional (pilot)	Yes	(depends on the pilot programme)
Malaysia	Conditional	No	Children attending government primary and secondary schools
	Unconditional	Yes	Orphans and children lacking family support
	Conditional	Yes	Government primary school pupils from poor households
Myanmar	Conditional	No	Children attending primary schools
	Conditional	Yes	Children attending primary and secondary schools from poor households, priority to single-headed households and orphans
Philippines	Conditional	Yes	Children aged 0–18 years from very poor households
Singapore	Unconditional	No	New-borns
	Conditional	No	Children aged 0–12 years (matched savings fund for educational and health-related expenses)
Thailand	Unconditional	No	Children aged 0–6 years (under Art. 33 and 39 of the Social Security Act)
Viet Nam	Unconditional	Yes	Orphans and vulnerable children (including adolescent aged 16–18 years if in school/training) with disability, lack family support, from single-headed poor households, with HIV/AIDS and from poor households

Sources: JAPEM, 2013; WFP, 2014; Royal Government of Cambodia, 2014; Ministry of Social Affairs, 2011; Satriana and Schmitt, 2012; Satriana, 2014; UNICEF, 2013; Tessier et al., forthcoming; Government of the Philippines, 2015; Ministry of Social and Family Development, 2014; Schmitt et al., 2013; Bonnet et al., 2012.

Some of the cash benefit programmes are tied to obligations such as ensuring school attendance and/or health check-ups in the case of the *Program Keluarga Harapan* (PKH) in Indonesia (detailed in box 4) and the *Pantawid Pamilyang Pilipino Programme* (4Ps) in the Philippines. Similarly, several donor-funded conditional cash transfer pilot programmes linked to school attendance and maternal and child health have been initiated in the Lao People's Democratic Republic and Cambodia (Ngay, 2013; Satriana, 2014; WFP, 2014; Royal Government of Cambodia, 2014). Despite the proliferation of “conditional cash transfer” (CCT) programmes in ASEAN and beyond, they demand considerable administrative capacity and adequate coverage of public services – without which the

most needy and vulnerable would be excluded (among others, see Schüring, 2010). The ratio of administrative costs to programme budget for Indonesia's CCT scheme, PKH is 18 per cent compared to 8 per cent for its unconditional cash benefit scheme, *Bantuan Langsung Tunai* (Vita Febriany and Asep Suryahadi, 2012). Furthermore, the relative impact of conditionality in cash benefit schemes has not been conclusively established so far (Baird et al., 2014).

Despite cash benefit schemes (conditional or otherwise) reducing demand-side barriers in school enrolment and access to health care, their effects on final outcomes such as child health status and school performance have been fairly mixed (Arnold et al., 2011; ILO, 2012b; World

Bank, 2012a). Cash benefits alone, even with conditionality, cannot improve educational and health outcomes without the adequate supply of quality services (mentioned in the review of Philippine’s 4Ps programme in Fernandez and

Olfindo, 2011; and Chaudhury et al., 2013). Ultimately, supply-side factors such as the availability of high quality and accessible education and health care services matter equally if not more.

Box 4

Conditional cash benefit scheme in Indonesia

The *Program Keluarga Harapan* (PKH) in Indonesia was introduced as a conditional cash benefit pilot programme in 2007. It targets the “very poor” households (*Rumah Tangga Sangat Miskin*, RTSM) with at least one child aged below 15 years (or 18 years if still in primary or middle school) and/or an expectant or lactating mother. With the Millennium Development Goals in mind, its main objectives are to improve the socioeconomic, health, and child educational outcomes of these households. This is done via the following two phases:

The first phase identifies the eligible very poor recipients through an extensive validation procedure (as part of the Unified Database or Basis Data Terpadu) and distributes the first cash payment.



The second phase monitors and verifies the adherence of the household members to their school attendance and/or health check-up and immunization commitments before distributing subsequent cash payments.

Despite expanding its operations to all provinces of Indonesia since 2012, it has yet to achieve full coverage of beneficiaries nationwide. By 2015, PKH had disbursed approximately 5.3 trillion rupiah (IDR) cash payments to an estimated 3.5 million households, which is still well below the estimated 6.5 million households living below the poverty line in 2012. PKH cash benefits average up to IDR1.8 million per household per year. The amount of cash benefit depends on the household composition with the annual cash benefit per household capped at IDR3.7 million with a minimum benefit of IDR950,000 for 2015:

Cash benefit component	Level of benefit per household per year (IDR)
Basic cash benefit	500,000
<i>Additional cash benefit for each beneficiary:</i>	
+ Expectant/lactating mother	1,000,000
+ Child below age 6 years	1,000,000
+ Child attending primary school	450,000
+ Child attending middle school	750,000
+ Child attending secondary school	1,000,000

Source: Ministry of Social Affairs, 2014.

Source: Anjani, 2015; Ministry of Social Affairs, 2014; Suahasil Nazara and Sri Kusumastuti Rahayu, 2013.

Childcare

Policies and schemes aimed at supporting childcare are quite limited in ASEAN countries as childcare is still primarily perceived to be a responsibility of the child’s family. The Singapore government has some of the more inclusive and comprehensive schemes which include a birth grant and subsidies for childcare and preschool. Like the birth grant, the basic childcare subsidy is available for all children of Singaporean

citizenship who are enrolled in licensed childcare centres (Early Childhood Development Agency). Additional subsidy is at hand for working mothers from low- and middle-income households. The Kindergarten Fee Assistance Scheme (KiFAS) also targets low- and middle-income families with children attending approved kindergartens. The level of subsidy depends on household income (per capita) and the lowest income group qualifies for a lump-sum annual grant to cover additional expenses such as

uniforms and registration fees (Early Childhood Development Agency).

Some progress has been made in promoting preschool education within ASEAN countries under the policy umbrella of “early childhood care and education” (ECCE) or its variants, “early childhood care and development” and “early childhood education”. Every Member State has established ECCE-specific national legislation and/or policies, the most recent being Myanmar’s Early Childhood Care and Development Bill enacted in early 2014 (UNESCO and UNICEF, 2012; Ministry of Education Myanmar, 2014).

Early childhood care and education refers to “a range of processes and mechanisms that sustain, support and aid in the holistic development of children, from birth to age eight years” (UNESCO and UNICEF, 2012). This range of public or privately provided services and the corresponding target groups differ across ASEAN countries, (see table 6). Despite the national provisions, a joint UNESCO-UNICEF regional assessment for Asia and the Pacific reveals major gaps in public funding, coverage especially among marginalized communities and the very young (age 0–3 years), and training for teachers and caregivers (2012).

Table 6. Definitions of early childhood care and education with age groups

Country	Definition and age range(s)
Brunei Darussalam	Early Childhood Care and Education (0–6 years): private childcare centres (birth to 3 years), private preschools (3–6 years), government preschools (5–6 years)
Cambodia	Early Childhood Education (conception to 6 years): home-based education programme (0–6 years), formal preschool (3–6 years), private preschool, community preschool
Indonesia	Early Childhood Education (0–6 years): childcare services (3 months to 6 years), playgroup (3–6 years), kindergarten (4–6 years), <i>Rauhatul Athfal</i> (4–6 years)
Lao PDR	Early Childhood Care and Development: crèches (2 months to 3 years), kindergarten (3–5 years)
Malaysia	Early Childhood Care and Education (0–6 years): childcare centres (0–4 years), preschools (4–6 years)
Myanmar	Early Childhood Care and Education (0–5 years): child rearing and day care (under 3 years), preschool (3–5 years)
Philippines	Early Childhood Care and Development (0–6 years): home-based ECCD (0–3 years), day care (0–4 years), kindergarten (5–6 years)
Singapore	Early Childhood Care and Development (0–6 years): childcare centres (0–6 years), kindergartens (4–6 years)
Thailand	Early Childhood Care and Development (0–5 years)
Viet Nam	Early Childhood Care and Education (0–6 years): day care, crèche, nursery (0–3 years), government-run kindergarten (4–5 years), pre-primary schools (3 months to 6 years)

Source: Rao and Sun, 2010; SEAMEO-INNOTECH, 2014; Ministry of Education Brunei Darussalam, 2014.

The Universal Declaration of Human Rights (1948, Articles 23, 24, and 25) stipulates the right to just and favourable employment conditions, remuneration, and social security. Income security for people of working age can be provided via social insurance, social assistance, cash and in-kind transfers in the event(s) of sickness, injury, unemployment, maternity, disability, or death of the breadwinner. Employment promotion programmes are instrumental as well to help sustain income security for this group.

Work injury benefit

Workers' compensation for occupational injury and illnesses is stipulated under Convention No. 102 and the Employment Injury Benefits Convention, 1964 (No. 121). Compensation schemes for employment injury and occupational diseases are usually the first of the social security schemes to be introduced in a country.¹ Hence, its legal coverage can help gauge a country's social

¹ Within the confines of this report, work injury schemes are assessed purely based on the financial compensation perspective, whether to cover costs of medical care or income loss. A more holistic employment injury scheme would take into account preventive measures such as occupational safety and health (OSH) regulations and return-to-work rehabilitation programmes. The report's focus however is consistent with the existing weak linkage between these components of work injury in the Asia-Pacific region (Kim, 2012).

R. 202: Social Protection Floors Recommendation (2012)

"The social protection floors [...] should comprise at least the following basic social security guarantees:

- (a) access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- (b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
- (c) **basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability;** and
- (d) basic income security, at least at a nationally defined minimum level, for older persons."

protection performance in protecting those of working age. None of the ASEAN Member States have ratified Conventions Nos 102 and 121. Table 7 summarizes the types of existing work injury schemes in ASEAN Member States with their levels of legal coverage. Legal coverage rates range from a low 6.7 per cent to a high 88.0 per cent within the ASEAN region (excluding Myanmar). The population-weighted² regional average legal coverage rate for work injury (excluding Myanmar) is 46.2 per cent.

Most ASEAN countries (with the exception of Brunei Darussalam) have social insurance or mandatory private insurance systems to cover risks of work injury. This risk pooling feature is advocated by Article 71 of Convention No. 102 that specifies insurance and/or taxation as the means for the collective shouldering of work injury compensation expenses. Social insurance is more prevalent than private insurance in the

region. Kim (2012) cites three main reasons why this is commonly observed: (i) the provision of compensation for occupational injury and illness is often compulsory by law, at least for job sectors with significant health and safety risks; (ii) the scheme's eligibility criteria and benefit level are usually set in legislation; and (iii) the subsidization of preventive and rehabilitation programmes to reduce work injury claims.

The employer-liability system that is prevalent in Brunei Darussalam and the Lao People's Democratic Republic does not conform to Convention No. 102. The drawbacks of employer-liability systems include: (i) risk of insolvency from exorbitant injury claims, particularly for small and medium-sized firms; (ii) vulnerability of workers and their dependents due to potential firm insolvency or time-consuming legal disputes; and (iii) "excessive" insurance premiums if private insurers make

Table 7. Work injury schemes and legal coverage as proportion of labour force

Country	Work injury scheme type	Legal coverage	
		Mandatory	Voluntary
Brunei Darussalam	Employer-liability	88.0	0.0
Cambodia	Social insurance	10.2**	...
Indonesia	Social insurance	28.7	44.3
Lao PDR	Social insurance or Employer-liability	6.7	0.0
Malaysia	Social insurance	36.2	0.0
Myanmar	Social insurance	...	...
Philippines	Social insurance	45.8	0.0
Singapore	Employer-liability with compulsory private insurance	72.6	0.0
Thailand	Social insurance*	26.2	0.0
Viet Nam	Social insurance	30.4	0.0

...: data not available.

* Thailand's work injury scheme type has been reclassified to "social insurance".³

** Based on 2008 estimates of number of employees in firms with eight or more workers (706,842) and the size of labour force (6.96 million) in Cambodia (Hennicot, 2012).

Source: ILO, 2014g; Hennicot, 2012.

² The "regional" average of legal coverage rate (excluding Myanmar due to lack of data) has been weighted by the 2010 national labour force estimates (UN DESA, 2012).

³ Thailand's work injury scheme is usually defined as an "employer-liability" system with compulsory insurance but effectively, it is a "social insurance" system according to the following criteria (see also ILO, 2013b):

(i) compensation rights for workers is statutory under the Workmen's Compensation Act B.E. 2537 (1994) via the Workmen's Compensation Fund (WCF);

(ii) the WCF is separate from the Social Security Fund but is administered by the national Social Security Office through the Office of Workmen's Compensation Fund. The government agency is responsible for contribution collection, claims assessments, compensation payments, and the fund's financial sustainability.

(iii) the WCF is led by a tripartite board consisting of government, employee, and employer representatives;

(iv) and the WCF may receive general public funds via the Ministry of Labour and Social Welfare up to a capped amount for the costs of medical care, rehabilitation, and the promotion or protection of industrial safety.

unfair profits and spend on competition-related measures such as marketing (Kim, 2012; AASCIF, 2007). The employer-liability system also undermines the principles of solidarity and social redistribution across enterprises, economic sectors, social and income classes, and geographical regions. To (partially) overcome these drawbacks, Singapore has made private insurance compulsory to cover the risk of work injury and illnesses. The insurance policies must be compatible with the employer liabilities defined under the Work Injury Compensation Act 2009 and are necessary for the work permit issuance or renewal for migrant workers (Ministry of Manpower, 2013).

The low legal coverage rates reported in table 7 are likely due to the exclusion of self-employed and informal economy workers who make up the majority of workers in many low- and medium-

income countries. Other exceptions to statutory insurance coverage could involve employees working under short contracts (defined as less than three months⁴ duration in Viet Nam), small firms (with fewer than eight employees in Cambodia or fewer than five employees in Myanmar), or non-manual work above a salary threshold (monthly earnings above 3,000 ringgit (MYR) in Malaysia and at least 1,600 Singapore dollars (SGD) in Singapore). Self-employed workers can voluntarily participate in the statutory social insurance scheme for employment injury and illnesses in the Philippines and Indonesia. Indonesia stands out by incorporating informal workers in its reforms of the national social security system, *Sistem Jaminan Sosial Nasional* (SJSN).

Like many insurance schemes, work injury coverage remains low when it is without

Box 5

Cambodia's National Social Security Fund for occupational injury and disease

Social security benefits for private sector wage workers in Cambodia are enshrined under the Social Security Law, 2002 (Royal Kram NS/RKM/0902/018). The National Social Security Fund of Cambodia (NSSF) was established under Anukret or Sub-decree No. 16 OrNKr. BK (2007) and begun operations with the work injury insurance branch in November 2008. At present, compulsory coverage under NSSF is limited to larger firms employing at least eight employees in the following economic sectors: manufacturing (notably garment and footwear), mining and construction, transport and communications, wholesale and retail trade, and services.

Financing: The NSSF work injury scheme is financed solely by employer contribution since occupational injury and illnesses fall under employer's liability according to the national labour code. Contribution rate is set at 0.8 per cent of insurable monthly wage 'class' (out of 18 predetermined wage classes) which is capped at 1 million riel (KHR).

Benefits: Work injury benefits under the NSSF include medical care, nursing cash allowance, temporary disability cash benefit, funeral (death) benefit, permanent disability pension and caretaker benefit, survivor pension, and in-kind rehabilitation benefit. In 2010, the amount of in-kind and cash benefits disbursed totalled up to KHR2.4 billion.

Coverage: 1,021,588 insured workers in 7,041 firms under the NSSF work injury scheme in 2014, among which 725,327 or 71.0 per cent are female workers.

Since its implementation, several major issues of the NSSF work injury scheme have been identified such as low coverage rate, the under-reporting of injuries as judged by the low disbursement of benefits, and its electronic database that is employer-based and not individual worker-based. The latter can result in multiple social security numbers issued to the same employee which would impede the introduction of schemes that are (also) based on worker contributions, for example, social health insurance.

Source: Hennicot, 2012; NSSF, 2015.

⁴ Following recent reforms, coverage of the Social Insurance Law will be extended to formal economy employees with contract duration with a minimum of one month starting from 1 January 2018.

government-enforced compliance (see box 5 for the example of work injury scheme of Cambodia), or if it is offered on a voluntary-basis. As an example for the latter, the effective coverage rate among 71.1 million informal economy and self-employed workers for employment injury social insurance in Indonesia is approximately 1.5 per cent with 1,071,633 participants as of April 2015 (BJPS Ketenagakerjaan, 2015, personal communication, 3 June). This is significantly lower than the legal coverage rate (44.3 per cent) reported in table 7 for voluntary work injury social insurance coverage in Indonesia. For other ASEAN countries, the *World Social Security Report 2010/11* (ILO, 2011b) provides some limited data on effective coverage by the number of active contributors or protected persons as proportion of the working age population (with the reference year in bracket): 32.3 per cent for Malaysia (2006), 41.0 per cent for the Philippines (2003), 17.1 per cent for Thailand (2006), and 12.4 per cent for Viet Nam (2007). In Thailand, despite the inclusion of migrant workers in its Workmen's Compensation Act, most do not qualify for work injury compensation due to their informal employment status.

Sickness benefit

Another key contingency covered under basic social security is illness that renders one temporarily incapable of performing one's job. The most recent and related ILO Convention, Convention on Medical Care and Sickness Benefits, 1969 (No. 130), stipulates the provision of sickness cash benefits of "at least 60 per cent of the total of the previous earnings" that is "limited to not less than 52 weeks in each case of incapacity" or 26 weeks for countries "whose economy and medical facilities are insufficiently developed". Besides cash benefits, paid sick leave protects one's employment status by affording leave from work due to sickness. However, none of the ASEAN Member States have ratified the ILO Conventions related to sickness benefits: Nos. 102 and 130.

Paid sickness leave is provided to varying extents in ASEAN countries with two dominant scheme types: employer's liability and social insurance (see table 8). Sickness leave is considered an employer's liability under the related labour laws of Brunei Darussalam, Cambodia, Indonesia, the

Table 8. Sickness benefit schemes in ASEAN countries.

Country	Type of programme	Coverage of self-employed	Length of benefit (weeks)	Max. % wages covered
Brunei Darussalam	Employer-liability	No	2/8.5	100
Cambodia	Employer-liability	No	n.a.	n.a.
Indonesia	Employer-liability	No	52	100
Lao PDR	Social insurance or Employer-liability	No	52; 4	70; 100
Malaysia	Employer-liability	No	2/8.5	100
Myanmar	Social insurance	No	26	60
Philippines	Social insurance	Yes	17	90
Singapore	Employer-liability	No	2/8.5	100
Thailand	Employer-liability and Social insurance	Yes	4; 26/52	100; 50
Viet Nam	Social insurance	No	4/26	75

n.a.: Not applicable.

Note: Length of benefits provided within a year depending on the severity of illness: non-hospitalized/hospitalized condition. For non-hospitalized illnesses, the lowest threshold is reported for countries where length of benefits is tied to duration of employment or social insurance contribution (assuming that the qualifying period has been exceeded) and type of work. For Cambodia, the parameters for sickness benefit are left to the "internal regulations" set by the company in accordance with Article 23 Section 3, Chapter 2 of the Labour Law 1997 (see official copies of arbitral awards in Arbitration Council website).

Sources: Brunei Darussalam: Employment Order 2009; Cambodia: Labour Law 1997; Indonesia: Manpower Act 2003; The Lao People's Democratic Republic: Law on Social Security 2013 and Labour Law 2006; Malaysia: Employment Act 1955; Myanmar: Social Security Law 2012; Philippines: Social Security Act 1997; Singapore: Employment Act 1968 (Revised 2009); Thailand: Social Security Act B.E. 2533 (1990); Viet Nam: Law on Social Insurance 2014.

Lao People's Democratic Republic, Malaysia, Singapore, and Thailand. It is covered under the national social insurance programmes for the Lao People's Democratic Republic, Myanmar, the Philippines, Thailand, and Viet Nam. In Thailand, benefits from both employer's liability and social insurance entitlements can be combined. It is also exceptional in the region by providing sickness benefits for contributors working in the informal economy at a rate of 200 baht (THB) a day for a maximum 20 days a year.

In order to receive sickness benefits, an employee should satisfy a minimum duration of employment or social insurance contribution. The level of sickness benefit is usually differentiated by the severity of illness, most typically a higher benefit for workers hospitalized or diagnosed with a chronic condition. For countries like Indonesia and the Lao People's Democratic Republic, the level of sickness benefit can vary by the duration of illness. Under the Indonesia Act of Manpower 2003, the level of sickness benefit is set as follows: 100 per cent of the average wage for the first four months; 75 per cent for the second four months; 50 per cent for the third four months; and 25 per cent for subsequent months until the employer terminates the employment. The Lao People's Democratic Republic social security programme stipulates 70 per cent of the average insurable earnings (over the last six months) for the first six months of illness and 60 per cent for the following six months.

Maternity benefit

Acknowledging the benefits of maternity leave for the well-being of pregnant women, mothers, and children, the ILO Maternity Protection Convention, 1919 (No. 3), was adopted during the 1st International Labour Conference in 1919. More recently, the ILO Maternity Protection Convention, 2000 (No. 183), has increased the minimum maternity leave from 12 to 14 weeks and prescribes a benefit that is at least two-thirds of previous earnings. The related ILO Maternity Protection Recommendation, 2000 (No. 191), goes further by stipulating full income

replacement rate for a minimum of 18 weeks. Similar to the provision of sickness benefit, none of the ten ASEAN Member States have ratified the ILO Conventions related to maternity protection: Nos 102 and 183.

Despite the importance of maternity benefits, the compensation against income loss during maternity leave is usually limited to the formal economy and employer's liability. This could be a source of workplace discrimination (for example, in hiring and dismissal policies) against women of childbearing age as employers prefer to evade the costs of maternity allowances and staff replacement. And like most employer-liability provisions without a strong compliance enforcement system, it is subject to the risk of non-payments. Hence, Convention No. 183 recommends either compulsory social insurance or government-funded schemes (ILO, 2014b).

Maternity income replacement is covered under the Lao People's Democratic Republic, Myanmar, the Philippines, Thailand, and Viet Nam social security systems (see table 9). Benefit levels range from half to full income replacement rate and for a period between 60 days in the Philippines to six months in Viet Nam. Like its sickness benefit scheme, an eligible employee in Thailand can combine separate benefits, by receiving employer-liability benefit for the first 45 days at the higher replacement rate of 100 per cent of earnings and social insurance benefit for the next 45 days at the lower 50 per cent rate (ILO, 2014b). Among ASEAN countries, Viet Nam is the only country providing social insurance-funded maternity cash benefit that is equivalent to previous earnings for at least 18 weeks as prescribed by Recommendation No. 191.

Cambodia, Indonesia, and Malaysia have employers' liability-only provisions for maternity benefits while Brunei Darussalam and Singapore supplement employer-liability provisions with government-subsidized maternity benefits. As part of the government's pro-family outlook, Singapore has an interesting mix of employer-paid and government-paid maternity benefits. The government-paid benefit is accessible to all

Table 9. Maternity cash benefit schemes in ASEAN countries

Country	Type of Programme	Coverage of self-employed	Length of benefits (weeks)	Max. % wages covered
Brunei Darussalam	Employer-liability (and Government)	No	8; 13	100
Cambodia	Employer-liability	No	13	50
Indonesia	Employer-liability	No	13	100
Lao PDR	Social insurance or Employer-liability	No	15; 13	100
Malaysia	Employer-liability	No	8.5	100
Myanmar	Social insurance	No	12	67
Philippines	Social insurance	Yes	8.5	100
Singapore	Employer-liability (and/or Government)	Yes	8; 16	100
Thailand	Employer-liability and Social insurance	Yes	13	100; 50
Viet Nam	Social insurance	No	26	100

Source: ILO, 2014g with updated information for Brunei Darussalam, the Lao People's Democratic Republic, Viet Nam, and Singapore (The Lao People's Democratic Republic Law on Social Security 2013; Ministry of Manpower, 2014b; Syed Rory Malai Hassan, 2011; Bédard, 2014).

working women, including self-employed and foreign women, who are legally married and will bear children of Singapore citizenship (Ministry of Manpower, 2014b). In Brunei Darussalam, employer's liability funds eight weeks of maternity cash benefit, subject to minimum employment duration, under Employment Order 2009. From 2011, the Brunei Darussalam government introduced five additional weeks of maternity cash benefit for citizens and permanent residents who are registered under the national provident fund (TAP), legally married, and have worked for at least 180 days⁵ (Department of Labour, 2011). The additional benefit is provided via the employer but is fully reimbursed by the government. Unlike Singapore, those not covered by employer's liability, for example, the self-employed, cannot independently receive the maternity allowances from the government. In both Brunei Darussalam and Singapore, government-financed maternity benefits preclude single mothers.

Besides Singapore, maternity benefits for self-employed workers are covered on a mandatory-basis in the Philippines (for earnings above a specified threshold) and voluntarily in Thailand.⁶ Even so, a large number of self-employed and informal workers in the ASEAN region remain excluded from income compensation during maternity leave. For instance, the legal coverage of Viet Nam's generous maternity benefit provisions is less than 30 per cent of its employed female population (ILO, 2014a). This is due to its large agricultural and informal economies and the exclusion of workers without employment contracts of at least three months⁷ under the Viet Nam Social Insurance Law of 2006 (Nguyen Thang et al., 2011). Informal workers in Thailand are also not legally covered for maternal and family allowances despite enjoying social security provisions for sickness, disability, death, survivor, and (an optional) old-age benefits under Section 40 of the 1990 Social Security Act (Schmitt et al., 2013).

⁵ Married female civil servants with a minimum of 90 worked days are entitled to 105 days of paid maternity leave at 100 per cent replacement rate for those in service for more than 180 days and 50 per cent replacement for those who have worked between 90 and 180 days (Prime Minister's Office, 2011).

⁶ This applies to those who were formerly employed in the formal economy under Article 33 of the Social Security Act.

⁷ Starting from 1 January 2018 with the implementation of the new Social Insurance Law reform in 2014, coverage is extended to formal economy employees with contract duration with a minimum of one month; part-time civil servants in communes, wards and townships; and foreign citizens working in Viet Nam with a work permit.

Unemployment benefit

Besides Convention No. 102, the Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168) is an up-to-date legal instrument to protect against loss of income.⁸ To cover basic living costs, Convention No. 168 prescribes an unemployment benefit that is at least 50 per cent of one's previous earnings or the statutory minimum wage (or the wage of an average labourer). To ensure adequate income protection during unemployment, the upper limit to the benefit duration (after the initial waiting period) should be at least 26 weeks.

In the ASEAN region, two countries have introduced unemployment or employment insurance schemes: Thailand in 2004 and Viet Nam in 2009. In the Lao People's Democratic Republic and Myanmar, the unemployment benefit is part of the Social Security Decree regarding the Social Security Regime for Employees in Enterprises, 1999 (No. 207/PM) and the new Social Security Law 2012 respectively but they await further implementation plans. For Viet Nam, the unemployment insurance scheme was rolled out despite the global financial crisis to gradually replace the then severance pay system (see box 6). After several years of implementation, the 2013 adoption of the Employment Promotion Law has broadened mandatory coverage to all wage workers from January 2015 regardless of firm size⁹ (Bédard, 2014). During the same financial crisis, the Thai government has made use of the scheme's flexibility to protect the affected unemployed by extending the period of income compensation from 180 to 240 days (Carter et al., 2013). During the 2011 catastrophic floods, unemployment insurance benefit was used to provide income compensation for the insured unemployed for up to six months (ibid).

Recognizing the use of other forms of financial compensation against income loss such as

severance pay, Article 22 in Convention No. 168 allows for unemployment benefits to be partially reduced or suspended in accordance to the duration or amount of severance pay received. This is not the case in Thailand: eligible workers receive full unemployment insurance benefits on top of their severance payments upon termination of employment (Carter et al., 2013). The severance payment system can be a less reliable system to protect unemployed workers compared to unemployment insurance for the following reasons: (i) severance payments do not take into account employment status and duration of unemployment; (ii) they are not paid if employers make (unfair) claims on worker misconduct; (iii) they are not prefunded and guaranteed by the government like most social insurance benefits, leaving workers vulnerable to non-payments in case of firm bankruptcy; (iv) they rely on worker's capacity to enforce payment; and (v) they do not allow for risk pooling across firms, economic sectors, social and income classes, and geographical regions (Carter et al., 2013; Peyron Bista et al., forthcoming). Risk pooling is desirable for both employers and employees since unemployment incidences are often localized (whether in a sectoral or geographical sense) and period-specific (in the case of macroeconomic crises). Employers, particularly small and micro-enterprises, face less volatility in financial burden within a social insurance system compared to an employer liability-based severance payment system during economic crises.

While countries with unemployment benefit schemes can tailor their schemes to ensure income security in times of economic downturns (or restructuring), some countries in the ASEAN region without such a system have relied on non-contributory cash benefits, for example, the *Bantuan Rakyat 1Malaysia* (BR1M) programme and the *Bantuan Langsung Tunai* (BLT) programme for low-income households in Malaysia and Indonesia respectively.

⁸ Additionally, Convention No. 168 encourages member countries to also protect against full or partial loss of income during temporary time-related underemployment (or partial unemployment defined as a "temporary reduction in the normal or statutory hours of work") and temporary suspension of work.

⁹ Prior to 2015, unemployment insurance was only mandatory for wage workers with a contract duration of at least 12 months working in firms with ten or more employees.

Box 6

Unemployment insurance scheme in Viet Nam

The statutory unemployment insurance scheme in Viet Nam was legislated as part of its Law on Social Insurance (Law No. 127/2008/ND-CP) in 2006. It was rolled out in January 2009 despite the global financial crisis. Benefits were payable from January 2010 phasing out the severance pay system. As of 2013, the unemployment insurance scheme had 8,676,081 contributors representing 47.7 per cent of the population of wage earners.

Unemployment insurance was initially mandatory for wage workers with a contract of at least 12 months in firms with ten or more employees. Given the new Employment Law (No. 38/2013/QH13) in 2013, mandatory coverage has been extended to wage workers with a minimum three-month contract from January 2015, regardless of firm size. This partly removes the legal loophole that had previously permitted firms to evade workers' enrolment through short-term contracts.

The scheme is financed by monthly contributions from workers and employers at 1 per cent of insurable wage each, capped at 20 times the "common minimum wage" set by the government. With the accumulated surplus of the unemployment insurance fund, the government plans to stop its subsidization (that is, 1 per cent of insured wage for each wage worker) while maintaining the government's guarantee on the fund's viability.

For an insured unemployed to qualify for cash benefit, he or she will need to have at least 12 months of contributions within the last 24 months (or in the last 36 months for seasonal and short-term contract workers) prior to unemployment. Benefits can be claimed from the 16th day after registration at the employment office. To prevent the misuse of unemployment insurance, unilateral resignation is covered only if it satisfies Article 37 of

the 2012 Labour Code (10/2012/QH13) for example, by providing adequate justification and/or sufficient termination notice to employer.

The insured unemployed satisfying all qualifying conditions are eligible for monthly cash benefit that is equivalent to 60 per cent of the average earnings in the last six months prior to unemployment. The unemployment benefit is capped at five times the minimum salary of government employees or the respective regional minimum salary for private sector workers. The maximum duration of the benefit is 3 months for someone with 12 to 36 months of contributions, plus an extra month of benefit for every additional 12 months of contribution up to a maximum of 12 months of benefits.

Besides monthly cash benefit, the scheme also provides access to job matching services, vocational training allowance for up to six months, and subsidy of social health insurance premium when receiving unemployment benefit. Previously, as an incentive for re-employment, the insured unemployed could receive the remainder of the unused benefits in the form of a lump-sum benefit. However, this lump-sum has been converted into additional monthly insurance contributions, that is 12 extra months of contribution for every month of unused benefit.

The Ministry of Labour, Invalids, and Social Affairs (MOLISA) holds primary responsibility over the scheme with the assistance of Viet Nam Social Security (VSS) in managing contribution collection and benefit disbursement along with provincial Departments of Labour, Invalids, and Social Affairs (DOLISA) and their Employment Service Centres (ESCs) delegated with operational delivery. ESCs in particular register and process unemployment claims, organize job postings and referrals, and provide counselling and training guidance.

Source: Bédard, 2014; Carter et al., 2013; Lein Hoang, 2015; and Social Security Administration, 2015a.

Public employment and active labour market policies

Food subsidies and public works programmes were implemented to help reduce the adverse effects of the 2008–09 economic crisis (ILO and World Bank, 2012; ASEAN and World Bank, 2010). As an example, the Emergency Food Assistance Project (EFAP) initiated in 2008 in Cambodia with the support of development partners, had food- and cash-for-work components linked to rehabilitation works of roads and canals (ILO, 2012b).

Other forms of employment promotion instruments such as employment services, vocational training and guidance as advocated under Convention No. 168 and Employment Policy (Supplementary Provisions) Recommendation, 1984 (No. 169), fall under active labour market policies (ALMPs). Several examples from the Philippines have been highlighted in box 7. Despite the relatively low unemployment rate in the ASEAN region, issues of skills mismatch and low job quality are subject to growing concern amidst regional economic integration (ILO and ADB, 2014). ASEAN countries aspire to improve

Box 7

Active labour market policies in the Philippines

Active labour market policies (ALMPs) or labour market interventions (LMIs) constitute one of the four key components of the Philippines Social Protection Operational Framework and Strategy (SPOFS) adopted in 2012. Primarily coordinated by the Department of Labor and Employment (DOLE), they include skills development programmes, self-employment support and career assistance services.

The DOLE Integrated Livelihood and Emergency Employment Program (DILEEP) is a major intervention. Its various sub-programmes target the generation of jobs and reduction of poverty to make growth more inclusive, by providing assistance and employment to marginalized and vulnerable workers including informal economy workers, persons with disabilities (PWDs), and female workers. *Tulong Pangkabuhayan sa Ating Disadvantaged Workers* (TUPAD) is one of those sub-programmes targeting disadvantaged, displaced or unemployed workers, and victims of economic shocks and natural disasters, such as Typhoon Yolanda in 2013. The programme provides short-term wage employment at the minimum wage for ten to 30 days a year, accident insurance (through the Government Service Insurance System, GSIS), health insurance (through PhilHealth), safety and health orientation, and protective gear. From 2010 to June 2014, a total of 417,009 informal economy workers benefitted from DILEEP's various programmes.

Targeting the unemployed and underemployed, the Technical Education and Skills Development

Authority (TESDA) provides technical and vocational education and training, facilitates apprenticeships and leaderships and dual technology-based education and training in school and companies. In 2013, more than 1.9 million TESDA students were enrolled in training programmes while more than 1.7 million students graduated. The Community-based Employment Program (CBEP) is a monitoring and reporting system that consolidates information on all government-run infrastructure and non-infrastructure projects which generated more than 2.1 million jobs for low-skilled, semi-skilled, and skilled workers in local communities in 2013.

Furthermore, the Public Employment Service Offices (PESOs) are service facilities with the goal of facilitating full employment and equal employment opportunities for all. PESOs target jobseekers, employers, and students; and offer special assistance to out-of-school youth, migrant and returning workers, PWDs and displaced workers. The Philippine Job Exchange Network (PHIL-JobNet) is the official online portal that provides real-time information on available job vacancies and the labour market, matching vacancies with applicants. As of August 2014, there are more than 1.3 million registered applications. In addition, the Special Program for Employment of Students (SPES) and the Government Internship Program (GIP) provide short-term employment opportunities and internships to qualified students and fresh graduates respectively.

Source: ILO Philippines, 2014.

the level of skills of its labour force yet the provision of responsive and well-designed skills development programmes remains limited in most countries. For the abovementioned reason and others, the number of insured unemployed workers attending vocational training¹⁰ in Thailand and Viet Nam have been found to be extremely low despite the support from the respective Department for Skills Development and Employment Service Centres (Carter et al., 2013).

Labour market inclusion of people with disability

An important beneficiary group of the ALMPs are persons with disability (PWD). Prevalence of disability in the ASEAN region, depending on the definition and measurement methodology of “disability” in the country, ranges from 1.0 per cent in the Lao People’s Democratic Republic to 7.8 per cent in Viet Nam with an average prevalence rate of 2.3 per cent (UNESCAP, 2012). Focusing on the social inclusion of people with disabilities (like any other marginalized groups) into mainstream society shifts the perspective of disability from a biomedical condition to a socially created condition. Ratified by all ASEAN Member States, the UN Convention on the Rights of Persons with Disabilities provides guidelines for states to help safeguard the human rights of those with disabilities. Along the same line, rehabilitation and job placement services for persons with disability have been stipulated under the ILO Invalidity, Old Age and Survivors Benefit Convention, 1967 (No. 128), Employment Policy (Supplementary Provisions) Recommendation, 1984 (No. 169) and the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159).

There are numerous AMLPs targeted at persons with disability within the ASEAN region. Public and private employers in Thailand are mandated by the Rehabilitation of Disabled Persons Act B.E. 2534 (1991) and corresponding Ministerial

Regulation in 2010 to hire one person with disability for every 100 person with no disability (Ministry of Foreign Affairs, 2011). Should they fail to do so, they are obliged to contribute to the Rehabilitation of Disabled Persons Fund which among others, disburse zero-interest (for first five years) entrepreneurship loans to persons with disability (ibid). A similar 1:100 ratio in hiring quota is implemented by the Malaysian Civil Service Department (Implementation of service circular No. 3/2008) and for hypermarket companies with foreign ownership according to the guidelines set out by the Ministry of Domestic Trade Co-operatives and Consumerisms (UNESCAP, 2012). The Malaysian government also awards tax incentives to companies that employ or provide job-related training to persons with disabilities and income benefit in the form of the Disabled Worker Allowance for those who earn below MYR1,200 a month (ibid). In Singapore, the government’s Open Door Fund provides grants to companies that employ, train, and adapt jobs or workplace to accommodate persons with disability (Ministry of Social and Family Development, 2014b).

Several ASEAN Member States provide some form of skills training for persons with disability, for example, Community Learning Centres in Thailand (Ministry of Foreign Affairs, 2011). The government of Brunei Darussalam provides a series of tax-financed benefits, including vocational training, work placement, and monthly stipend based on skill level (JAPEM, 2013). Malaysia’s Return to Work programme implemented by its Social Security Organization (SOCISO) is comprehensive, offering physical and vocational rehabilitation and job placement support, but limited to SOCISO-insured persons with disability (SOCISO, 2014). Likewise, despite the high unemployment rate among persons with disability in Viet Nam (who work predominantly in the informal economy), there is no specialized legal provision to facilitate their access to unemployment insurance benefits and vocational training (Carter et al., 2013).

¹⁰As a percentage of secondary school enrolment, the overall technical and vocational education and training (TVET) enrolment ranges from less than 1.0 per cent in Lao People’s Democratic Republic to 18.0 per cent in Indonesia for a select group of ASEAN countries (ILO and ADB, 2014).

Old-age is one of the nine social security contingencies recognized in Convention No. 102. With the relative rapid ageing of their populations (see figure 7), one of the key concerns for ASEAN countries is whether they are “growing old before getting rich” or more accurately, growing old before having saved and invested sufficiently for old-age income security. The old-age dependency ratios (that is, the number of elderly aged 65 and above per working-age person aged between 15 and 64) for these countries are increasing with the bulk of ASEAN populations not possessing adequate, if at all, pension savings for the future.

Both the Conventions Nos 102 and 128, stipulate a maximum statutory retirement age of 65 with the possibility of earlier retirement for arduous or unhealthy work. The provision of retirement benefits in the form of periodical payments of at least 45 per cent of their previous earnings (subject to qualifying conditions) is delineated in Convention No. 128.

Population coverage

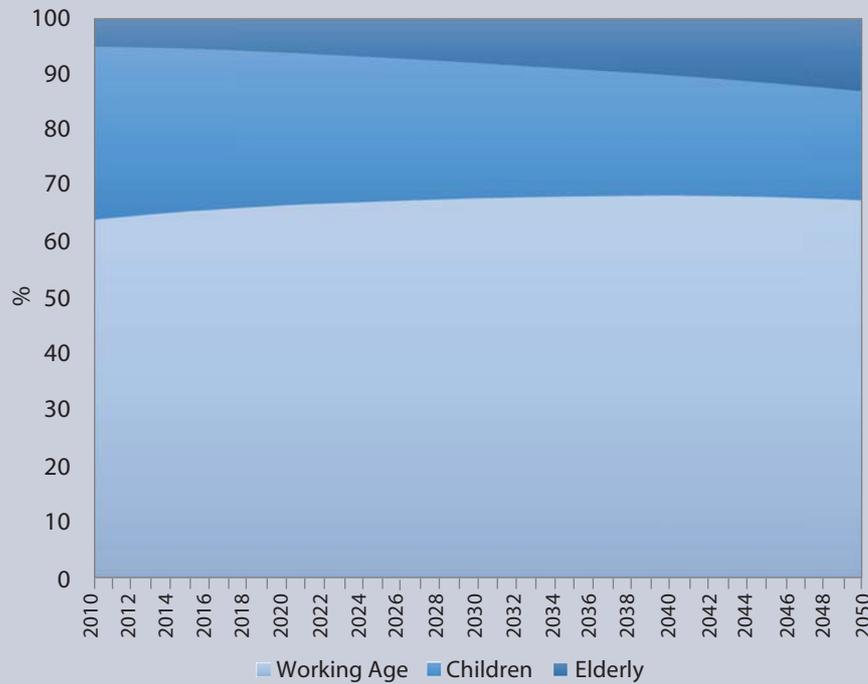
Table 10 summarizes the types of existing pension schemes in ASEAN Member States with their relevant statutory retirement age(s) and levels of legal coverage. Statutory pension schemes in the ASEAN region are either provident saving funds

R. 202: Social Protection Floors Recommendation (2012)

“The social protection floors [...] should comprise at least the following basic social security guarantees:

- (a) access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- (b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
- (c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- (d) **basic income security, at least at a nationally defined minimum level, for older persons.”**

Figure 7. Age transition of ASEAN, 2010-2050



Note: Elderly refers to those aged 65 and above, children aged 0 to 14, and working aged 15 to 64.

Source: UNDESA, 2012.

(Indonesia, Malaysia, and Singapore), social insurance schemes (the Lao People's Democratic Republic, the Philippines, Thailand, Viet Nam), or a combination of both (Brunei Darussalam). Next to lump-sum withdrawals upon retirement, provident funds in Malaysia and Singapore allow for periodic payments during retirement as prescribed by Conventions Nos 102 and 128. This is not an option under the provident funds of Indonesia and Brunei Darussalam. Two Member States – Cambodia and Myanmar – have yet to introduce national pension schemes for formal workers in the private sector although legal provisions are already in place.

Self-employed and informal economy workers who make up the majority in many low- and medium-income countries are usually excluded from the statutory pension system offered to formal economy employees. The prevalence of women engaged in the informal economy and domestic work also reduces their legal coverage

(see table 10). In the Philippines, coverage under the Social Security System (SSS) is mandatory for self-employed workers with a minimum net monthly income of 1,000 Philippines peso (PHP). Meanwhile voluntary coverage for self-employed and/or informal economy workers within the respective national pension systems is offered in Brunei Darussalam,¹ Indonesia, the Lao People's Democratic Republic, Malaysia, Singapore, Thailand, and Viet Nam. The effectiveness of voluntary pension schemes are limited by the low coverage rate among self-employed and informal economy workers. As an illustration, while 34.4 per cent of wage workers aged 15 to 64 years in Thailand in 2010 were affiliated to contributory schemes, this is only the case for 6.4 per cent of own-account workers and employers, and 0.4 per cent of unpaid family workers for the same age group.² A recent ILO global assessment shows that attempts to extend coverage through voluntary affiliations are rarely effectively implemented (ILO, 2015a).

¹ Voluntary coverage for self-employed workers in Brunei Darussalam is possible under the Supplementary Contributory Pension scheme and not the national Employees Trust Fund (TAP), see TAP website.

² Estimates provided by the ILO Research Department based on national household survey data and administrative data.

Table 10. Types of pension schemes, statutory pension age and legal coverage rate

Country	Type of schemes	Statutory pension age (M/F)	Total legal coverage (Total/F)*	Contributory		Non-contrib.
				Mandatory	Voluntary	
Brunei Darussalam	Provident fund	55/55	100.0 (100.0)	59.4	2.9	100.0***
	Social insurance	60/60***				
	Universal non-contributory	60/60				
Cambodia	**					
Indonesia	Provident fund	55/55	42.9 (24.2)	10.5	32.4	0.0
	Means-tested non-contributory	60/60				
Lao PDR	Social insurance	60/55	9.5 (6.4)	9.5	0.0	0.0
Malaysia	Provident Fund	55/55	45.0 (34.4)	45.0	0.0	0.0
	Means-tested non-contributory		60/60			
Myanmar	**					
Philippines	Social insurance	60/60	53.2 (39.0)	53.2	0.0	...
	Means-tested non-contributory	65/65****				
Singapore	Provident fund	55/55	53.5 (47.9)	53.5	0.0	0.0
Thailand	Social insurance	55/55	100.0 (100.0)	35.9	25.9	38.2
	Pension-tested non-contributory	60/60				
Viet Nam	Social insurance	60/55	64.6 (59.0)	26.4	39.2	...
	Means-tested non-contributory		60/60			
	Pension-tested non-contributory	80/80				

* legal coverage refers to eligible beneficiaries as a percentage of working age population (15–64 years) with female legal coverage rates in brackets.

** the tax-financed pension schemes for civil and military personnel in Cambodia and Myanmar are not included in this table.

*** Adjusted coverage rate for non-contributory pension and statutory pension age for the social insurance pension scheme in Brunei Darussalam.

**** Adjusted social pension age in the Philippines.

...: data not available.

Source: ILO, 2014g; Department of Social Welfare and Development, 2015; TAP website, www.tap.com.bn.

The first groups to be covered under a statutory pension scheme are civil servants and military personnel. The switch from tax-financed to contributory insurance or savings schemes for government employees have already taken place in Brunei Darussalam, Indonesia, the Lao People's Democratic Republic, the Philippines,

Thailand, Viet Nam, and Singapore. The government's contributions as an employer in the civil, military, and police personnel pension schemes in Indonesia are derived from public expenditure although civil servants do contribute a proportion of their wages to their pension fund (Satriana and Schmitt, 2012; ADB, 2007). In

contrast, the Malaysian government as an employer contributes a percentage of workers' salaries to both civil and military employees' pension schemes but civil servants have the option of a government pension to which they do not contribute, or a provident fund saving scheme to which they will contribute (see JPA).³ Government pension schemes for civil servants and military officers are excluded in table 10, notably the general tax-financed schemes of Cambodia and Myanmar which are subject to become contributory funds in the near future (Tessier et al., forthcoming; ILO, 2012b).

As a benchmark, the legal coverage of 75 per cent of the economically active population has been prescribed under ILO Convention No. 128. Following the same Convention, social insurance-type pension schemes have lower statutory retirement ages for those engaged in hazardous work in the Lao People's Democratic Republic,

the Philippines, and Viet Nam. Non-contributory pensions, or social pensions, are popular as a last resort measure for ensuring income security among the elderly, particularly women, and they can be means-tested (Indonesia, Malaysia, the Philippines, and Viet Nam), pension-tested (Thailand and Viet Nam), or universal (Brunei Darussalam). Social pensions without means-testing appear to be most effective in terms of ensuring full legal coverage and very high (more than 80 per cent) effective coverage (see the examples of Brunei Darussalam and Thailand in table 10 and table 11). By definition, means-testing criteria reduce the eligibility rate of the elderly population which may leave some vulnerable elderly unprotected (for country examples, see Handayani and Babajanian, 2012). The population-weighted⁴ regional average coverage rate of pensionable persons receiving monthly pension (excluding Myanmar) is 29.9 per cent.

Table 11. Effective coverage rate for old-age monthly pension

Country	Total effective coverage (%) [*]	Proportion by type of programme (%)		Year
		Contributory	Non-contributory	
Brunei Darussalam	81.7	...	81.7	2011
Cambodia	5.0	...	...	2010
Indonesia	8.1	...	...	2010
Lao PDR	5.6	...	...	2010
Malaysia	19.8	16.2 ^{**}	3.6	2010
Myanmar	...	...	...	...
Philippines	28.5	24.3	4.2 ^{***}	2011
Singapore	0.0	0.0	0.0	2011
Thailand ^{****}	81.7	13.1	68.6	2010
Viet Nam	34.5	25.8	8.7	2010

^{*} Old-age pension effective coverage rate refers to the (minimum) proportion of older persons above statutory pensionable age receiving an old-age monthly pension, contributory or non-contributory.

^{**} Only government pension scheme included, not accounting for the voluntary periodical payment offered under the provident fund.⁵

^{***} The old-age grant, launched in 2011, and the retirement programme for veterans, are considered non-contributory schemes.

^{****} These proportions refer only to beneficiaries of the old-age or disability social pensions. As a result the reference taken is not the statutory pensionable age of 55 but the age of eligibility for the old-age social pension (60 and over).

...: data not available.

Source: ILO, 2014g.

³ Malaysian military personnel contribute to their own scheme (*Lembaga Tabung Angkatan Tentera*, LTAT) (Asher, 2011).

⁴ The "regional" average of effective coverage rate (excluding Myanmar due to lack of data) has been weighted by the 2010 estimated national populations above age 60 years (UNDESA, 2012).

⁵ Very few take up for the voluntary periodical payment under the Employees Provident Fund (EPF), for example, only 1,980 members opted for it in 2014 (EPF, 2015).

Adequacy of benefits

Introducing non-contributory pension schemes, whether means-tested or not, has a direct impact on a country's level of effective pension coverage (refer to table 11). The effective pension coverage rate however, is not indicative of the amount of pension savings and the total pension savings and/or benefits can be exceptionally low for many in ASEAN countries. This is the case for tax-financed social pension schemes which rely on fiscal capacity and the political will to ensure income security for the elderly. Social pension schemes that currently exist in six ASEAN countries – Brunei Darussalam, Indonesia, Malaysia, the Philippines, Thailand, and Viet Nam – disburse monthly benefits ranging from 44 to 729 per cent of the US\$1.25 a day poverty line or in aggregate, 5 to 10 per cent of the respective country's GDP per capita (see table 12). Nonetheless, social pensions have been found to be an effective poverty reduction tool: in Thailand, the old-age allowance (*Bia Yung Cheep*) halves the poverty rate of elderly single-person households (from 5.8 per cent to 2.5 per cent) and decreases the poverty rate of all households from 9.6 per cent to 8.3 per cent

(Suwanrada and Wesumperuma, 2012; see also Handayani and Babajanian, 2012; Hanlon et al., 2010).

Mandatory provident fund schemes found in Brunei Darussalam, Indonesia, Malaysia, and Singapore tend to have lower replacement rates compared to social insurance pension schemes found in the Philippines, Thailand, and Viet Nam. The median wage male worker in Indonesia is only expected to receive a pension income of about 14 per cent of his lifetime average earnings (OECD, 2013). This ratio is higher in Malaysia and Singapore: slightly above 40 per cent of the country's respective median wage male worker's average earnings.⁶ With the exception of Brunei Darussalam,⁷ social insurance-type schemes clearly provide higher replacement rates than provident fund schemes (see figure 8).

Regardless of pension scheme-type, figure 8 illustrates the inadequacy of pension benefits of the selected ASEAN countries in relation to average earnings. In addition to providing income security and reducing old-age poverty, the secondary function of the pension is to maintain

Table 12. Social pension schemes in ASEAN countries

Country	Universal or Targeted	Minimum benefit	% US\$1.25 poverty line	% GDP per capita	Number of beneficiaries	% of 60+ covered
Brunei Darussalam	Universal	BND250	729	6	19 757	86
Cambodia	(no social pension)					
Indonesia	Means-tested	IDR30 000	107	9	10 000	0
Lao PDR	(no social pension)					
Malaysia	Means-tested	MYR300	414	10	120 496	5
Myanmar	(no social pension)					
Philippines	Means-tested	PHP500	51	5	250 000	4
Singapore	(no social pension)					
Thailand	Pension-tested	THB600	88	4	5 698 414	64
Viet Nam	Pension-tested (>80)	VND180 000	44	5	948 111	12
		VND180 000	56	6	...	...

...: data not available.

Source: HelpAge International, Pension Watch database.

⁶ The forecast for Malaysia based on actual Employees' Provident Fund (EPF) data in 2013 proves to be more dire: "majority of Malaysians would be without any savings for more than a decade after retirement" (Kamal Salih, Lee, and Muhammed Abdul Khalid, 2014).

⁷ Based on a different methodology, the replacement rate for the average wage male worker in Brunei Darussalam with 30 years of contributions is approximately 48 per cent of his pre-retirement earnings (World Bank, 2007).

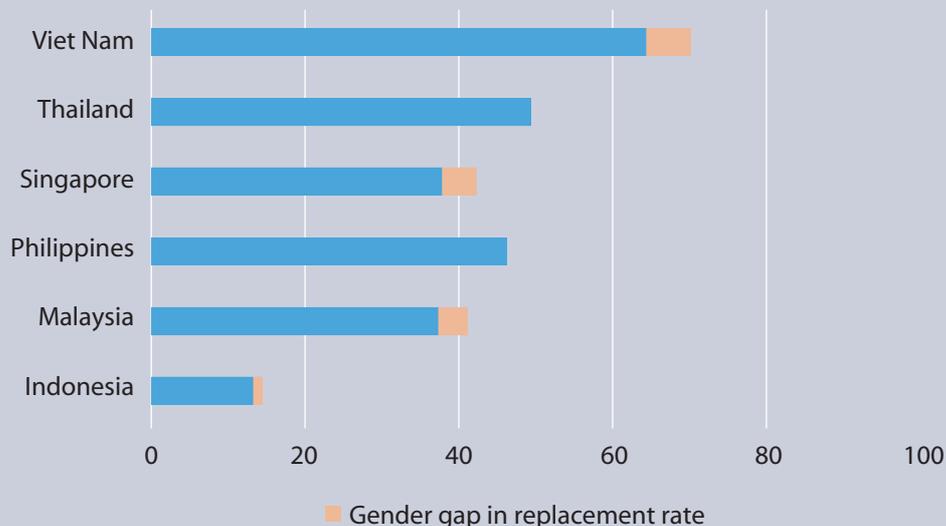
one's living standards by smoothing consumption. Thailand has established its voluntary Provident Fund, on top of its social security old-age benefit scheme, for formal economy workers since 1983 (Schmitt et al., 2013). To complement the mandatory provident fund schemes, voluntary “third pillar” saving schemes have been introduced in Singapore and more recently, Malaysia.

While there is little difference in the statutory retirement age for men and women in ASEAN Member States (with notable exceptions such as the Lao People's Democratic Republic and Viet Nam's social security schemes), women are still less likely to be covered by a pension scheme (see table 10), and even if they do, they accumulate lower lifetime pension contributions. The latter can be attributed to their lower average earnings compared to men and their involvement in informal, domestic, and care work. Women also tend to live longer than men, thus face higher risk of old-age poverty. Nonetheless, the design of the pension system appears to be crucial in addressing the gender imbalance. OECD (2013) estimates that earnings-related or “defined benefit” pension systems in the Philippines and Thailand could, under certain conditions, provide equal replacement rates for both men and women (see

figure 8). In contrast, individual pension savings schemes found in Indonesia, Malaysia, and Singapore do not allow for such redistribution between male and female workers.

Consistent with Convention No. 102, government-guaranteed periodic payments as opposed to lump-sum withdrawals ultimately protect the income security of the elderly against risks of longevity and economic crises (refer also to Bonnet et al., 2010). In recognition of the benefit of annuities in providing income security for the elderly and to promote its adequacy, Brunei Darussalam introduced the mandatory Supplemental Contributory Pension (*Persaraan Caruman Tambahan*) in 2009 to complement the employees' provident fund (*Tabung Amanah Pekerja*) and the social pension (*Pencen Umur Tua*). Similarly, the Singapore Parliament has recently passed a law introducing a social pension, the Silver Support scheme, targeted at the elderly poor and has since 2009 started to replace the Central Provident Fund (CPF) Retirement Sum Scheme with the Lifelong Income for the Elderly scheme (CPF Life) which provides lifelong monthly pension benefits (Central Provident Fund Board, 2014; Chia and Tsui, 2014; Sim, 2015; Shanmugaratnam, 2015).⁸ While the disbursement of monthly pension benefits upon

Figure 8. Pension replacement rates for men and women in selected ASEAN countries



Note: Estimate of pension replacement rates pertain to average-income earners in the country.
Source: OECD, 2013.

retirement (conditional upon sufficient savings) is a voluntary option under the Malaysian Employees' Provident Fund (EPF), Indonesia plans to introduce a new pension scheme (*Jaminan Pensiun*, JP) disbursing periodic benefits alongside its provident fund scheme (*Jaminan Hari Tua*, JHT). At present, most withdrawals of Indonesia's statutory old-age savings fund occur at prior unemployment with only 8.3 per cent withdrawals at retirement age of 55 (Guérard, 2012).

Even so, annuitizing without indexation to price inflation and wage growth will not ensure income adequacy over time (ILO, 2014c). ILO Invalidity, Old-Age and Survivors' Benefits

Recommendation, 1967 (No. 131) prescribes periodic adjustments “taking account of changes in the general level of earnings or the cost of living”. Pension benefits are linked to minimum wage increases in Viet Nam and are occasionally adjusted according to price inflation and wage growth in the Philippines and on a more discretionary basis in Thailand (OECD, 2013). Next to the adequacy of retirement benefits, the solvency of the retirement funds to ensure sustainable provision of future retirement benefits is equally if not more important. Box 8 below describes the sustainability of Viet Nam's contributory pension scheme alongside its other pension schemes.

Box 8 Pension system in Viet Nam

The retirement provisions for the old-age in Viet Nam are derived from three main channels:

- i) contributory pension under Viet Nam's Social Security Scheme (VSS);
- ii) non-contributory pension-tested or means-tested social pension; and
- iii) non-contributory pre-1995 government pension scheme that is being phased out.

Old-age pension is a priority and is exemplified by the mandatory coverage for public and private sector employees with contracts of at least three months. For the rest, voluntary coverage under VSS is possible. However, it is limited to old-age and survivor contingencies, excluding the other contingencies enshrined in Convention No. 102 such as work injury, maternity, and unemployment. As of 2014, compulsory pension contributions from workers and employers amount to 26 percent of the average monthly wage (8 percent and 18 percent respectively) for wage workers, while voluntary contribution from the self-employed amount to 20 per cent. Statutory retirement ages differ for men and women (60 and 55 respectively) and for those engaged in hazardous employment (55 and 50 for men and women respectively).

With steady growth in coverage rate over the years, VSS social insurance covered 59.8 per cent wage workers or 20.8 per cent of the 52.2 million employed population in 2013 (Bédard, 2014). Wage workers only represent 34.8 per cent of workers with the bulk (45.5 per cent) being self-employed workers (Bédard 2014), many who work in rural areas and/or the agricultural sector. Voluntary coverage among this group is still very low: 173,584 or 0.3 per cent of the labour force (Hong Thuy, 2014). Most voluntary contributors were originally part of the compulsory insurance scheme but were eventually transferred because they did not satisfy the minimum contribution duration for pension and funeral benefits (ibid).

Besides the relative low contributory pension coverage, increased life expectancy and decline in fertility have given Viet Nam one of the fastest ageing rate in the world: doubling from 7 per cent of the population aged 65 and older in 2011 to 14 per cent in 2030 (Thanh Nien News, 2014). The current national pension scheme has been assessed by the ILO to be unsustainable in the long run. Assuming that the coverage rate of the VSS contributory pension fund will be constant for the projection period, the initial actuarial review

⁸ Both CPF Life and the CPF Retirement Sum Scheme are conditional to minimum retirement savings and disburse monthly pension benefits – however, the former is lifelong while the latter allocates for about 20 years post-retirement.

forewarns depletion by 2034 (ILO, 2013e). To bolster the funds, the government has been advised, among others, to equalize and increase the retirement ages for men and women.

As a last resort social protection, the social pension or social assistance for the elderly in Viet Nam is offered in two forms: pension-tested cash benefit for

those aged 80 and above, and means-tested cash benefit for those aged 60 and above. The means-tested social pension is subject to strict eligibility criteria with pension benefit dependent on the household or individual characteristics such as age and health or physical condition (see table below). The coverage of the elderly was approximately 12 per cent in 2011.

Category	Beneficiaries	Multiplier	Benefit level (VND/1000s)
1	Age 80 and above without pension or social benefits	1	180
2	Older people living in poor households; and; a) living alone; or b) living with ill older spouse and do not have any relatives to support oneself		
	Age 60-79 years	1	180
	Age 60-79 and severely disabled; or age 80 and above	1.5	270
	Age 80 and above and severely disabled	2	360

Note: Table extracted from Giang and Wesumperuma, 2013.

Source: Bédard, 2014; Bonnet et al., 2012; Giang and Wesumperuma, 2013; ILO, 2013e; Thanh Nien News, 2014; Hong Thuy, 2014.

Long-term care

Income security for the elderly can be undermined by high costs of health care and long-term care services⁹ since exorbitant costs, particularly for privately sourced services, may drive families into poverty. The extension of average life expectancy and its related diseases translate into higher prevalence of elderly disability: an average of 52.8 per cent of older persons aged 60 and above in the Southeast Asia and Western Pacific regions have moderate to severe levels of disability (WHO, 2011), (see table 13). In the ASEAN region, family-based provision of income and care for the elderly is still prevalent with the majority of elderly co-residing with their children¹⁰ (Chan, 2005; Knodel et al., 2013; Knodel and Nguyen Minh Duc, 2014).

According to the 2012 Myanmar Survey of Older Persons, as many as 77 per cent of those aged 60 and above in Myanmar co-reside with their children (Knodel and Nguyen Minh Duc, 2014). Singapore has institutionalized the provision of income security for the elderly as the children's obligation via the Maintenance of Parents Act 1995 (Revised 1996). Older persons aged 60 and above who cannot financially support themselves (or their corresponding caretaking person or organization) may legally seek income support from one or more of his or her children (Attorney-General's Chambers Singapore, 1996). Consequently, government provision of long-term care for the elderly is meagre in ASEAN countries. Public or private residential care homes are considered only as a contingency measure for the underprivileged or "abandoned" minority.

⁹ The job creation aspect within the growing demand for elderly health care and long-term care services in ASEAN countries has yet to be explored.

¹⁰ We also note the care-giving role of older persons, especially as grandparents and in "skip generation" households where adult children are absent due to employment elsewhere (Knodel et al., 2013; Knodel, Nguyen Minh Duc, 2014).

Table 13. Estimated prevalence of elderly disability by WHO region in percentage, 2004

Level of disability	World	High-income countries	South-East Asia	Western Pacific
Severe	10.2	8.5	12.6	10.0
Moderate and severe	46.1	36.8	58.8	46.7

Note: Global Burden of Disease estimates for those aged 60 and above. ASEAN Member States are divided into two separate WHO regions: South-East Asia (Indonesia, Myanmar, Thailand, and other non-ASEAN countries: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Maldives, Nepal, Sri Lanka, and Timor-Leste) and Western Pacific (Brunei Darussalam, Cambodia, the Lao People's Democratic Republic, Malaysia, the Philippines, Singapore, Viet Nam, and other non-ASEAN countries: Australia, China, Cook Islands, Fiji, Japan, Kiribati, Marshall Islands, Federated States of Micronesia, Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Republic of Korea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu).

Source: WHO, 2011.

In at least two ASEAN Member States – Singapore and Thailand – tax incentives are in place to encourage the familial arrangements for elderly care. Tax reliefs for parental care of up to THB30,000 (THB60,000 if the care recipient has disability) per parent and for parent's health insurance of up to THB15,000 are available in Thailand (Deloitte, 2013). A similar tax relief amounting between SGD4,500 and SGD14,000 is offered to Singaporean taxpayers with low-income live-in and/or dependent parent(s) aged 55 years and above with an annual income not exceeding SGD4,000 (Inland Revenue Authority of Singapore, 2015). A higher tax relief is given for live-in parent(s) and for parents with physical or mental disability (the age criterion is waived for disability).

Singapore has several other innovative policies to ensure long-term elderly care. Within Singapore's public housing allocation, a quota-based priority

is given to parents and married children who wish to live in close proximity to one another under the Married Child Priority Scheme (HDB, 2014). Since 2002, all citizens and permanent residents with mandatory medical savings accounts (Medisave) are covered under the old-age disability insurance scheme (Eldershield) from the age of 40. The scheme is operated by private insurers and provides a monthly cash benefit of SGD400 to older persons with severe disability to cover out-of-pocket care expenses for up to 72 months (Ministry of Health, 2015a). Citizens and permanent residents who were ineligible to join Eldershield in 2002 due to overage and pre-existing disabilities are covered under the government social assistance scheme, the Interim Disability Assistance Program for the Elderly (IDAPE) which provides a monthly cash benefit of SGD150 or SGD250, depending on per capita household income, for a maximum of 72 months (Ministry of Health, 2013b).

Despite the diversity found across ASEAN countries, there are several, prevailing cross-cutting issues in social protection. They include: (i) implementing necessary improvements in inter-agency coordination at various levels; (ii) incorporation of migrant workers in social protection schemes in the midst of regional integration; (iii) reducing the persistent gender gap in social protection coverage; and (iv) tackling common threats in the form of natural disasters and climate change.

Improving coordination

ASEAN Member States have attempted to improve inter-agency coordination at various levels in the design and implementation of social protection schemes. As presented in figure 9, the key issues that have been identified are: (i) adoption of national social protection strategies; (ii) consolidation of existing schemes into a national system; (iii) establishment of centralized database of (prospective) beneficiaries; (iv) central coordination agency for social protection programmes; and (v) ASEAN-level coordination.



Adoption of national social protection strategies

Some ASEAN Member States have brought forth an explicit and concerted national commitment towards social protection by adopting national social protection strategies. For example, the

Royal Government of Cambodia adopted its National Social Protection Strategy (NSPS) in 2011 while in the Philippines, the Social Protection Operational Framework and Strategy was approved the following year (Royal Government of Cambodia, 2011; Villar, 2013). And more recently in Myanmar, a Technical Support Group was established in 2014 to support the preparation of the country's first national social protection strategic plan. At present, the first draft of the national social protection strategy is currently under review by the Myanmar government (Tessier et al., forthcoming).

These documents not only set objectives and targets for the extension of social protection but also seek to coordinate interventions from different ministries and agencies. Typically such strategies often link social protection with the employment promotion agenda, thus contextualizing social protection programmes within the broader socioeconomic development plan of the country.

Consolidation of existing schemes into a national system

Faced with a myriad of related but distinct schemes, some ASEAN countries have sought for consolidation under one national social security system (Indonesia, the Lao People's Democratic Republic, and Myanmar) or national health system (Indonesia, the Lao People's Democratic Republic, Thailand, and Viet Nam). While anticipating the unification of its social health schemes under the National Health Insurance system, the Lao National Assembly has already integrated its two statutory social security administrations – the State Authority for Social Security (SASS) for public sector workers and the Social Security Organization (SSO) for private sector workers – as stipulated under its Law on Social Security adopted in July 2013 (ILO, 2014e).

Like the Lao People's Democratic Republic, Indonesia is in the process of consolidating both its national health system (*Jaminan Kesehatan*

Nasional under the national health provider, BPJS Kesehatan) since 2014 and national social security system (under the national social security provider, BPJS Ketenagakerjaan) since 2015. Despite the Law on the National Social Security System (No. 40/2004) adopted back in 2004, further elaboration of the schemes (for example, in terms of benefit and financing mechanism) had to wait for supplementary government regulations and presidential decrees, such as the Law No. 24/2011 on Social Security Providers and Presidential Regulation No. 12/2013 on Health Insurance (Asep Suryahadi et al., 2014). A major advantage of a national system is the capacity to address the uneven and unequal provision of social protection across social groups and administrative jurisdictions. Prior to the national health system, local governments with superior fiscal capacity initiated different non-contributory local health schemes (collectively known as *Jaminan Kesehatan Daerah*, Jamkesda) for residents identified as “poor” but not protected under Jamkesmas (*Jaminan Kesehatan Masyarakat*), the federal government's non-contributory scheme for the poor and “near poor” (Harimurti et al., 2013; Satriana and Schmitt, 2012).

Establishment of centralized database of (prospective) beneficiaries

Along with uniting related schemes, a number of ASEAN countries have sought to establish centralized databases of (prospective) beneficiaries for targeted and non-targeted schemes (an example of the latter is the database of beneficiaries for the disparate health schemes of Thailand). In Malaysia, the national poverty database, eKasih, was rolled out in July 2008 to coordinate poverty reduction schemes and projects across federal and subnational levels and between governmental and non-governmental agencies (ICU JPM, 2012). Besides increasing complementariness between programmes and reducing inefficiencies from programme duplication and overlapping assistance, it can also be utilized as a monitoring system to evaluate the effectiveness of poverty reduction schemes and projects. As of May 2012, the database contains

information for over 1 million households collected from a poverty census (*Banci Isi Rumah Miskin*, BIRM) and an open registration system that is subject to further verification of household income. It also contains details of poverty reduction schemes and projects offered by the participating agencies and recommends potential beneficiaries to the appropriate agencies (ICU JPM, 2012).

While means-testing is mainly income-based under Malaysia's eKasih database, Indonesia and the Philippines use proxy means testing for the poverty assessment of their respective databases of (potential) beneficiaries: Unified Database (*Basis Data Terpadu*, BDT) and the National Household Targeting System for Poverty Reduction (NHTS-PR or *Listahanan*). Proxy means testing is used to estimate a household's level of income or socioeconomic condition using a variety of proxy indicators such as household size, education status, asset ownership, and so forth. This estimate is then compared to the pre-determined threshold (which could vary, for example, between rural and urban areas) to identify eligible beneficiaries of the programmes.

One of the largest databases, BDT contains approximately information of the poorest 40 per cent in Indonesia or approximately more than 90 million potential beneficiaries for the various targeted schemes (TNP2K website). The BDT was compiled based on the poverty mapping of the population census, the socioeconomic survey (*Survei Sosial Ekonomi*, Susenas), and the "village potential" survey (*Potensi Desa*, Podes) conducted between 2010 and 2011. Consultations with the poor and observations from the field also helped complement and validate the poverty mapping exercise. The BDT has been used in many means-tested social programmes, including the school assistance programme for poor children (*Bantuan Siswa Miskin*, BSM) and the enrolment of poor households under the national health insurance scheme (JKN).

Cambodia has also utilized a form of proxy means test for its Identification of Poor Households

Programme (IDPoor) database. IDPoor employed geographical targeting of Cambodia's poorest rural provinces in 2006 which were gradually expanded to include other poor rural provinces. By 2011, the database covered 22 out of 23 provinces and 88 per cent of the whole population (Kwon et al., 2014). Future plans include the identification of poor households living in urban areas (Ministry of Planning).

Central coordination agency for social protection programmes

Duplication among fragmented social protection-related programmes, agencies (different line ministries, local implementers, development partners, and so forth), and sources of funding (such as insurance premiums, general tax revenues, and donor aid) can be resource-inefficient and an impediment to the goal of providing social protection to all. In this case, a social protection-specific coordination unit or agency may be necessary. Cambodia has a dedicated Social Protection Coordination Unit established within the Council for Agriculture and Rural Development (CARD) to "provide policy oversight, monitoring and evaluation, and coordinate inter-agency dialogues and information management on social protection" as part of its National Social Protection Strategy, NSPS (Royal Government of Cambodia, 2014).

In Indonesia, the central role of the National Social Security Council (*Dewan Jaminan Sosial Nasional*, DJSN) in formulating social security policies and harmonizing the implementation of the National Social Security System (SJSN) was delineated in the National Social Security System Law in 2004. The Council is also tasked with the monitoring and evaluation of social security programmes at the various administrative levels (Jaminan Sosial Indonesia, 2015). Currently, the Council has sought to encourage the voluntary integration of hundreds of existing, local health insurance programmes (Jamkesda) under the new National Health Insurance system (JKN) administered by BPJS Kesehatan (CHEPS, 2015).

ASEAN-level coordination

At the same time, progress has been made at the regional-level in terms of developing normative frameworks for strengthening social protection in the region, such as the 2009 ASEAN Socio-Cultural Community (ASCC) Blueprint and 2007 Cebu Declaration on Migrant Workers. The most significant achievement nevertheless is the 2013 ASEAN Declaration on Strengthening Social Protection. Presently, ASEAN sectoral bodies (ACDM, SLOM, SOMSWD, SOMHD, and SORDPE) are in the process of preparing a list of commonly agreed upon concrete actions that will help realize the regional social protection declaration. The process has also engaged ASEAN-level social partners and development partners, notably during the ILO-led ASEAN Tripartite Seminar on Strengthening Social Protection in November 2014 and the ASEAN Multi-Sectoral Consultation on Social Protection in December 2014.

In addition to the normative frameworks, the ASEAN Secretariat has also developed the ASCC Scorecard with indicators to monitor and evaluate social development as outlined in the ASCC Blueprint at the national and regional levels (ASEAN, 2014b). Additionally, the ASEAN Community Statistical System (ACSS) has facilitated direct consultations and enhanced coordination among national data producing agencies (ASEAN, 2014a). High quality data and indicators have been acknowledged to be crucial instruments within the upcoming ASEAN Framework for Equitable Economic Development (AFEED) and Post-2015 Sustainable Development Goals in the ASEAN region (ibid).

Social protection of migrant workers

The Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) defines a “migrant worker” as:

a person who migrates or who has migrated from one country to another with a view to being employed otherwise than on his own account and includes any person regularly admitted as a migrant worker.¹

Despite the definition, international labour standards set out by ILO Conventions and Recommendations are “minimum labour standards that have been universally agreed upon at the international level” and do not make a distinction between workers based on nationality (ILO, 2007).

Within the ASEAN region, intraregional migration increased from 1.5 million to 6.5 million between 1990 and 2013 (ILO and ADB, 2014).² More than 90 per cent of intraregional migrants within ASEAN are hosted by its three main receiving countries – Malaysia, Singapore and Thailand (ibid). The main sending countries of these intraregional migrants (as a proportion of the respective country’s nationals abroad) are: Myanmar, the Lao People’s Democratic Republic, Cambodia, and Indonesia. With the high intraregional labour mobility among ASEAN Member States, equal treatment of migrant workers and the portability of social security rights are major issues. At this point, six ASEAN Member States – Indonesia, Malaysia,³ Myanmar, the Philippines, Thailand, and Singapore – have ratified the Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19) that provides occupational injury protection for non-national workers (see table 14).

¹ This definition excludes “frontier workers; artistes and members of the liberal professions who have entered the country on a short-term basis; seafarers; persons coming specifically for purposes of training or education; employees of organizations or undertakings operating within the territory of a country who have been admitted temporarily to that country at the request of their employer to undertake specific duties or assignments, for a limited and defined period of time, and who are required to leave that country on the completion of their duties or assignments” and is narrower than the “migrant worker” definition under the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).

² These figures may have been underestimated by the large undocumented migration within the ASEAN region. Undocumented migrants often earn very low wages, engage in informal economy and/or hazardous sectors, and yet receive the least social protection.

³ The state of Sabah in Malaysia has ratified the Migration for Employment Convention (Revised), 1949 (No. 97) which overlaps with the Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19) ratified by the remaining components of Malaysia (Sarawak and Peninsula Malaysia).

Table 14. Ratification of Conventions related to migrant workers

Country	Migrant workers' rights			Equal treatment in social protection		
	Migration for Employment Convention (Revised), 1949 (No. 97)	Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143)	International Convention on the protection of the rights of all migrant workers and members of the families, 1990	Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19)	Equality of Treatment (Social Security) Convention, 1982 (No. 118)	Maintenance of Social Security Rights Convention, 1982 (No. 157)
Brunei Darussalam
Cambodia	2004 ^(c)	...	...	...
Indonesia	2012	1950	...	...
Lao PDR
Malaysia	1964 ^(a)	...	...	1964	...	...
Myanmar	1927	...	...
Philippines	2009 ^(b)	2006	1995	1994	1994 ^(d)	1994
Singapore	1965	...	...
Thailand	1968	...	...
Viet Nam

...: Convention not ratified.

^(a) only Malaysia-Sabah (also excludes the provisions of Convention No. 97, Annexes I to III).

^(b) excludes the provisions of Convention No. 97, Annexes II and III.

^(c) year of signature (yet to be ratified).

^(d) includes branches (a) to (g) only.

Source: Table reproduced from ILO and ADB, 2014, p. 95.

Migrant workers are double disadvantaged because they receive less social protection both at home and in the host country.

Progress with respect to other migrant worker-related Conventions (see table 14) or bilateral social security agreements between ASEAN Member States has been less promising. In the absence of bilateral social security agreements, some countries with retirement provident fund schemes (Brunei Darussalam, Indonesia, Malaysia, and Singapore) allow migrant workers to make lump-sum withdrawals of accrued pension contributions upon departure from the country. Participation in the national provident funds of Brunei Darussalam and Singapore is only possible for workers with permanent residence status (Pasadilla, 2011). In Malaysia,

migrant workers can opt to contribute, in which case, both employee and employer will be liable to make monthly contributions from then on (Employees Provident Fund, 2014). Even so, the large majority of migrant workers do not have the option of enrolling in their own national social security systems or that of the host country,⁴ or they cannot transfer the accrued contributions or entitlements between social security systems (see also the Maintenance of Social Security Rights Convention, 1982 (No. 157)).

Migrant workers are doubly disadvantaged because they receive less social protection both at home and in the host country (see box 9). In the latter case, they are often excluded from tax-financed schemes such as social assistance programmes or social pension schemes despite

⁴ Recent reforms in the Law on Social Insurance anticipates the extension of coverage to migrant workers with valid work permits in Viet Nam as of January 2018 (SSA, 2015b).

Box 9**Equal treatment of migrant workers?**

Many migrant workers in the ASEAN region are vulnerable to discrimination and exclusion in the destination countries. Two overlapping main reasons are the status of their migration (as irregular or undocumented migrants) and the nature of their employment (for example, informal work or informal economy). Even for the regularized migrant workers in the formal economy, they are not subject to equal treatment across all four social protection guarantees. In recent years, the main receiving ASEAN countries – Brunei Darussalam, Malaysia, Singapore, and Thailand – have also reduced public subsidization for non-nationals at public health facilities by reducing hospital subsidies for non-nationals or obliging mandatory take-up of private insurance. Here, several work injury and health insurance schemes in ASEAN countries are examined under the notion of equal treatment of migrant workers.

To begin with, six out of ten ASEAN Member States have ratified the Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19) to ensure some occupational injury protection for non-national workers: Indonesia, Malaysia, Myanmar, the Philippines, Thailand, and Singapore. Under the Work Injury Compensation Act 2009, private insurance for work injury and illnesses is compulsory in Singapore for both migrant and non-migrant workers as long as they engage in manual work or earn less than SGD1,600 in doing non-manual work. In contrast, although the equality of treatment for accident compensation is recognized in Thailand under its Workmen's Compensation Act B.E. 2537 of 1994, in reality, most migrant workers are not insured for occupational injury and diseases. This is due to their undocumented status, non-compliance of employers, migrants' lack of awareness on their rights, language barriers, onerous administrative procedures, and other factors. In Malaysia, non-permanent resident migrant workers do not qualify for work injury and invalidity protection under its Social Security Organization (SOCSO) but instead,

are obliged to be insured under the lesser Foreign Workers Compensation Scheme (FWCS). Though not a signatory of Convention No. 19, the Viet Nam government has recently amended its Law on Social Insurance to permit the coverage of migrant workers with valid work permits as of January 2018.

As for health care coverage, health insurance for migrant workers is mandatory in the main migrant recipient ASEAN Member States: Malaysia, Singapore, and Thailand. Thailand's tax-financed Universal Coverage Scheme excludes migrant workers, ethnic minorities, and displaced or stateless persons who do not possess a national identity document. Nevertheless, social health insurance coverage is available for documented migrant workers in the formal economy (i.e. those under Section 33 of the Social Security Act). Those from Cambodia, the Lao People's Democratic Republic, and Myanmar who do not qualify are obliged to take up the Compulsory Migrant Health Insurance (CMHI) to access public health care facilities.

In Malaysia where public health care providers are tax-financed, the Foreign Workers Health Insurance Protection Scheme (SPIKPA) by private medical insurance was implemented between 2011 and 2013 to reduce the government subsidization of migrant workers' health care. Similar to Malaysia, Singapore obliges employers to purchase mandatory private insurance for their (non-permanent resident) migrant workers and to bear any excess medical expenses. Migrant workers who are Permanent Residents in Singapore are covered under the compulsory medical savings and opt-out insurance schemes but receive less health care subsidies than Singapore citizens.⁵ More recently in 2015, mandatory take-up of private insurance for non-permanent resident migrant workers was introduced in Brunei Darussalam. On a positive note, Indonesia now permits the enrolment of migrant workers who have worked in the country for at least six months under its new national health insurance scheme (JKN).

Source: CEACR, 2011; Huang, 2010; Koo, 2014; Ministry of Manpower, 2014a, 2013; Schmitt et al., 2013; SSA, 2015b.

⁵ Revised subsidy rates in 2012 have halved the government subsidy for Permanent Residents (PRs) in Singapore for most medical services while non-PR foreigners do not receive any subsidy (Ministry of Health, 2012).

contributing to the host country economy through work, consumption, and taxation.⁶ To compensate for this shortfall among its large labour population working abroad, Overseas Filipino Workers (OFW) are covered for invalidity and death risks by the Philippine Overseas Workers Welfare Administration (OWWA) schemes and can optionally enrol under the Philippine Social Security System (SSS). With the imminent ASEAN Economic Community (AEC) integration, decent work conditions for migrant workers and a multilateral social security agreement as proposed in the 2007 ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (or the Cebu Declaration on Migrant Workers) would be indispensable to responsibly manage intraregional migration.

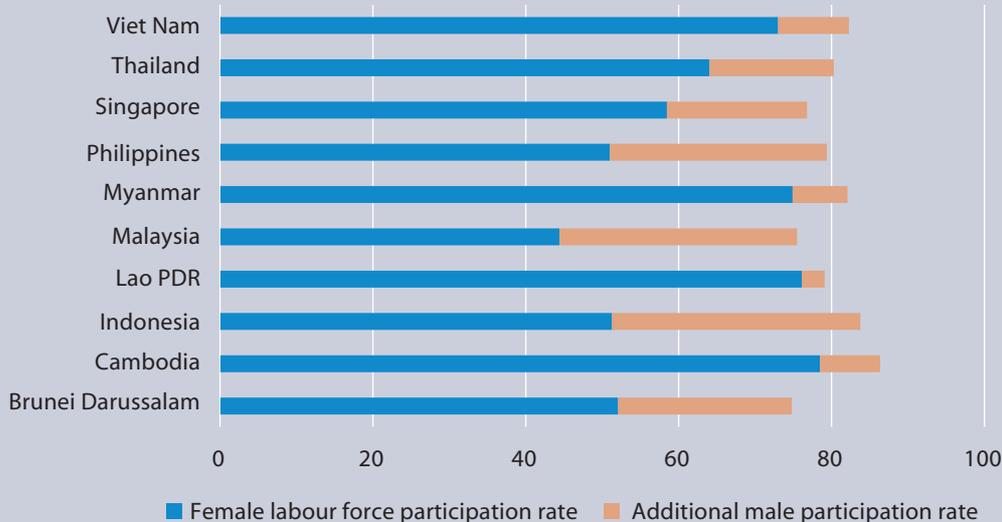
Gender disparities

Gender differences in social protection can manifest in several ways. Two of which pertain to: (i) gender differentials in employment status and sectors that affect their income and social

security entitlements; and (ii) gender differentials in socio-demographic risks that necessitate additional social protection.

Across ASEAN Member States, female labour market participation rates vary from 44.5 per cent in Malaysia to 78.7 per cent in Cambodia, with the regional average at 59.2 per cent⁷ in 2014 (see figure 10). The gender gap in participation rate varies tremendously. The largest gap of 32.6 per cent in Indonesia is more than ten times that of the smallest gap of 3.0 per cent in the Lao People's Democratic Republic (ILO, 2015b). The female labour market participation rate is the highest (more than 70 per cent) with the gender gap being the smallest in the current and former socialist economies: Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam (CLMV). Non-participation in the labour market effectively limits these women's rights to social security benefits to that of dependents or survivors in the event of the death of breadwinner. This is an extremely precarious position in countries that lack non-contributory benefit schemes. By not possessing their own

Figure 10. Gender differences in labour market participation



Note: Preliminary estimates for 2014.

Source: ILO, 2015b.

⁶ Except for Brunei Darussalam, migrant workers could be subject to direct taxes such as personal income tax and indirect taxes such as value added tax (VAT) or the goods and services tax (GST) in the other nine ASEAN Member States (KPMG International, 2013).

⁷ The regional average of female labour participation rate has been weighted by the 2010 national labour force (UN DESA, 2012).

income and independent rights to social security benefits, the predominantly female dependents also occupy weaker positions in intra-family decision-making and other dynamics.

For women who do work, many engage in informal work such as domestic and caregiving work which are typically beyond the remit of national labour laws thus affecting their labour rights and income security (ILO, 2013a; 2013f). For instance, 28.1 per cent women in the ASEAN region constitute “contributing family workers” who often do not possess contractual work agreements, while this is only the case for 10.8 per cent of employed men in 2014 (ILO, 2015b). The Philippines is the only ASEAN country and the second country in the world that has ratified the Domestic Workers Convention, 2011 (No. 189). In 2013, the Philippine government enacted Republic Act 10361 otherwise known as the Domestic Workers Act (*Batas Kasambahay*) to institute policies for the protection and welfare of domestic workers working in the country, which includes enhanced access to and coverage in social protection schemes. Although not a signatory of the Convention, Viet Nam has adopted a new Labour Code in June 2012 that recognizes domestic work as a form of employment, providing them access to the national social insurance system (ILO, 2012c).⁸

In other ASEAN countries, progress has been piecemeal particularly where domestic workers tend also to be migrant workers. The Singapore government introduced paid weekly rest days for domestic workers from January 2013 (Ministry of Manpower, 2012). Next to a weekly rest day, Thailand’s provisions under Ministerial Regulation No. 14 (B.E, 2555) are more generous with additional paid leave provisions in a year: 13 traditional holidays, 6 annual leave days (conditional to a year of uninterrupted work), and a maximum of 30 days for sickness (ILO, 2013d). Sending countries however have made efforts to improve the employment

conditions in destination countries such as the Philippine Overseas Employment Agency’s (POEA) minimum wage-setting for domestic workers abroad at US\$400 a month in 2006 (POEA, 2007) and the Indonesia government-led Memorandum of Understanding (MoU) in 2011 with the Malaysia government to improve the work conditions of Indonesian domestic workers in Malaysia, including the provision of weekly rest days. Even so, domestic workers remain excluded from the Minimum Wage Order 2012 that had benefitted many other migrant workers in Malaysia (National Wages Consultative Council Secretariat, 2012).

Previous chapters have also covered potential gender discrimination due to employer’s liability-based maternity benefits and the gender gap in pension savings. Here, we see that even with labour market participation, gender differences in reproductive roles, lifetime average wages, duration in social contribution, and so forth, preclude gender parity in social protection. Without social insurance coverage for maternity benefit, employers in Cambodia, Indonesia, Malaysia, Brunei Darussalam, and Singapore may prefer not to hire women of childbearing age in order to evade the costs of maternity allowances.

Women also have longer average life expectancy compared to men, a phenomenon known as the “feminization of ageing”

Women also have longer average life expectancy compared to men, a phenomenon known as the “feminization of ageing”. But due to their lower average lifetime wage and higher engagement rate in the informal economy or unpaid work, women tend to have lower income replacement rates in provident fund systems of Indonesia, Malaysia, and Singapore (OECD, 2013). Their income replacement rates however are more “equalized” in the defined benefit pension systems of the Philippines and Thailand (*ibid*). State-guaranteed retirement pensions, whether contributory or non-contributory, can protect them from

⁸ Even with statutory social insurance coverage, progress in terms of the effective coverage among domestic workers can still be slow and challenging (for example, the case of Brazil, see ILO, 2013a).

longevity risk. To promote poverty reduction and gender equality, non-contributory “social pensions” are desirable because: (i) they protect women from their higher longevity and old-age poverty risks; (ii) they foster overall household wellbeing because women are found to invest their income in the family; and (iii) they compensate for elderly women who are likely, more than elderly men, to be engaged in unpaid care and domestic work instead of paid work (Vlachantoni and Falkingham, 2012).

Disasters and climate change

The ASEAN region is very vulnerable to natural hazards and suffers high costs in terms of human mortality, physical destruction, and economic loss (see table 15). The high costs are explained by the confluence of geophysical factors, high population density, poverty, and ill-equipped infrastructure. In 2013, the region had the most number of natural disaster victims relative to its population size and the highest cost of reported damages relative to its gross domestic product (Guha-Sapir et al., 2013). The damages were mainly the result of tropical storms in the Philippines and Viet Nam and the widespread floods in Cambodia and the Lao People’s Democratic Republic that year. Seventy-seven per cent of all global victims of geophysical disasters in 2013 – or approximately 3.2 million people – were victims of two earthquakes in the

Philippines and Indonesia (Guha-Sapir et al., 2013).

The ASEAN region is vulnerable to natural hazards and suffer high costs in terms of human mortality, economic loss, and physical destruction

As illustrated in table 15, damages and losses caused by natural calamities can be extremely high, undoing years of development and economic gains. For instance, the 2011 catastrophic floods in Thailand were estimated to have reduced its predicted real GDP growth by 1.1 per cent (World Bank, 2012b). The poor and marginalized households were also disproportionately affected by the physical destruction and loss of income caused by the floods, raising the additional role of social protection in times of natural disasters (see also Sann et al., 2012 for the case of Cambodia). One common scheme involves the provision of income relief, for instance one-off cash transfers are given to affected households in Thailand (see box 10). Emergency employment and “cash-for-work” programmes are also increasingly seen to be viable short-term measures for re-establishing livelihoods, for example Typhoon Haiyan (Yolanda) in 2013. Apart from providing income security at the minimum wage level, the public employment programme in the Philippines has also promoted skills development

Table 15. The long-term climate risk index, 1994–2013

CRI Rank	Country	Annual deaths per 100,000 inhabitants	Total annual losses in million US\$ PPP	Annual losses per unit GDP in %	Number of events
2	Myanmar	14.80	1 256.20	0.87	41
5	Philippines	1.13	2 786.28	0.74	328
7	Viet Nam	0.48	2 918.12	1.01	216
11	Thailand	0.26	7 863.87	1.26	201
12	Cambodia	0.43	294.12	1.30	40
63	Indonesia	0.12	1 932.88	1.20	405
67	Lao PDR	0.10	81.45	0.46	18
78	Malaysia	0.15	290.92	0.07	160
131	Singapore	0.00	0.07	0.00	20
152	Brunei Darussalam	0.03	0.54	0.00	8

Note: Compared across 159 countries, the climate risk index (CRI) rank is based on the country’s weighted score over the 20-year period. Annual indicators reflect the annual averages over the observation period.

Source: Kreft et al., 2014.

Box 10**Social protection mechanisms during the 2011 catastrophic floods in Thailand**

The large-scale flooding of 2011 in Thailand resulted in an estimated total cost of damages and losses of US\$46 billion, with another US\$50 billion estimated as the cost of rehabilitation and reconstruction. The number of unemployed individuals almost doubled compared to the year before. To counter the devastating effects of the floods, the government utilized a range of innovative instruments: (i) cash benefit for the affected households and farmers; (ii) modification of parameters within the social insurance system; (iii) tax deductibles to offset the cost of damages to households and enterprises; (iv) debt moratorium and low-interest loans for farmers and enterprises; and (v) subsidization of private sector employment and public employment programmes.

Cash benefit: One-off cash benefit of THB5,000 per household was disbursed to all affected households with poor households receiving an additional THB2,000 each. Affected farmers were eligible for monetary compensation proportional to the size of their damaged farmland of up to THB275,000 per household.

Social insurance: To reduce the social contribution burden on workers and employers, their contribution rates to the Social Security Fund were reduced for the whole year of 2012, from 5 per cent of insurable wage each to 3 per cent for the first half of the year and 4 per cent for the second half of the year. Unemployment benefit was granted to insured workers who were laid off during the flood

at 50 per cent of insurable wage for up to 6 months. To provide additional flexibility, the insured unemployed could register themselves in person or over the phone with the Department of Employment within 60 days (instead of 30 days) if they were unemployed from 30 September to 30 November 2011.

Tax relief: Household repairs and car damages can also be deducted from taxable income for up to THB100,000 and THB30,000 respectively. Affected enterprises were supported by import tariff waivers and tax deductibles for flood-related damage and depreciation of machine value.

Debt moratorium and low-interest loans: Farmers and small enterprises with good credit records were granted a three-year debt moratorium of up to THB500,000. The Central Bank and government-owned banks provided low fixed interest rate loans to affected firms.

Public or subsidized employment: Affected firms were offered salary subsidies of THB2,000 per worker to protect employment and income security of workers and their dependents. Workers who were not insured under the unemployment insurance scheme had the option to engage in a public works programme providing THB150 wage per day for 20 days. Local social security offices, such as the provincial office in Ayutthaya, had also organized job fairs with employer partners, for example, the Japanese Chamber of Commerce.

Source: Carter et al., 2013; Peyron Bista, 2012; Ministry of Labour, 2011; Sathirathai, 2012; World Bank, 2012b.

and access to social insurance and workplace safety (ILO, 2014f). The examples provided here and in box 10 underscore the benefits of having social assistance, social insurance, and disaster-related employment schemes in place prior to the occurrence of natural disasters. For these schemes to be adequately “disaster-responsive”, a certain degree of flexibility in adjusting the qualifying conditions and benefit levels within a short time frame is critical.

In addition to resilient reconstruction, Member States can improve on disaster relief and risk

management along with developing early warning systems in order to reduce the impact of natural hazards. Some ASEAN countries have national disaster management agencies in place. For example, the National Board for Disaster Management (BNPB) in Indonesia and the National Disaster Risk Reduction and Management Council (NDRRMC) in the Philippines. At every level – subnational, national, regional, and international – coordination mechanisms between the government and other actors such as non-governmental and international organizations can

be introduced or tightened (IRIN, 2012). As an example, the Philippines has since 2007 adopted the ‘cluster approach’ of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) that clusters organizations based on sectors of humanitarian action which are coordinated and led by one Cluster Lead Agency (OCHA, 2012a). With the right support and training, local governments have started performing the role of Cluster Lead as seen

during the recovery efforts after Tropical Storm Washi in 2011 (OCHA, 2012b). At the ASEAN-level, efforts have been made to improve information-sharing, cooperation, and coordination on disaster relief, mitigation, and prevention between national agencies and through the regional ASEAN Coordination Centre for Humanitarian Assistance (AHA) (see for instance, the ASEAN Agreement on Disaster Management and Emergency Response ASEAN, 2005).

Recommendations to implement the ASEAN Declaration on Strengthening Social Protection

Chapter 7

“We, the Peoples of the Member States of the Association of Southeast Asian Nations (ASEAN), as represented by the Heads of State or Government [...] resolved to ensure sustainable development for the benefit of present and future generations and to place the well-being, livelihood and welfare of the peoples at the centre of the ASEAN community building process”

ASEAN Charter, 2007

Three ASEAN Community Blueprints – Economic (AEC), Political-Security (APSC), Socio-Cultural (ASCC) – have been recognized as building blocks of the imminent “ASEAN Community” under the Cha-am Hua Hin Declaration on the 2009–2015 Roadmap for the ASEAN Community (ASEAN, 2008; 2009a; 2009b; 2009c). While the AEC pillar has garnered wide interests, the other two pillars have received far less attention although all three pillars were supposed to work in tandem. Published at the dawn of ASEAN regional integration, this report is expected to contribute towards re-shifting the focus and reinforcing the ASEAN Socio-Cultural Community as an equal pillar of

the ASEAN Community.

Along with the ASEAN Socio-Cultural Community Blueprint, the 2013 ASEAN Declaration on Strengthening Social Protection is an important guide for Member States to improve social protection which will help strengthen the socio-cultural pillar of the ASEAN Community. In order to expedite the implementation process of the ASEAN Declaration on Strengthening Social Protection and based on the assessment of the state of social protection in ASEAN prior to regional integration, the report’s main conclusions are summarized as follows:

The ASEAN Economic Integration has the potential to drive innovation, create new jobs, increase productivity, and accelerate growth. However, this will also be accompanied by necessary changes of skills and jobs. Social protection is therefore a priority to smooth the transition and ensure that more men and women benefit from these changes, and that no vulnerable people are left behind.

Extension of social protection should be done in a way that will provide effective and adequate level of protection to the ASEAN populations. Risk pooling and social solidarity principles should be encouraged, and in some countries strengthened, to ensure redistribution of the economic growth and protection to all, including those in temporary and vulnerable employment. For universal social protection, ASEAN countries will still need to boost their efforts to increase the legal and effective population coverage, through the improvement of existing and the establishment of new social insurance and tax-funded schemes. ILO Social Protection Floors Recommendation, 2012 (R202) offers a relevant guideline for this effort.

Several factors are important to the success of social protection. Better coordination of social protection interventions will increase outreach and efficient use of resources. Participation of social partners in the design and implementation helps raise awareness on social protection programmes, secure their compliance and financial commitment in contributory schemes, among others. Monitoring and evaluation of social protection policies are needed at both national and ASEAN levels with the development of a shared denominator for social protection outcomes across the ASEAN countries.

Finally, creating the fiscal space for financing social protection floors is also a question of political will that can benefit from improved coordination alongside the reallocation and efficient use of existing resources. Social protection floors, as stepping stones towards higher level of social security, are affordable, feasible, and highly commendable in the context of ASEAN regional integration and beyond.

These recommendations are chiefly based on the principles and parameters of the international labour standards related to social security (see box 11).

Box 11

Relevant international standards related to social security

- Equality of Treatment (Accident Compensation) Convention, 1925 (No.19)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Equality of Treatment (Social Security) Convention, 1962 (No. 118)
- Employment Injury Benefits Convention, 1964 (No. 121)
- Invalidity, Old-age and Survivors Benefits Convention, 1967 (No. 128)
- Employment Promotion and Protection against Unemployment Convention, 1968 (No.188)
- Medical Care and Sickness Benefits Convention, 1969 (No. 130)
- Maintenance of Social Security Rights Convention, 1982 (No.157)
- Maternity Protection Convention, 2000 (No. 183)
- Social Protection Floors Recommendation, 2012 (No. 202)

Universal coverage: innovative examples of extending social protection floors

Social protection can be expanded in at least three different dimensions: (i) the extent or proportion of the population or labour force who are covered by social protection schemes; (ii) the scope or the number of contingencies covered; and (iii) the level of protection offered by the schemes (ILO, 2014g).

Extending coverage: population

To widen the population or labour force coverage of social protection schemes, a number of ASEAN countries have implemented legal and policy reforms. In Viet Nam, the government has relied on premium subsidization and a series of laws to extend compulsory social health insurance coverage, including the recent January 2015 amendments on the Law on Health Insurance. In Singapore, the national social health insurance scheme, Medishield will be replaced by a more “universal” coverage scheme, Medishield Life at the end of 2015. Government subsidies will be instrumental in facilitating the full coverage of all Singaporean citizens and permanent residents, in particular those overage, low-income, and have pre-existing conditions who do not qualify for Medishield coverage (Ministry of Health, 2015c). Coverage extension can also involve reforms in non-contributory schemes, for example, the lowering of qualification age from 77 to 65 years for the general tax-financed social pension in the Philippines in 2015 (Department of Social Welfare and Development, 2015).

Exemptions in compulsory social insurance coverage within the formal economy are still commonplace in ASEAN countries, whether they involve employees working under short contracts (less than three months in Viet Nam), small firms (with fewer than eight employees in Cambodia or fewer than five employees in Myanmar), or

non-manual work above a salary threshold (monthly earnings above MYR3,000 in Malaysia). They can contribute to the exclusion of specific groups of workers while at the same time act as legal loopholes for employers (and employees) to avoid contributing to the social security system. As a measure against this, the Social Insurance Law in Viet Nam was amended to extend compulsory social insurance coverage to workers who have shorter contracts of at least one month from January 2018. Other ASEAN Member States can also emulate the experience of the Thailand Social Security Act which covered only firms with at least 20 employees in 1991 but has since broadened its coverage in stages: to firms with at least ten employees in 1993 and to firms with at least one employee in 2002 (Boonpiam, 2012).

The legal coverage of some social protection schemes has also been extended to self-employed and/or informal economy workers in Brunei Darussalam, Indonesia, the Lao People’s Democratic Republic, Malaysia, the Philippines, Singapore, Thailand, and Viet Nam.¹ However, many are offered on a voluntary basis, making their effective coverage a pressing issue. Among self-employed and informal economy workers in Indonesia, the unstable and low participation rate due to the voluntary nature of the social insurance scheme has been acknowledged by the national social security provider (PT Jamsostek, 2013). A comparable example is Thailand’s rocky experience of striving towards universal health coverage. After years of limited success with the subsidized voluntary Health Card Scheme for the self-employed, Thailand’s universal health coverage was eventually achieved based on a mixed contributory and general tax-financed approach to effectively extend health care coverage to the large informal economy (Bitrán, 2014; Sakunphanit, 2008; Mongkhonvanit and Hanvoravongchai, 2014; Tangcharoensathien et al., 2013).

¹ Note that some schemes are not recent, for example, Malaysia and Singapore’s voluntary coverage for self-employed workers under the national provident funds were initiated in 1977 (under the EPF Ordinance, 1951 and later the Employees’ Provident Fund Act, 1991) and 1992 respectively. The Social Security Board of Myanmar is also planning to introduce a voluntary scheme for informal economy workers (Tessier et al., forthcoming).

Another method for the extension of social insurance coverage is the formalization of employment, most commonly (assuming compliance) with a labour contract. Here, ASEAN examples in the formalization of domestic workers in Viet Nam and the Philippines are instructive. The enactment of the Domestic Workers Act (*Batas Kasambahay*) in 2013 not only helped formalize the employment arrangements of domestic workers in the Philippines, it also mandated their coverage (with a minimum of one month's work) under the national Social Security System (SSS) and social health insurance scheme, PhilHealth. Contributions are shared equally between employers and workers except in the case of domestic workers earning below PHP5,000 a month. In Viet Nam, the Decree on Domestic Workers in 2014 recognizes domestic work as employment and with compulsory contract enables domestic workers' access to the Viet Nam Social Security system (VSS). Both legal provisions for domestic workers also ensure

that they receive an income that is not lower than the corresponding regional minimum wage thresholds. Other methods for the extension of social coverage to the informal economy, like adapting premium contribution requirement to informal workers' capacity to contribute and reducing compliance costs for micro and small enterprises, have been outlined in the new ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204) (see box 12) and exemplified by positive examples from other regions.

Extending coverage: scope

The extension of social protection also involves widening the scope of social protection areas covered by public schemes, such as the nine contingencies – medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit, and survivors' benefit – outlined in ILO Convention

Box 12

Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204)

At the 104th International Labour Conference, a new international labour standard, the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204) was adopted by the ILO's 186 member States. The Recommendation outlines a roadmap for policies to facilitate transition from the informal to the formal economy.

This Recommendation recognizes that decent work deficits are most pronounced in the informal economy with the denial of rights at work, the absence of sufficient opportunities for quality employment, inadequate social protection and the absence of social dialogue. Participation in the informal economy is often not a choice but a consequence of a lack of opportunities in the formal economy and in the absence of other means of livelihood.

With regard to social protection, the Recommendation sets out that countries should progressively extend social protection and decent working conditions, in law and practice, to all workers in the informal economy. The needs and circumstances of

those in the informal economy and their families should be taken into account when building and maintaining national social protection floors and facilitating the transition to the formal economy. The extension of social insurance coverage to those in the informal economy is key and may entail necessary steps such as adapting administrative procedures, benefits and contributions according to their contributory capacity. With respect to the formalization of micro and small economic units, countries should reduce compliance costs by introducing simplified tax and contributions assessment and payment regimes, and improve access to social security coverage.

Besides social protection, Recommendation No. 204 covers various policy areas, including legal and policy frameworks; employment policies; rights and social protection; incentives, compliance and enforcement; freedom of association, social dialogue and role of employers' and workers' organizations; as well as data collection and monitoring.

No. 102. For instance, Cambodia's National Social Security Fund is expected to launch its social health insurance branch in 2015 after several years of administering the work injury insurance scheme. Imminent plans for the national fund include a pension scheme for formal economy employees. In Thailand, the Social Security Act had its scope expanded from five contingencies – medical care, sickness, maternity, invalidity, and death or survivorship – in 1991 to seven contingencies – with the addition for old-age and family (child allowance) – in 1998 and finally, eight contingencies in 2004 with the inclusion of unemployment benefit (Boonpiam, 2012). Together with its Workmen's Compensation Act B.E. 2537 (1994) which covers employment injury and illnesses, a formal economy worker can be covered under all nine contingencies prescribed under Convention No. 102. Far-reaching changes are also anticipated in Myanmar since the enactment of its Social Security Law in 2012. Despite its measured implementation, the scope of social protection areas delineated in the legal provisions is substantial: adding five additional contingencies – family, old-age, disability, survivorship, and unemployment – to the original four – work injury, maternity, sickness, and medical care – to eventually cover all contingencies under Convention No. 102 (Tessier et al., forthcoming).

Extending coverage: level of protection

Finally, the level of social protection offered under the public schemes can be increased as part of the extension of social protection. Due to the relatively low existing provisions, some Member States have increased protection against old-age income insecurity. To complement the mandatory old-age savings or pension schemes, voluntary “third pillar” saving schemes have been introduced in Singapore and Thailand, and more recently, Malaysia. Brunei Darussalam also introduced a supplemental contributory old-age

scheme but in the form of annuitized pension (that is periodical payments received during retirement) in 2009 to complement its old-age mandatory savings scheme and social pension. In Thailand, the monthly social pension benefit was increased in 2011 from THB500 to THB600 for those aged between 60 and 69 years, THB700 for those aged between 70 and 79 years old, THB800 for those aged between 80 and 89 years old, and THB1,000 for those aged 90 years and above.

Benefits of risk pooling via social insurance

A national social protection system with full coverage can allow for risk pooling and redistribution across generations, socioeconomic groups, and geographical regions. Besides the rationale of social justice, the lack of sufficient risk pooling in a social insurance system could be disastrous. For instance, prior to 1998, separate provincial health insurance funds in Viet Nam did not allow for risk pooling across rich and poor provinces and led to the failure of some of the weaker funds² (Somanathan et al., 2013). Similar experiences resonate in some of the Indonesian districts and provinces where local health insurance schemes for the poor in Indonesia – collectively known as Jamkesda – have failed due to financial deficits (Hardini, 2013). The alternative of private insurance is less desirable because existing findings show that the poor and sickly are often excluded in the absence of premium subsidization and government regulation on mandatory coverage (to expand the risk pool), benefit package, and premium pricing (Scheil-Adlung, 2014).

Risk pooling is also a neglected feature in mandatory provident fund schemes found in Brunei Darussalam, Indonesia, Malaysia, and Singapore. On the one hand, a provident fund scheme facilitates saving during working life and receiving the accumulated deferred pay with

² Even with the present single-fund, social health insurance scheme in Viet Nam, other factors such as method of resource allocation and consolidation of insurance groups are necessary for effective risk pooling and ensuring equity across socioeconomic groups and geographical areas (for details, see Somanathan et al., 2013).

accrued interests upon retirement. It however exposes one to longevity risks (or outliving one's retirement savings) and changes in purchasing power that occur over time. Women, on average, tend to be worse-off in terms of old-age protection with lower labour market participation rate and lower lifetime wage while facing higher lifetime expectancy. A social insurance form of pension benefit on the other hand disburses periodical payments from retirement until death and by fixing a certain "flat" contribution rate based on wage, it pools risks across gender, occupational, socioeconomic, geographic, and age groups.

Better coordination, governance, and administrative capacity

The last few decades of implementing social protection programmes in most ASEAN countries have revealed the primary difficulty of reaching out to those most in need and vulnerable, especially in providing them with appropriate and timely benefits and services. Against the background of limited fiscal space, there is growing demand for more efficiency and effectiveness in the design and delivery of social protection policies and programmes. In the context of administrative decentralization (within reforms taking place in several Member States such as Indonesia and Cambodia), the need for better coordination, governance, and administrative capacity at all levels of government has rarely been stronger.

Decentralization has led to increased responsibilities of subnational authorities in delivering social services – many of which still lack administrative capacity, resources (trained staff in particular), and clear guidance from the higher administrative level(s) as highlighted in the UNDP-UNCDF joint publication on *Strengthening the Governance of Social Protection: The Role of Local Government* (2014). In the case of Indonesia, the lack of monitoring and enforcement officers at the central and subnational levels, among others, has delayed the implementation of the Social Security Law (Satriana and Schmitt, 2012). Developing

administrative capacity will be crucial for the effective implementation of social protection.

To reduce the overlapping functions of different programmes and exploit possible synergies (by combining benefit packages to simultaneously address the various dimensions of poverty, among others), concrete tools and processes can be developed such as: (i) a coordination mechanism; (ii) an inter-agency registry of beneficiaries (such as the BDT database in Indonesia), and (iii) implementation of shared delivery facilities (like the Social Services Delivery Mechanism that is currently piloted in Cambodia). The integration of social services can also reduce the present dichotomy between social assistance and social insurance. In Thailand, the creation of a coordination committee and implementation of a shared database of beneficiaries between disparate health care schemes were key features in ensuring the universality of health protection (HISRO, 2012). Disadvantages of not having a centralized database of vulnerable households were apparent during the Thai flood of 2011 when emergency cash transfers had to be targeted (World Bank, 2012b).

Role of social partners and other stakeholders

ILO Recommendation No. 202 and Convention No. 102 both require the participation of representatives of persons protected, employers and public entities in the supervision of social security schemes. Effective social dialogue is needed to achieve a high degree of cooperation and coordination among the various parties and is essential for good governance, policy coherence and a fair distribution of the costs and benefits of any reforms. Social dialogue is the most appropriate method for adapting social security schemes to the needs and capacity of each of the participants.

One of the main advantages of the Assessment Based National Dialogue (ABND) process is the participatory approach involving, from the very beginning, all relevant stakeholders: line ministries, subnational authorities, workers'

and employers' representatives, civil society organizations, researchers, and development partners. Through multiple tripartite workshops, bilateral consultations, and technical seminars, all stakeholders will be engaged in jointly defining national social protection floors, identifying existing policy and implementation gaps, and eventually deciding on "priority policy options" that will help achieve the social protection floors (Schmitt and De, 2013). The process aims to create a sense of ownership among all stakeholders while they are sensitized to the importance of social protection.

As a country example, the ABND process in Thailand was jointly led by the Ministry of Social Development and Human Security and the ILO, involving representatives from workers, employers, civil society, and academia (Schmitt et al., 2013). Likewise, the ABND in Indonesia began under the guidance of the United Nations Partnership for Development Framework (UNPDF) sub-working group on the social protection floor but the leadership was progressively taken over by the Ministry of Planning and Development (Bappenas). The process also incorporated consultations at the provincial level due to the decentralized administrative system of Indonesia.

At the ASEAN level, regional-level workers' and employers' organizations have been involved in the drafting of a plan of action for the effective implementation of the ASEAN Declaration on Strengthening Social Protection – notably in the ILO-led ASEAN Tripartite Seminar on Strengthening Social Protection in November 2014 and the ASEAN Multi-Sectoral Consultation on Social Protection in December 2014. The "effective consultation at the national level between public authorities and employers' and workers' organizations" has been advocated for the implementation of international labour standards under the ILO Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144). Engagement of social partners at all regional, national, and subnational levels has several positive effects, among others: to raise awareness of social protection programmes

among workers and employers; to secure their compliance and financial commitment in contributory schemes; to improve accountability, transparency and good governance of funds; and to assist in the successful design and monitoring of schemes. For the latter, it is imperative to have in place tripartite boards (with representatives of workers' and employers' organizations) supervising the national social security agencies.

Monitoring progress in extending social protection

In order to monitor progress in extending social protection, ASEAN Member States need a comprehensive monitoring framework with relevant indicators across all social protection guarantees that could be populated feasibly and consistently over time. Indeed, the ASEAN Declaration on Strengthening Social Protection calls for "assessment tools", "regional statistical indicators", and "benchmarking of social protection delivery services" to monitor and evaluate the implementation of social protection in Member States. In addition to indicators, objective targets are indispensable for the evaluation of progress. To illustrate, the World Health Organization has proposed the following four indicators to monitor and evaluate progress in relation to universal health coverage (WHO, 2009):

- (i) Total health expenditure should be at least 4–5 per cent of the gross domestic product;
- (ii) Out-of-pocket spending should not exceed 30–40 per cent of total health expenditure;
- (iii) Over 90 per cent of the population is covered by prepayment and risk pooling schemes; and
- (iv) Close to 100 per cent coverage of vulnerable populations with social assistance and safety-net programmes.

Regionally, targets can be accommodated to the country's level of social protection coverage. The ASEAN Community Progress Monitoring System, for instance, utilized the same indicators but different targets for older Member States, "ASEAN-6" (Brunei Darussalam, Indonesia, Malaysia, the Philippines, Singapore, Thailand)

and the newer Member States, “CLMV” (Cambodia, the Lao People’s Democratic Republic, Myanmar, Viet Nam) countries (ASEAN, 2013). Targets can also be framed relative to the status quo, for instance, 5 per cent decrease in headcount poverty rate, or 10 per cent increase in primary school enrolment rate compared to the previous measurement year. They should also be adjusted to account for the fact that “progress” could invariably be: (i) non-linear with slow and fast phases; (ii) reversible; and (iii) uneven both across social protection guarantees and across ASEAN Member States.³

Affordability and financial sustainability

Previous research and assessments have shown that public investments in social protection need not be expensive and there is national capacity for it, even in low-income countries (Ortiz et al., 2015; Satriana and Schmitt, 2012; Schmitt et al., 2013; Bonnet et al., 2012; ILO, 2012a; Tessier et al., forthcoming). In the ASEAN region, social protection expenditure, including public health care expenditure, varies from a low 0.94 per cent of GDP to a relatively high 7.24 per cent of GDP (ILO, 2014g), (see table 16).

The Assessment Based National Dialogue (ABND) scenario cost estimates for social protection floor extensions (from the status quo social protection provisions) in Indonesia range from an additional 0.7 to 2.5 per cent of the GDP by the end of the projection period in 2020 (Satriana and Schmitt, 2012). Similar “affordable” estimates of additional public investment were produced during the ABND processes of Thailand and Myanmar: between 0.5 to 1.2 per cent of GDP in 2020 (Schmitt et al., 2013) and between 2.2 and 7.2 per cent of GDP in 2024 respectively (Tessier et al., forthcoming).

The social investment burden on national budget can be spread out over time by sequencing the implementation of further extensions of the social protection floor guarantees. To create the additional fiscal space, governments have at least the following methods: (i) reallocation of public expenditures; (ii) increase in tax revenues; (iii) revenue generation through contribution-based schemes; (iv) development aid and transfers; (v) reduction in illicit financial flows; (vi) use of fiscal and foreign exchange reserves; (vii) borrowing or debt restructuring; and (viii) expansionary monetary and fiscal policies

Table 16. Public social protection expenditure, latest available year (% of GDP)

Country	Total public social protection expenditure		Public health care expenditure		Public social protection expenditure excluding health care	
	(% GDP)	Year	(% GDP)	Year	(% GDP)	Year
Brunei Darussalam	...		...		...
Cambodia	2.23	2013	1.45	2013	0.79	2013
Indonesia	2.63	2010	1.03	2010	1.60	2010
Lao PDR	1.74	2005	1.22	2010	0.52	2010
Malaysia	2.99	2012	1.99	2012	1.00	2012
Myanmar	0.94	2010	0.24	2010	0.70	2010
Philippines	1.55	2012	0.56	2012	0.99	2012
Singapore	2.83	2011	1.20	2011	1.63	2011
Thailand****	7.24	2011	2.27	2011	4.98	2011
Viet Nam	6.28	2010	2.54	2010	3.74	2010

...: data not available.

Source: ILO, 2014g.

³ These challenges have also been identified in the review of country performances towards the MDGs (UNDP, 2010). The ensuing MDG Acceleration Framework (MAF) was established to guide lagging countries in achieving the MDG outcomes (UNDP, 2011).

(Ortiz et al., 2015). Regionally, the Philippine government provides an excellent example in its financing of universal health coverage plan using the additional tax revenues gained from the 2012 ‘Sin Tax’ Act on tobacco and alcohol (WHO, 2014b). The present Indonesian government has maintained the social protection financing strategy of its predecessors by reallocating public expenditures from fossil fuel subsidies to financing its universal health coverage plan, cash benefit scheme for the poor, and other social programmes (*The Economist*, 2015).

As illustrated in the previous chapters, social protection can be provided through different means and financing methods. For the latter, Article 71 of Convention No. 102 stipulates

either insurance contributions or taxation or both, which should in any case, ensure that the cost of the benefit schemes to be in line with the country’s economic circumstances. This realization on the diverse prevailing national circumstances and necessity for “tailored” social protection benchmarks and pathways has led to the nationally defined social protection floors notion under Recommendation No. 202. Both in Recommendation No. 202 and the ILO Declaration on Social Justice for a Fair Globalization 2008 (ILO, 2008), the consideration of national capacities has been acknowledged to be a crucial factor in securing affordable and sustainable advancements in social protection.

Annex I: Recommendations of the Tripartite Seminar on Strengthening Social Protection in ASEAN, Bangkok, 17–18 November 2014

Preamble

The tripartite seminar on strengthening social protection in ASEAN was held on the 17–18 November 2014, Bangkok, Thailand. The representatives of the Senior Official Meeting on Social Welfare and Development (SOMSWD), Senior Official Meeting on Labour (SLOM), employers' and workers' organizations of Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand and Viet Nam, together with representatives of the ASEAN Secretariat,

ASEAN Confederation of Employers, ASEAN Trade Unions Council, ASEAN Social Security Association, civil society organizations and United Nations agencies, namely the International Labour Organization (ILO), World Health Organization (WHO) and UNICEF participated in the Seminar.

Recalling the collective commitment of the ASEAN Member States to build an ASEAN Community comprising of the ASEAN Economic Community, ASEAN Socio-Cultural Community and the ASEAN Political and Security Community by 2015,

Recalling the commitment of the ASEAN Member States to give effect to the ILO Social Protection Floors Recommendation adopted in 2012 (No. 202),

Guided by the principles embedded in the ASEAN Declaration on Strengthening Social Protection adopted at the 23rd ASEAN Summit, 2013, Brunei Darussalam and the ILO Social Protection Floors Recommendation, 2012 (No. 202),

We, participants, urge the forthcoming ASEAN inter-sectoral consultation, 8–9 December 2014, Siem Reap, Cambodia, to consider and take into account the following recommendations in the development of the ASEAN Plan of Action for the implementation of the ASEAN Declaration on Strengthening Social Protection:

A. Extending social protection coverage

Area of Action 1. Support national policies, strategies and mechanisms to strengthen the implementation of social protection programme, as well as effective targeting systems to ensure social protection services would go to those most in need;

1. Develop or enhance national social protection policies and strategies in line with the ASEAN Declaration on Strengthening Social Protection and ILO Social Protection Floors Recommendation, 2012 (No. 202), based on evidence-based research and empirical data, to be accessible and applicable to all beneficiaries;
2. Review national Early-Child Development policies and programmes focusing on the first 1,000 days of life in the ten ASEAN Member States and make recommendations for improving such policies and programmes;
3. Establish a policy or scheme for young graduates to undertake internships or apprenticeships in government agencies and private companies aimed at increasing their interest in some jobs available in the labour market;
4. Develop specific programmes that will link social protection with labour market inclusion i.e. vocational training for the vulnerable groups including occupational-based rehabilitation of persons with disabilities and skills development of older persons, supporting job creation with the provision of loans, credits and public work programmes;
5. Conduct legal reviews and assessments of migrant workers' coverage under existing social protection systems; based on this review, encourage reciprocity for protection of migrant workers and establish coordination standards;
6. Organize tripartite workshops on strategies for extending social protection coverage and access to basic services by migrant workers and their families in ASEAN;
7. Organize capacity building, training, and workshops for the stakeholders on issues related to the extension of social protection at national and regional levels.

Area of Action 2. Advocate strategies that promote the coverage, availability, comprehensiveness, quality, equitability, affordability and sustainability of various social protection services, including the expansion of social insurance to the informal sector; strengthening social assistance programmes for persons with disabilities, elderly, children and other vulnerable groups; greater access to social protection programmes and services, including vocational trainings as part of active labour market interventions and human resource development;

8. Include in the ASEAN Post-2015 vision the extension of social protection coverage;
9. Design and implement awareness raising and advocacy programmes for increasing social protection coverage; including through the involvement of workers' organizations and employers' organizations, and exploring possible partnership with the civil society to better reach informal and rural workers;
10. Provide information to people about their social protection rights and existing schemes through mass media, community-based organizations, and cooperatives;
11. Develop, expand or strengthen the social insurance for the informal sector, including old-age pension, when needed, after due research and studies on the sustainability and affordability of the schemes in consultation with social partners.

Area of Action 7. Collectively accelerate the progress towards universal health coverage (UHC) in all ASEAN Member States by strengthening capacity to assess and manage health systems to support UHC through sharing of experiences, information and experts;

12. Advocate for the achievement of universal health coverage (UHC), and establish specific targets for and plan with adequate resources the progressive extension of universal social health protection coverage (by 2015);
13. Raise awareness among beneficiaries of social health protection schemes on their rights and entitlements (by 2015);
14. Develop capacities for managing health systems at all levels (from policy to planning and delivery of health care services and social protection benefits) (by 2020);
15. In view of high cost of medical care and treatment, levy be imposed on global medical companies.

B. Facilitating policy-oriented research, evidence-based assessment and monitoring framework

Area of Action 3. Promote results-based and evidence-based national assessments and benchmarking of social protection delivery services in ASEAN Member States that would contribute to the progressive implementation, effective monitoring and evaluation, as well as optimum impact of social protection;

16. Conduct evidence-based national assessments on social protection for the remaining ASEAN Member States using social dialogue between government, employers and workers within a specified time frame, in order to establish the baseline information on the current needs of the population, identify missing laws and policies, demand-side and supply-side issues, estimate the cost, assess the fiscal space, and determine possible allocations of budget resources to social protection;

17. Annually update information of the existing evidence-based national assessments on social protection that have already been conducted by the UN agencies and government, in consultation with social partners, for the seven Member States, and encourage the three remaining Member States to conduct assessment based-national dialogue on social protection;
18. From the national assessments, develop and biennially update an ASEAN report on social protection that will be used as common and synchronized baseline information to measure progress in extending social protection.

Area of Action 4. Explore and develop assessment tools and regional statistical indicators where appropriate to measure the impact of social protection to the holistic development of vulnerable groups for future planning towards available accurate baseline data collection;

19. Define, through the national inter-ministerial coordination mechanisms and with the social partners, national tailor-made monitoring and evaluation (M&E) framework, that will include specific targets and indicators (e.g. coverage and target group, level of benefits, qualifying conditions, and cost estimate) for measuring the effective implementation of social protection policies and programmes;
20. Build, through the national inter-ministerial coordination mechanisms and with the social partners, a common assessment and monitoring framework, with targets and a timeframe, to regularly measure the progress in extending social protection;
21. Select core regional targets and statistical indicators which are common across all Member States to measure progress on social protection;
22. Compile and update biennially regional statistical database on social protection, prepare and disseminate monitoring and evaluation reports;
23. Conduct impact studies of social protection on, but not limited to, poverty, productivity, employment and economic growth;
24. ASEAN Commission on the Promotion and Protection of the Rights of Women and Children (ACWC) to monitor the outcomes of the child's development and family support programmes across the ASEAN Member States.

C. Ensuring good governance, effective coordination and delivery, efficient use of resources, and social dialogue mechanisms at national and regional levels

Area of Action 5. Allocate adequate financial resources for social protection in line with national targets and subject to the capacity of each Government;

25. Conduct analysis of the State's financial capacity and fiscal space in each of the ASEAN Member States to assess affordability of social protection floors and propose recommendations for extending social protection;

26. Estimate the needed budget by each agency for implementing and sustainability the social protection programmes through for instance a Social Protection Expenditure Review (SPER).

Area of Action 6. Strengthen the capacity of government officials, communities, service providers, and other stakeholders for better responsiveness, coordination and effectiveness of social protection and delivery services at regional, national and local levels;

27. Ensure availability of social protection-related services (i.e. health, education, employment services), with specific attention to remote and rural areas;
28. To optimize transparent and cost-efficient delivery of social protection services and benefits, adopt a single-window-service or one-stop-shop approach, including integrated information system and beneficiaries database;
29. For delivery of social protection benefits and services, build on and enhance services already provided by employers', workers' organizations and government agencies;
30. Consolidate public-private partnership with service providers who are also involved in delivering social security services;
31. Improve identification mechanisms for beneficiaries of social protection programmes (i.e. up-to-date databases, generation of individual identification number and/or social security numbers), in both formal and informal economy, irrespective of nationality (by 2025);
32. Conduct training and capacity building courses at national and regional levels for people who manage and implement social protection schemes (i.e. good governance) by developing a common training toolkit across schemes; adopting a training of trainers approach; adjusting the training content according to people's capacities and needs; phasing training courses in several sequences; evaluating and constantly improving training content;
33. Appoint competent team for the administration of the schemes; regularly train and inform members of the national social security tripartite board, where applicable;

Area of Action 7: Build and strengthen the networking and partnerships within and among ASEAN Member States as well as with Dialogue Partners, UN Agencies, civil society, private sectors, development partners, and other stakeholders in supporting adequate resources and effective implementation of the commitments reflected in this Declaration.

34. Establish or strengthen institutional coordination mechanisms across ministries implementing social protection policies and programmes, for both policy formulation (national level) (by 2015) and programme implementation (local level) (by 2020);

35. Establish, institutionalize and reinforce social dialogue mechanisms at the national and regional level to better involve social partners in the design, implementation, monitoring and evaluation of social protection programmes (for instance, national tripartite committee on social protection issues);
36. Promote the link of social protection and sustainable economy in the post-2015 ASEAN economic agenda;
37. Facilitate and organize South-South exchange on specific issues related to social protection between ASEAN Member States and beyond ASEAN when relevant;
38. Explore avenues for possible bilateral social security agreements that will facilitate relevant portability of social security rights of migrant workers across countries; those bilateral agreements will then develop into a regional agreement in the long-run;
39. Compile and regularly update a compendium and database of good national and regional practices of social protection (online facility) among ASEAN Member States and from other relevant countries;
40. Establish a platform and mechanism at the ASEAN level to share information and good practices among ASEAN Member States receiving technical assistance from ILO, other international organizations, and bilateral aid;
41. Set up an ASEAN committee to promote the rights and social protection of older people.
42. Increase technical cooperation, exchange of expertise and information-sharing between ASEAN Member States, ILO, the ASEAN Social Security Association (ASSA), social partners and other relevant international organizations.

Bangkok, 18 November 2014

Annex II:

Country fact sheets

Key indicators: Definitions and data sources

- **Population:** Annual total population estimated at medium fertility.
- **Population age structure (0-14 years; 15-59 years; 60 years and above):** Annual total population by age groups estimated at medium fertility.
- **Dependency ratio:** The dependency ratio refers to the number of children aged 0 to 14 years plus the number of persons aged 65 years or over per 100 persons aged 15 to 64 years.

Data source:* United Nations, Department of Economic and Social Affairs (UNDESA). 2012. World Population Prospects, the 2012 Revision [Online]. Available at: <http://esa.un.org/unpd/wpp/> [Accessed: 25 September 2014].

* *Myanmar:* Ministry of Immigration and Population, Department of Population. 2015. *The 2014 Myanmar Population and Housing Census. The Union Report: Census Report Volume 2* (Nay Pyi Taw).

- **Labour force participation rate:** ILO preliminary 2013 estimates of the number of persons in the labour force (the sum of the number of persons employed and the number of unemployed) as a percentage of the working-age population (i.e. those aged 15 and older). Notes: Indonesia figures refer to the August period, and 2013 figures are revised estimates based on new population weights; Thailand figures refer to quarter three.
- **Female labour force participation rate:** Same as above using the number of women in the labour force as a percentage of the female working-age population (i.e. those aged 15 and older).
- **Unemployment rate:** ILO preliminary 2013 estimates of unemployment rate for population ages 15 and above based on official national sources. Notes: Indonesia figures refer to the August period, and 2013 figures are

revised estimates based on new population weights; Singapore figures are not seasonally adjusted and include only the resident labour force; Thailand figures refer to quarter three.

- **Average monthly wage:** ILO estimate of average monthly wage based on 2012 national labour force surveys at 2014 exchange rate between National Currency Unit (NCU) and US Dollar. Data for the Lao People's Democratic Republic refer to 2010 and to wage workers who receive monthly wages. Data for Singapore is based on administrative records from the Central Provident Fund Board.

Data source:* International Labour Organization (ILO); Asian Development Bank (ADB). 2014. ASEAN community 2015: Managing integration for better jobs and shared prosperity (Bangkok).

* *Myanmar:* Ministry of Immigration and Population, Department of Population. 2015. *The 2014 Myanmar Population and Housing Census. The Union Report: Census Report Volume 2* (Nay Pyi Taw).

- **Poverty rate (less than US\$2 a day):** Percentage of the population living on less than US\$2 a day at 2005 international prices.

Data source: World Bank. Data: Indicators [Online]. Available at: <http://data.worldbank.org/indicator> [Accessed: 5 November 2014].

- **Out-of-pocket payment (percentage of total health expenditure):** Direct payments made by households to health care providers (netted from reimbursements from health insurance) as a percentage of total expenditure on health. Total expenditure on health is the sum of all outlays for health maintenance, restoration or enhancement paid for in cash or supplied in kind, and is measured by the sum of General Government Expenditure on Health and Private Expenditure on Health.

Data source: World Health Organization (WHO). 2014. Global Health Expenditure Database [Online]. Available at: <http://apps.who.int/nha/database> [Accessed: 25 September 2014].

- **Primary school net enrolment rate:** Total number of students in the theoretical age group enrolled for primary school education, expressed as a percentage of the total population in that age group.
- **Primary school graduation rate:** Percentage of a cohort of students enrolled in the first grade of primary school education in a given school year who are expected to reach a given grade, regardless of repetition.

Data source:* United Nations Educational, Scientific and Cultural Organization – Institute for Statistics (UNESCO-UIS). Data by theme: Education [Online]. Available at: <http://data.uis.unesco.org/> [Accessed: 4 November 2014].

* *Singapore:* primary school net enrolment rate data from UNESCO – International Bureau of Education (UNESCO-IBE): “Singapore”, in *World Data on Education. 7th edition (2010/2011)* (Geneva, 2011).

- **Legal coverage for work injury (percentage of working age):** Estimates of statutory coverage for occupational injury and diseases schemes as a percentage of the working-age population (aged 15 to 64) based on statutory provisions and national legislations.
- **Active pension contributors (percentage of working age):** The number of current contributors to a social security institution providing periodic cash benefits in old-age (basic schemes only and excluding provident funds) as a proportion of the working-age population (aged 15 to 64).
- **Old-age pension beneficiaries (percentage of population above statutory pensionable age):** The number of old-age pension recipients above statutory retirement age, including mean-tested and periodic cash benefit while excluding schemes that provide only lump-sum payments (e.g. most provident funds). Notes: For Malaysia, the figure includes government pension scheme and a social assistance programme targeting poor elderly with no family support; the figure for Thailand refer only to beneficiaries of the old-age or disability social pensions so the reference taken is not the statutory pensionable age of 55 but the age of eligibility for the old-age social pension (60 and over).

Data source:* International Labour Organization (ILO). 2014. *World Social Protection Report 2014/15. Building economic recovery, inclusive development and social justice* (Geneva).

* *Cambodia* (for legal coverage for work injury): Hennicot, J.-C. 2012. *Actuarial review of the NSSF employment injury branch and assessment of social health insurance* (Phnom Penh).

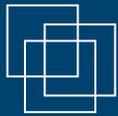
* *Myanmar* (for old-age pension beneficiary coverage rate): Tessier, L. et al. forthcoming. *Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Myanmar* (Yangon).

* *Singapore:* Considering that the Central Provident Fund (CPF) has introduced a national retirement annuity scheme (CPF Life) since 2009, two indicators have been adjusted: active pension contributors and old-age pension beneficiaries (as a proportion of the working-age population).

- **Total social protection expenditure (percentage of GDP):** As a percentage of national gross domestic product (GDP), the sum of expenditures (including benefit expenditure and administration costs) of all existing public social protection schemes which include all types of benefits from contributory and non-contributors schemes, in cash or in kind, means tested or not. GDP is the value of all final goods and services produced within a nation in a given year.
- **Public health care expenditure (percentage of GDP):** As a percentage of GDP, the total expenditure of all levels of government on health. It consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and non-governmental organizations) and social (or compulsory) health insurance funds.

- **Public social protection expenditure for children (percentage of GDP):** As a percentage of GDP, the sum of public expenditure on children which include family allowances and social assistance from private (international organization and civic/private society) or from public (government or local agencies) institutions. General social assistance and other benefits which may indirectly benefit children (e.g. maternity benefits) are not included.
- **Sickness, maternity, work Injury, disability benefits (percentage of GDP):** As a percentage of GDP, the sum of public expenditure on sickness, maternity, work injury, and disability cash benefits.
- **Public social protection expenditure for older persons (percentage of GDP):** As a percentage of GDP, the sum of public expenditure on older persons which include all types of benefits (excluding long-term care) provided by mandatory or quasi-mandatory (voluntary but with very wide coverage) schemes established by legislation, regulations or collective agreements.
- **General social assistance (percentage of GDP):** As a percentage of national gross domestic product, public expenditure on non-contributory assistance that provides protection to society's most vulnerable groups and cash/in-kind transfers and temporary subsidies for utilities and staple foods.

Data source (compilation from multiple sources, for example, ADB Social Protection Index Database): International Labour Organization (ILO). 2014. ILO Social Protection Department database. In World Social Protection Report 2014/15. Building economic recovery, inclusive development and social justice (Geneva).



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Brunei Darussalam

Brunei Darussalam Country Fact Sheet | 2015

Key indicators

Socio-demography and economy		Year
Population (million)	0.4	2014
Population age structure		
0-14 years (%)	24.9	2014
15-59 years (%)	67.0	2014
60+ years (%)	8.0	2014
Dependency ratio	41.8	2014
Labour force participation rate (%)	...	
Female labour force participation rate (%)	...	2013
Unemployment rate (%)	1.7	2011
Average monthly wage (US\$)	...	
Poverty rate (% less than US\$2 a day)	...	
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	8.1	2012
Primary school net enrolment rate (%)	91.7	2012
Primary school completion rate (%)	96.4	2011
Legal coverage for work injury (% working age)	88.0	2012
Active pension contributors (% working age)	...	
Old-age pension beneficiaries (% population above statutory pensionable age)	81.7	2011
Social Production Expenditure, SPE (% GDP)		
Total social protection expenditure	2.95	2009
Public health care expenditure	2.04	2009
Public SPE for children	...	
Sickness, maternity, work injury, disability	...	
Public SPE for older persons	...	
General social assistance	...	

Sources: ADB, ILO, UNDESA, UNESCO, WHO.

Social protection context

The first social security regulations have been in effect since the 1950s: Old Age and Disability Pensions Act (pension scheme for civil servants), 1954 and the Workmen's Compensation Act, 1957 (Revised 1984). Since then, the civil servants' pension scheme has been phased out and the Employees Trust Fund (TAP) established in 1992 now forms the backbone of the social security system, providing old-age, survivors, disability, and housing benefits for both public and private sector employees. A universal

non-contributory pension (OAP) was introduced in 1984 for all citizens and permanent residents aged 60 years and above, followed by the Supplemental Contributory Pension (SCP) in 2009. The latter complements the existing pension schemes and extends voluntary coverage to self-employed workers who are excluded from TAP.

Besides work injury compensation, the national labour code, Employment Order 2009 was enacted to ensure decent work conditions such as maximum working hours and paid leave (including maternity leave) for all workers regardless of nationality. Work injury, maternity, and sickness benefits are covered under employers' liability.

The public health care system in Brunei Darussalam is comprehensive (for example, out-of-pocket health payments make up only 8 per cent out total health expenditure¹), entirely tax-financed, and universal, covering all citizens and permanent residents.

Free education is provided by the government from pre-school to tertiary-level for citizens and up to secondary-level for permanent residents.² The country's universal school feeding programme distributes drinks and snacks during the morning break to all public primary school students. Breakfasts and lunches are also provided for low-income primary and secondary school students. Social assistance in the form of cash benefit and skills training is also provided to the poor and vulnerable such as single mothers, persons with disability, and orphans.

Economic and social trends

- Between 2010 and 2025, the proportion of elderly aged 65 years and above, is forecasted to increase more than twofold from 3.7 per cent to 10.0 per cent – the fastest growth within ASEAN.
- Compared to the global average, Brunei Darussalam was the exception within ASEAN to have below average growth rate during 2007–13.

¹ Global Health Expenditure Database, WHO, 2014, <http://apps.who.int/nha/database> [accessed 25 September 2014].

² Ministry of Education: *Education for All 2015 National Review Report: Brunei Darussalam* (UNESCO, 2014).

ILO-ADB report: Impact of economic integration³

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises economic growth and job gains to Brunei Darussalam. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Within the region, the country has the highest share of wage workers in employment (94.9 per cent in 1993), most are in the service sector (77.2 per cent in 2001). Average wage is relatively high despite the lack of statutory minimum wage.

Skills development: Secondary school net enrolment rate is high at 94.7 per cent, of which 11.4 per cent pursue technical and vocational training (TVET). Gross enrolment rate for tertiary education is also high at 24.3 per cent. However the proportion of children out of school is relatively high (more than 4 per cent).

Intraregional migration: As the second highest income country in the region, it is one of the main receiving countries in intraregional migration. In 2012, there were 87,110 employed migrants, nearly half the size of its working population (186,000 in 2011).

Recent and ongoing reforms

- Under Maternity Leave Order 2011, paid maternity leave stipulated under Employment Order, 2009 has been extended from eight to 13 weeks, with the additional weeks of benefits being tax-funded.
- To encourage the hiring of national workers, a migrant worker levy has been introduced in 2014. The issuance of work permits have also been restricted for certain occupations and sector.⁴
- From April 2015, employers are mandated to insure migrant workers without permanent residency status under private health insurance.⁵

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- (i) Risk-pooling
Redistribution of social risks by risk-pooling is limited by the fact that most social security

provisions are provided either via provident fund savings (old-age, survivorship, and invalidity) or employer's liability (sickness, maternity, and work injury). Workers and their dependents are more vulnerable without state-guaranteed benefits. Women could face workplace discrimination if employers prefer to evade the costs of maternity allowances and staff replacement.

- (ii) Sustainability
Many social protection schemes such as the public health care and education systems, the non-contributory social pension, and other means-tested social assistance programmes are tax-financed. The schemes' sustainability could be challenged by the national economy's current overreliance on the hydrocarbon sectors which make up more than 60 per cent of GDP and over 90 per cent of total exports.⁶
- (iii) Migrant workers
Migrant workers without permanent residence status do not qualify for TAP participation but are covered under the Workmen's Compensation Act, 1957 (Revised 1984) and Employment Order 2009. While the public health care system is still accessible, mandatory take-up of private health insurance is expected for the near future.⁷ Domestic workers who are predominantly migrant workers also lack labour protection such as sickness and maternity benefits offered by the national labour code.

Examples of ILO work

- In 2012, the ILO has provided technical inputs to a workshop on the Maritime Labour Convention, 2006 (MLC 2006) as part of the government's plan to ratify the convention.
- The first technical cooperation between ILO and the government on Labour Market Information System was launched on 9 April 2014 and is scheduled to operate from May 2014 to April 2016.
- With the assistance of the ILO, the country's first National Occupational Safety and Health (OSH) Profile was launched on 28 April 2014.

³ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

⁴ Piri: "Foreign worker levy can go up to \$960", in *The Brunei Times*, 29 May 2014.

⁵ *Announcement – Medical Insurance*, Department of Labour, 2015, <http://www.buruh.gov.bn/Lists/Announcement/> [accessed 5 June 2015].

⁶ OECD: "Structural Policy Country Notes: Brunei Darussalam", in *Economic Outlook for Southeast Asia, China and India 2014: Beyond the Middle-Income Trap* (Paris, OECD, 2013), pp. 91–274.

⁷ J.S. Koo: "Health insurance for foreign hires to be mandated", in *The Brunei Times*, 6 March 2014.



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Key indicators

Socio-demography and economy		Year
Population (million)	15.4	2014
Population age structure		
0-14 years (%)	31.1	2014
15-59 years (%)	60.8	2014
60+ years (%)	8.1	2014
Dependency ratio	57.6	2014
Labour force participation rate (%)	68.8	2012
Female labour force participation rate (%)	62.4	2012
Unemployment rate (%)	2.7	2012
Average monthly wage (US\$)	121	2012
Poverty rate (% less than US\$2 a day)	41.3	2011
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	61.7	2012
Primary school net enrolment rate (%)	98.4	2012
Primary school completion rate (%)	65.9	2011
Legal coverage for work injury (% working age)	10.2 ¹	2008
Active pension contributors (% working age)	0.0	2010
Old-age pension beneficiaries (% population above statutory pensionable age)	5.0	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	1.79	2011
Public health care expenditure	1.26	2011
Public SPE for children	0.10	2011
Sickness, maternity, work injury, disability	0.00	2011
Public SPE for older persons	0.15	2011
General social assistance	0.18	2011

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

The development of social protection is a key priority of the Government. This is stated in the Rectangular Strategy, National Strategic Development Plans (NSDP), and National Social Protection Strategy for the Poor and Vulnerable (NSPS-PV). The NSPS-PV developed under the leadership of the Council for Agricultural and Rural Development (CARD) was launched in December 2011 to provide for the phased development of a social protection system, starting with

the Social Protection Floor. Its implementation began with a four-year (2011–2015) pilot-testing phase at the national and sub-national levels.

The National Social Security Fund (NSSF) was established in March 2007 and provides Employment Injury Insurance to 880,000 private sector employees.² After the launch of a social health insurance scheme in 2015, a pension scheme is expected to be implemented in 2016. The National Social Security Fund for Civil Servants covers civil servants and their dependants, providing sickness, work injury, maternity, old age, invalidity, and survivor benefits. The National Fund for Veterans covers war veterans and members of the Royal Cambodian Armed Forces and National Police Force.

Social assistance is provided through a number of social welfare programmes, mostly driven by non-governmental organizations and funded by development partners. These include the Health Equity Funds (HEFs) and other programmes covering school feeding, scholarship, food- or cash-for-work, and Maternal, Child Health & Nutrition (MCHN).

Despite these efforts, only a small minority of the population currently benefit from the fragmented and often inadequate social protection coverage.

Economic and social trends

- Since the global financial crisis, annual GDP growth has bounced back to above 7 per cent.
- Continued decline in national poverty rate (based on the national poverty line) from 47.8 per cent in 2007 to 19.8 per cent in 2011 (NSDP 2014–18).³
- Persistent inequalities between the rich and the poor, men and women, and urban and rural areas, with the latter group being particularly vulnerable to environmental and economic shocks.

¹ Based on 2008 estimates of the labour force population and the number of employees in firms with eight or more workers in J.-C. Hennicot: *Actuarial review of the NSSF employment injury branch and assessment of social health insurance* (Phnom Penh, GIZ, 2012).

² A. Pheap and M. Blomberg: 2014. "Social Security Fund Starts New Insurance Scheme"; in *The Cambodia Daily*, 1 April 2014.

³ The poverty rates are based on the new 2011 national poverty line which is still substantially lower than the US\$2 a day threshold.

ILO-ADB report: Impact of economic integration⁴

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) is expected to greatly benefit Cambodia. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Low wages have prompted large-scale strikes and protests. Despite the introduction of a statutory minimum wage (US\$100) in early 2014, it is only applicable to workers in the garment and footwear industries. Stronger wage-setting institutions and collective bargaining mechanisms could improve social cohesion while raising living standards.

Skills development: Cambodia will have to address its populace's relative low level of education to meet the large demand increase expected for medium-skilled workers. Literacy rate among those aged 15 and over is one of the lowest in the region at 73.9 per cent. Net enrolment for secondary education is 38.2 per cent, of which one in five students drops out of lower secondary education.

Intraregional migration: With one of the lowest average wages the region (US\$121), many have emigrated for better wages. Approximately 69 per cent of total Cambodian emigrants have moved to other ASEAN countries, a trend that is forecasted to continue with the regional wage disparities, deeper economic integration, and increasing labour demands from ageing neighbouring countries.

Recent and ongoing reforms

- A Social Protection Coordination unit has been established within CARD to improve inter-agency coordination and information management on social protection (NSDP 2014–2018).
- The NSSF is planning to launch a compulsory social health insurance scheme for companies with more than seven employees in 2015. The introduction of a mandatory pension scheme is expected to follow thereafter.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

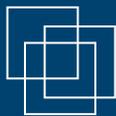
- (i) Coverage
Social security coverage remains limited to the small formal sector, excluding the large informal economy that is concentrated in rural areas.

- (ii) Institutional capacity
The lack of institutional capacity remains a major impediment, in particular with the decentralization reform that has led to increased responsibilities of sub-national authorities in providing social services.
- (iii) Sustainability
Despite an average annual GDP growth rate of more than 7 per cent in the last decade, the food and fuel price shocks, the global financial crisis, and adverse weather conditions have raised questions over the resilience and inclusiveness of its growth model. Continued reliance on external funding and support also casts doubts on the sustainability of the existing social assistance schemes.

Examples of ILO work

- Under the ILO-EU project “Improving Social Protection and Promoting Employment” (2010–2012) extensive studies were conducted on the existing provisions and gaps, including a social protection expenditure review and financial assessment of the NSPS-PV.
- The ILO and CARD piloted an integrated Social Service Delivery Mechanism (SSDM) in 2013. It is designed to be a one-stop shop for social protection and employment services. It is linked with flagship programmes of the NSPS-PV and the One Window Service Office of the Ministry of Interior, which provides decentralized administrative services.
- The ILO supports the design and implementation of the NSSF social health insurance branch via support on actuarial studies and financing arrangements, and on the development of: (1) IT systems for management and monitoring, and (2) capacity building and training programmes for NSSF staff.
- A new ILO/China South-South Cooperation Project to “Expand Employment Services and Enhance Labour Market Information” in Cambodia and the Lao People’s Democratic Republic was launched in 2014.

⁴ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).



The State of Social Protection in ASEAN 2015



ILO/Japan
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International
Labour
Organization

Indonesia

Indonesia Country Fact Sheet | 2015

Key indicators

Socio-demography and economy	Year	
Population (million)	252.8	2014
Population age structure		
0-14 years (%)	28.5	2014
15-59 years (%)	63.2	2014
60+ years (%)	8.3	2014
Dependency ratio	51.0	2014
Labour force participation rate (%)	66.9	2013
Female labour force participation rate (%)	50.3	2013
Unemployment rate (%)	6.2	2013
Average monthly wage (US\$)	174	2013
Poverty rate (% less than US\$2 a day)	43.3	2011
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	45.3	2012
Primary school net enrolment rate (%)	92.2	2012
Primary school completion rate (%)	89.0	2011
Legal coverage for work injury (% working age)	73.0	2012
Active pension contributors (% working age)	6.0	2010
Old-age pension beneficiaries (% population above statutory pensionable age)	8.1	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	2.63	2010
Public health care expenditure	1.03	2010
Public SPE for children	0.68	2010
Sickness, maternity, work injury, disability	0.03	2010
Public SPE for older persons	0.45	2010
General social assistance	0.38	2010

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

Since its amendment in 2002, the Indonesian Constitution recognizes the right of all people to social security and the responsibility of the state in the development of social security.

Social security schemes primarily managed by four state-owned limited liability companies are being consolidated as two public social security service providers of BPJS Kesehatan (Health) and BPJS Ketenagakerjaan (Employment). Previously, the four companies targeted private sector employees (PT Jamsostek), civil servants

(PT Taspen and PT Askes), and the armed forces and the police (PT Asabri). In addition to the contributory schemes, the national social health insurance scheme (Jaminan Kesehatan Nasional, JKN) also consolidated non-contributory schemes targeted at the poor, near poor, and informal sector workers (such as Jamkesmas and Jamkesda).

The progressive implementation of the National Social Security Law (Law No. 40/2004) and the Social Security Service Providers Law (Law No. 24/2011) aims to contribute to extending social security coverage for the whole population in the areas of health, work injury, old age, and death of breadwinner. The National Social Security Law follows a staircase approach with non-contributory schemes for the poorest people, contributory schemes (with nominal contributions) for the self-employed and informal economy workers, and statutory social security schemes for formal sector workers and their dependents.

Social assistance is provided through a number of social welfare programmes delivering access to free basic education until grade nine (school assistance programme called BOS), income security for families with children (conditional cash transfer and scholarship programmes), food security (Raskin), social infrastructure and employment opportunities (PNPM and BLK).

Economic and social trends

- The total unemployment rate hides the very high youth unemployment rate (21.6 per cent) which is among the highest in the Asia-Pacific region.
- Inequality has increased over the years with Gini coefficient measured from 29.2 in 1991 to 38.1 in 2011. Income disparities between geographical regions, sectors, skills, and genders are expected to increase with the ASEAN economic integration.
- The relative decline of the agricultural sector in favour of the service sector: as much as 71.9 per cent of jobs created between 2003 and 2013 were in the service sector.

ILO-ADB report: Impact of economic integration¹

The ASEAN Economic Community (AEC) promises opportunities for Indonesia to become a higher value-added economy. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Wage setting is important with almost half of total employment comprising wage workers. The lack of effective collective bargaining mechanisms has prompted unions to resort to using minimum wages to achieve wage gains. A decentralized minimum wage setting system has resulted in large intra-country disparity between US\$74 and US\$199. Strengthening collective bargaining mechanisms should allow for productivity-driven wage gains and pacify industrial disputes.

Skills development: The populace's relative low level of education and skills mismatch problem will need to be addressed to meet the large growth in demand expected for high-skilled workers. In spite of the high government spending, progress in education attainment and skills matching has been slow.

Intraregional migration: Given regional wage disparities, continued outflow of low- and medium-skilled labour is forecasted, especially for the younger workforce facing high unemployment. However, once abroad, these workers often lack (equal) social security rights.

Recent and ongoing reforms

- The implementation of the National Social Security System has started in 2014 for health care under BJPS Kesehatan. With state-subsidization of health insurance premiums for the poor and vulnerable, almost half of the population are currently covered under BJPS Kesehatan with universal coverage expected by 2019.
- The National Social Security System's social insurance branch for employment injury, old-age (provident fund and pension), and death benefits, BJPS Ketenagakerjaan, was launched on 1 July 2015. The pilot implementation of the work injury scheme for both formal and informal economy workers has begun in the Special Capital Region of Jakarta.²

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- (i) **Coverage**
The implementation of the National Social Security System Law, the social insurance branch in particular, has been slow since its enactment in 2004. The aim was to extend social security coverage from the small formal sector to encompass the large informal economy, migrant workers with at least six months residency, and nationals working abroad. Number of participants has reached 15.9 million (including 1.2 million "informal workers")³ or 12.4 per cent of its 128.3 million labour force in 2015.⁴
- (ii) **Institutional capacity**
Distances spanning Indonesia's 17,000 islands are barriers of access to social services. The lack of institutional capacity remains a major impediment, in particular with the decentralization reform that has led to increased responsibilities of sub-national authorities in providing social services.
- (iii) **Education and training**
Adequate education and relevant skills training are important to address the issue of high youth unemployment. If they remain unable to secure decent work, the demographic dividend of Indonesia's relatively young population could turn into a demographic liability.

Examples of ILO work

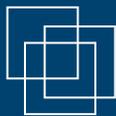
- The ILO led the United Nations Partnership for Development Framework (UNPDF) sub-working group on the Social Protection Floor established in May 2011.
- The Assessment Based National Dialogue (ABND) on social protection was conducted in Indonesia and the report was jointly launched with the Ministry of Planning (Bappenas) in December 2012.
- A delivery mechanism called the Single Window Service was piloted in several provinces in 2012. It aims at increasing outreach and efficiency of social security and anti-poverty programmes.
- An actuarial study on the proposed modifications to the social security system for employment injury, old age, and death benefits was conducted in 2014.

¹ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

² Folmer: "Jakarta Becomes Pilot Implementation of BPJS Ketenagakerjaan", in *Berita Jakarta*, 15 October 2014.

³ "Informal worker" here follows the National Statistics Office (BPS) definition. Coverage information as of April 2015 from BPJS Ketenagakerjaan, personal communication, 3 June 2015.

⁴ Labour force data as of February 2015 from Badan Pusat Statistik: *Indikator Pasar Tenaga Kerja Indonesia Februari 2015* (Jakarta, 2015).



The State of Social Protection in ASEAN 2015



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International
Labour
Organization

The Lao People's Democratic Republic

The Lao People's Democratic Republic Fact Sheet | 2015

Key indicators

Socio-demography and economy	Year	
Population (million)	6.9	2014
Population age structure		
0-14 years (%)	34.7	2014
15-59 years (%)	59.4	2014
60+ years (%)	5.9	2014
Dependency ratio	62.6	2014
Labour force participation rate (%)	79.2	2010
Female labour force participation rate (%)	77.8	2010
Unemployment rate (%)	1.9	2010
Average monthly wage (US\$)	119	2010
Poverty rate (% less than US\$2 a day)	62.0	2012
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	38.2	2012
Primary school net enrolment rate (%)	95.9	2012
Primary school completion rate (%)	69.9	2011
Legal coverage for work injury (% working age)	6.7	2012
Active pension contributors (% working age)	1.3	2010
Old-age pension beneficiaries (% population above statutory pensionable age)	5.6	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	1.74	2005
Public health care expenditure	1.22	2010
Public SPE for children	0.02	2010
Sickness, maternity, work injury, disability	0.06	2010
Public SPE for older persons	0.10	2010
General social assistance	0.34	2010

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

The existing social protection provisions consist mainly of compulsory social security insurance for formal economy workers and social welfare programmes for poor and vulnerable groups. In July 2013, the Lao National Assembly adopted the Law on Social Security with social security provisions for public and private sector workers. The National Social Security Fund administers social security schemes for public and private sector workers. The new law also targets the extension of voluntary coverage to a broader population including the self-employed and informal economy workers who make up the majority of the labour force.

The health care system is fragmented, comprising of the social health insurance branches of SSO and SASS, the Community-Based Health Insurance schemes (CBHI) for the non-poor self-employed persons and their dependents, Health Equity Fund (HEF) for the poor, and other related health programmes such as free health care in maternity and for children under age 5 under the Maternal, Neonatal and Child Health (MNCH) policy. The adoption of the National Health Insurance Decree No. 470/PM in 2012 created a National Health Insurance Bureau as a centralized coordination mechanism for all social health protection schemes. The government strategy on health insurance envisions a rapid expansion of coverage from the current 27.2 per cent towards universal coverage by 2025.

Other social welfare programmes (some in collaboration with development partners) include the National School Meals Programme targeting school children in poor areas, scholarships for poor students, disaster relief, community development (mainly infrastructural) grant assistance, and temporary shelters for vulnerable groups such as street children and trafficking victims.

Economic and social trends

- High annual GDP growth of over 7 per cent since 2007 has propelled real GDP per capita (based on purchasing power parity, PPP) to rise from US\$1,896 to US\$2,682 between 2007 and 2013.
- The national headcount poverty rate was halved within two decades from 46 per cent in 1993 to 23 per cent in 2013 (Lao Expenditure and Consumption Survey 2012–13).¹
- Despite the changing structure of employment from agriculture to industry and services, the bulk of employment (71.4 per cent in 2010) remains in agriculture. The proportion of those in vulnerable employment is high at 83.9 per cent in 2010.

¹ S. Satriana: *Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Lao People's Democratic Republic* (ILO, 2014), unpublished.

ILO-ADB report: Impact of economic integration¹

Deeper economic integration within the ASEAN Economic Community (AEC) promises further growth that could assist Lao People's Democratic Republic to graduate from the 'Least Developed Country' status by 2020. Three critical intersections between the AEC and social protection have been identified:

Wage setting: The national minimum wage of US\$78 per month is the lowest in ASEAN with the average wage hovering at US\$119. The government has periodically raised minimum wages in line with increasing cost of living. Wage setting effects however are dampened by the small fraction of wage workers (15.6 per cent) out of total employment.

Skills development: The country will have to address its populace's relative low level of education to meet the large growth in demand expected for medium-skilled workers. Literacy rate among those aged 15 and over is one of the lowest in the region at 72.7 per cent. Net enrolment rate for secondary education is approximately 40 per cent, less than 1 per cent of which pursue technical and vocational training (TVET).

Intraregional migration: With one of the lowest average wages in the region, many have emigrated for better wages. Approximately 72 per cent of total Laotian emigrants have moved to other ASEAN countries, a trend that is forecasted to continue with the regional wage disparities, deeper economic integration, and increasing labour demands from ageing countries.

Recent and ongoing reforms

- Recent legislations enacted in 2013–14 – the Decree of Social Welfare (No. 169) and Decree on Persons with Disabilities (No. 137) – provide a legal framework for establishing non-contributory social assistance schemes beyond the current social welfare system. Beneficiary groups have been extended to include orphans, people with disabilities, and elderly who are poor.
- The National Health Insurance Bureau established in 2013 is currently piloting the merger of social health protection schemes in several districts.
- After successful pilot programmes in 2012, the Ministry of Health and development partners are rolling out the MNCH policy towards universality.
- The National School Meal Programme started in 2012 is expected to gradually take over donor-initiated school meal programmes.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

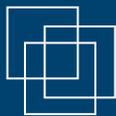
- Coverage**
Social security coverage remains limited to the small formal sector, excluding the large informal economy which is concentrated in rural areas and the agricultural sector. Despite mandatory social security enrolment, coverage rate is low even for formal economy workers due to weak enforcement.
- Health care**
Besides the inefficiencies and inequities of a fragmented public health care system, inconsistent and unreliable funding and disparate implementation by the Ministry of Health and various development partners can jeopardize existing programmes such as the HEF and MNCH. Voluntary insurance schemes such as the CBHI are vulnerable to adverse selection, difficulties in ensuring timely and consistent contribution payments, and high dropout rates.
- Geographic disparity**
Underfunded and understaffed health facilities in rural areas have resulted in low service utilization.³ Most work in the agriculture sector and informal economy, a large fraction of which is subsistence farming, and are vulnerable to natural disasters, seasonal fluctuations, and other shocks. In particular, communities living in remote and upland areas are among the groups to receive the least coverage of any social protection provision.

Examples of ILO work

- A joint ILO/WHO project is currently assisting the Ministry of Labour and Social Welfare (MOLSW) and Ministry of Health with the progressive harmonization and merger of existing social health protection schemes aiming to achieve universal coverage.
- The ILO is supporting MOLSW on policy formulation and institutional capacity building on social security provisions.
- The ILO is supporting the government in conducting an assessment based national dialogue (ABND) on social protection, which provides a consultative process for all stakeholders to assess the current social protection system and develop a national consensus on priority interventions to extend the social protection floor.

² This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

³ K. Akkhavong et al.: *The Lao People's Democratic Republic Health System Review* (Manilla, WHO, 2014).



The State of Social Protection in ASEAN 2015



ILO/Japan
Multi-bilateral
Programme



International
Labour
Organization

Malaysia

Malaysia Country Fact Sheet | 2015

Key indicators

Socio-demography and economy	Year	
Population (million)	30.2	2014
Population age structure		
0-14 years (%)	25.7	2014
15-59 years (%)	65.5	2014
60+ years (%)	8.8	2014
Dependency ratio	45.5	2014
Labour force participation rate (%)	67.0	2013
Female labour force participation rate (%)	52.4	2013
Unemployment rate (%)	3.1	2013
Average monthly wage (US\$)	609	2013
Poverty rate (% less than US\$2 a day)	2.3	2009
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	34.9	2012
Primary school net enrolment rate (%)	97.0	2005
Primary school completion rate (%)	99.2	2009
Legal coverage for work injury (% working age)	36.2	2012
Active pension contributors (% working age)	28.1	2010
Old-age pension beneficiaries (% population above statutory pensionable age)	19.8	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	2.99	2012
Public health care expenditure	1.99	2012
Public SPE for children	0.02	2012
Sickness, maternity, work injury, disability	0.07	2012
Public SPE for older persons	0.89	2012
General social assistance	0.03	2012

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

The first social security regulations have been in effect since the 1950s. Coverage of these schemes is envisaged mainly for formal public and private sector employees under the Employees Provident Fund (EPF) – for old-age and disability pensions, housing and educational allowances – and the Social Security Organization (SOCSO) for employment injury insurance and disability pension. Unemployment, maternity, and sick leave benefits are covered under employers' liability.

In addition, social assistance targeted programmes have been put under the coordination of the Ministry of

Women, Family and Community Development. To improve coordination and avoid overlapping functions among the different programmes, the national poverty database, '*eKasih*', has been introduced. To compensate for the food and fuel price increases, the government had also introduced a one-off cash transfer programme, the "1 Malaysia People's Aid" (BR1M) in 2012 for low-income households. It has since been continuously implemented and expanded in level of benefit and population coverage.

In line with the 10th Malaysia Plan (10MP), the Government aims at transforming Malaysia into a high-income, inclusive and sustainable economy by 2020. Among others, the 10MP proposes to modify the current labour law into a modern one entailing full flexibility in the hiring and firing of workers, in tandem with the extension of social protection. Moreover, the 10MP also aims at increasing income and employment opportunities of low income households and disadvantaged groups.

Economic and social trends

- Increasing life expectancy and cost of living renders EPF retirement savings to be insufficient for many with gross replacement rate estimated at 35.1 per cent for the median earner in 2012.¹
- Rising public health expenditure – with increases in life expectancy, prevalence of non-communicable diseases, and cost of healthcare – threatens the sustainability of the universal healthcare system.
- Uneven labour force participation rate between men and women (80.7 per cent and 52.4 per cent respectively) with Malaysian female labour participation being one of the lowest among ASEAN countries.
- Growing subpopulation of foreign nationals at 8.2 per cent of the overall population as of 2010.²
- Gini coefficient for inequality at 0.46 is one of the highest in the region.

¹ Organization for Economic Co-operation and Development (OECD): *Pensions at a Glance: Asia/Pacific Edition* (Paris, 2013).

² *Population Distribution and Basic Demographic Characteristic Report 2010*, Department of Statistics, 2011, www.statistics.gov.my [accessed 15 July 2015].

ILO-ADB report: Impact of economic integration³

The ASEAN Economic Community (AEC) promises new opportunities for Malaysia to become a high-income country. Three critical intersections between the AEC and social protection have been identified:

Wage setting: The weakness of collective bargaining in wage setting has led ASEAN countries like Malaysia to rely on minimum wage setting. With three-quarters of workers reliant on wages, the first national minimum wage was first introduced in 2013 (US\$244 a month for Sabah and Sarawak and US\$275 for Peninsular Malaysia).

Skills development: Gradual increases in wages have been shown to encourage firms to increase productivity via technology upgrading, efficiency-enhancing production organization, and training investment. As the economy moves up the value chain, highly skilled workers become increasingly indispensable. Technical and vocational education and training (TVET) could help address the current skills mismatch between the labour market demands and labour force supply.

Intraregional migration: Spurred by regional wage disparities, Malaysia is both a receiving and a sending country in intraregional migration. In 2013, 61.2 per cent of immigrants originated from other ASEAN countries. Labour immigrants are disproportionately low- and medium-skilled. Malaysians constitute the largest immigrant group in Singapore with 45.0 per cent of its migrant stock in 2013.

Recent and ongoing reforms

- The coverage of BR1M was extended to lower middle income households in 2014 with additional subsidy for life and invalidity insurance coverage. The level of cash benefit was increased again in 2015, between 17 to 67 per cent (depending on beneficiary category) from the previous year.
- The Foreign Workers Health Insurance Protection Scheme (SPIKPA) was implemented between 2011 and 2013. Private medical insurance under the Hospitalisation and Surgical Scheme for Foreign Workers (SKHPPA) was made mandatory for all migrant workers.
- Maternity protection under the Employment Act (including paid maternity leave and dismissal protection) was expanded to all female employees without a salary upper-limit from 1 April 2012.
- From January 2012, senior citizens aged 60 and above receive free health services and medicines in public

health facilities under the 2008 National Health Policy for Older Person.

- The first statutory minimum retirement age for private sector employees was set at age 60 under the 2012 Minimum Retirement Age Act (effective from 1 July 2013). This prevents employers from compelling their older staff to retire but still permits employees to retire earlier (although the EPF withdrawal age remains at age 55).
- In 2012, the Pension Retirement Scheme (PRS) was introduced as a tax incentivized voluntary “third-pillar” pension investment tool (tax relief up to MYR3,000 until 2021).

Further challenges and way forward

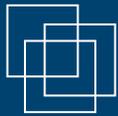
For further advancements in social protection for all, these key areas deserve attention:

- (i) **Sustainability of healthcare system**
The burgeoning public health expenditure next to high household out-of-pocket payments points towards an increasingly unsustainable healthcare system.
- (ii) **Sufficiency of pension savings**
The EPF faces a longevity risk with many (future) retirees risk outliving their pension savings. Women are especially vulnerable given their average lower lifetime wage, shorter contribution duration, and engagement with unpaid and informal work.
- (iii) **Extension of social protection**
Social protection gaps persist, among others, in the form of the exclusion of undocumented migrant children from the public school system and the exclusion from compulsory coverage of the Social Security Act for domestic workers, employees whose salaries exceed certain caps, own account workers, and unpaid family workers.

Examples of ILO work

- The ILO conducts regular actuarial valuation of SOCSO funds.
- In 2012–13, the ILO provided technical expertise and facilitated the tripartite national discussion aimed at reaching a national consensus on the introduction of employment insurance along with employment services and vocational training.
- The ILO’s five-year AusAID-funded project Tripartite Action for the Protection and Promotion of the Rights of Migrant Workers within and from the Greater Mekong Sub-region GMS – TRIANGLE – was also launched in Malaysia.

³ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).



The State of Social Protection in ASEAN 2015



ILO/Japan
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International
Labour
Organization

Myanmar

Myanmar Country Fact Sheet | 2015

Key indicators

Socio-demography and economy ¹	Year	
Population (million)	51.5	2014
Population age structure		
0-14 years (%)	28.6	2014
15-59 years (%)	62.5	2014
60+ years (%)	8.9	2014
Dependency ratio	52.4	2014
Labour force participation rate (%)	63.4	2014
Female labour force participation rate (%)	50.5 ²	2014
Unemployment rate (%)	4.0 ³	2014
Average monthly wage (US\$)	...	
Poverty rate (% less than US\$2 a day)	...	.
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	71.3	2012
Primary school net enrolment rate (%)	90.2	2010
Primary school completion rate (%)	74.8	2009
Legal coverage for work injury (% working age)	...	
Active pension contributors (% working age)	...	
Old-age pension beneficiaries (% population above statutory pensionable age)	9.5 ⁴	2014
Social Protection Expenditure, SPE (% GDP)		
Public health care expenditure	0.26	2011
Sickness, maternity, work injury, disability	0.06	2011
Public SPE for older persons	0.60	2011

Sources: ILO, MOIP-DOP, Tessier et al., UNESCO, WHO.

Social protection context

Mandatory social security schemes for workers from private and public formal companies are managed by the Social Security Board (SSB) and provided under the new Social Security Law, 2012. The new law anticipates the extension of voluntary coverage to workers who are excluded from mandatory coverage: those working in companies with fewer than five workers or are engaged in the informal economy. For civil servants, provisions are stipulated under the Civil Service Law, 2013 and its related amendments:

No. 9/1994, No. 7/2000, and No. 2/2001. For private sector workers who are not covered under the Social Security Board, work injury compensation funded entirely by employer's liability is governed by the Workmen's Compensation Act, 1923 and its amendment No. 6/2005.

The Social Security Medical Care Scheme (managed by the SSB) offers a comprehensive health care benefit package to insured workers. Nonetheless, coverage rate is limited to approximately 1.4 per cent of the population in 2014.⁵ The rest of the population rely on a number of free health programmes operated by the Ministry of Health that are general tax-financed and/or donor-funded, such as: the Free Medicine Programme, Hospital Equity Funds, and the National Tuberculosis Programme.

Besides free health programmes, the Ministry of Education, Ministry of Social Welfare, Relief and Resettlement and other ministries administer multiple, small-scale social assistance interventions. They target the poor and specific vulnerable groups and include school stipends, emergency relief programmes, and institutional care for orphans and dependent elderly.

Economic and social trends

- Annual GDP growth has been increasing with an average growth rate of 6.2 per cent between 2009 and 2013.
- Headcount poverty rate was 25.6 per cent in 2010. Poverty incidence is distributed unevenly between urban (15.7 per cent) and rural areas (29.2 per cent), and across regions or states ranging from the lowest rate of 11.4 per cent in Kayah State to the highest rate of 73.3 per cent in Chin State (Integrated Household Living Conditions Assessment 2009–10).⁶

¹ Population and labour force statistics from Ministry of Immigration and Population, Department of Population: *The 2014 Myanmar Population and Housing Census. The Union Report: Census Report Volume 2* (Nay Pyi Taw, MOIP, 2015).

² Refers to the 15-64 years age group.

³ Refers to the 15-64 years age group.

⁴ Estimate from L. Tessier et al.: *Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Myanmar* (Yangon, ILO, forthcoming), www.myanmar.social-protection.org.

⁵ L. Tessier et al., op. cit.

⁶ IHLCA Project Technical Unit: *Integrated Household Living Conditions Survey in Myanmar (2009-2010): Poverty Profile* (Yangon, UNDP, 2011).

ILO-ADB report: Impact of economic integration⁷

With the growing importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises further economic growth and job gains to Myanmar. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Statutory minimum wage is anticipated in the near future.⁸

Skills development: Public expenditure in education is less than 1 per cent GDP – the lowest in the ASEAN region. Even so, literacy rate is relatively high (92.7 per cent for those aged 15 and above). Secondary net enrolment rate however remains among the lowest in the region at 47.0 per cent. Less than one in ten employer respondents agreed that secondary school graduates in Myanmar were equipped with the relevant skills needed by firms.

Intraregional migration: Myanmar is one of the main sending countries in Intraregional migration. Many of the workers from Cambodia, Lao People's Democratic Republic, and Myanmar migrate through irregular channels and many find informal employment in Thailand and Malaysia.

Recent and ongoing reforms

- The planned provisions under the Social Security Law, 2012 that are anticipating gradual implementation include all the benefits provided by the Social Security Act, 1954 (medical care, sickness, maternity, and employment injury) and additional benefits for disability, old-age, survivorship, unemployment, and housing.
- The Rural Development Strategic Framework adopted in 2014 proposes several instruments to extend social protection to the rural economy.
- The civil servant pension scheme is currently under reform towards a fully-funded system.
- The National Social Protection Strategic Plan was launched in December 2014 and includes social assistance flagship programmes formulated through an assessment based national dialogue (ABND).

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- (i) **Coverage**
Social security coverage remains limited – less than 5 per cent of the working age population⁹ – to the formal sector, excluding the large informal economy that is concentrated in rural areas and the agricultural sector.
- (ii) **Geographical disparity**
Rural poverty rate almost doubles that of urban areas with even larger disparity – in terms of poverty incidence and social protection coverage – across states and regions.
- (iii) **Fiscal space mobilization**
Low tax revenue is a concern as sustainable revenue streams are needed to maintain tax-financed social protection entitlements over time. Additional fiscal space can be created through, among other ways, an increase of tax rates or an extension of the present tax base.

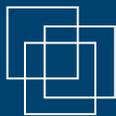
Examples of ILO work

- From October 2013 to September 2014, the Technical Support Group (TSG) on social protection conducted an assessment based national dialogue (ABND) on social protection, which provided a multi-stakeholder consultation platform to assess the current social protection system and develop a national consensus on priority interventions to extend a social protection floor for all.
- The ILO is supporting the SSB in the revision and implementation of the Social Security Law, 2012 through an evaluation of the SSB operations, and by providing support to the development of financial models and the drafting unit in-charge of the modification of the law.
- The ILO (with its International Training Centre) conducted training activities on unemployment protection and active labour market policies (January 2015) and work injury protection and prevention (February 2015).
- As part of the inter-ministerial TSG on social protection, the ILO facilitated training sessions on social protection floors and on social protection costing and financing.

⁷ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

⁸ A tripartite commission is currently discussing the level and scope of statutory minimum wage. Its potential impact remains difficult to anticipate due to the lack of data on the labour market structure. The first Labour Force Survey since 1990 is being conducted with the assistance of the ILO.

⁹ L. Tessier et al., op. cit.



The State of Social Protection in ASEAN 2015



ILO/Japan
Multi-bilateral
Programme



International
Labour
Organization

The Philippines

The Philippines Country Fact Sheet | 2015

Key indicators

Socio-demography and economy	Year	
Population (million)	100.1	2014
Population age structure		
0-14 years (%)	33.8	2014
15-59 years (%)	59.6	2014
60+ years (%)	6.6	2014
Dependency ratio	60.7	2014
Labour force participation rate (%)	63.9	2013
Female labour force participation rate (%)	49.9	2013
Unemployment rate (%)	7.1	2013
Average monthly wage (US\$)	206	2012
Poverty rate (% less than US\$2 a day)	41.7	2009
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	52.0	2012
Primary school net enrolment rate (%)	88.2	2009
Primary school completion rate (%)	75.8	2008
Legal coverage for work injury (% working age)	45.8	2012
Active pension contributors (% working age)	17.5	2011
Old-age pension beneficiaries (% population above statutory pensionable age)	28.5	2011
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	1.55	2012
Public health care expenditure	0.56	2012
Public SPE for children	0.14	2012
Sickness, maternity, work injury, disability	0.25	2012
Public SPE for older persons	0.58	2012
General social assistance	0.01	2012

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

The national Social Security System (SSS) began in 1957 and provides work injury, sickness, disability, maternity, retirement, and death benefits to private sector employees in the Philippines. Despite its inclusive enrolment – covering domestic workers, self-employed, citizens working abroad, insured persons separated from employment, and nonworking spouses of insured persons – its coverage remains low. The AlkanSSSy initiative under the SSS acts as a voluntary micro saving mechanism for the poor and informal sector workers to afford the minimum monthly contribution of 330 peso (PHP).

In 1995, the Philippines passed the National Health Insurance Act which aims at providing equitable access to quality health care. The Philippines health insurance programme (PhilHealth) was established to implement the universal health care by 2016. It targets poor households through its indigent and sponsored programs. The National Health Insurance Act of 2013 amends the previous law to ensure mandatory health care for the whole population with Point-of-Care enrolment and government-subsidized premiums for the poor. This has resulted in the high health care coverage of 87 per cent of the population.¹

In 2007, the government adopted an official definition of social protection and identified its four components: (1) social insurance; (2) social welfare; (3) social safety nets; and (4) labour market interventions. Under the social welfare component, a conditional cash transfer programme, the Pantawid Pamilyang Pilipino Programme (4Ps), was introduced in 2008 to disburse cash assistance to the poor.

The presence of a large emigrant labour force has motivated the national government to include them in SSS and PhilHealth and ratify all ILO conventions related to migrant rights and equal treatment in social protection.

Economic and social trends

- Unemployment rate at 7.1 per cent and vulnerable employment at 38.3 per cent in 2013.²
- With more than half of the female labour force not working, the country has the biggest gender gap in labour force participation and employment-to-population ratio in the region.
- Despite the decadal average annual GDP growth rate of 5.4 per cent, the number of workers living on less than US\$2 a day increased from 11.2 million in 1991 to 13.0 million in 2009. Social inequality remains high (Gini coefficient of 43.0).

¹ PhilHealth: "Stats and Charts. 2nd Semester 2014" (PhilHealth, 2014).

² ILO Country Office for the Philippines: *Philippine Employment Trends 2015* (Manila, 2015).

ILO-ADB report: Impact of economic integration³

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises the Philippines significant economic growth and job gains. Three critical intersections between the AEC and social protection have been identified:

Wage setting: A decentralized minimum wage setting system has resulted in its wide range – from US\$120 to US\$273 – within the country. The second half of the two-tier wage setting system is productivity-based. For productivity-enhancing outcomes, collective bargaining mechanisms should be extended since its coverage was only limited to 10 per cent of wage workers in December 2013.

Skills development: Notable growth in the business process outsourcing (BPO) sector suggests the country's potential to be an e-services hub. The Philippines should strive to improve access and quality of upper secondary education and technical and vocational education and training (TVET) to meet the large demand increase expected for medium-skilled workers.

Intraregional migration: As a global labour sending country, outmigration of the Philippines workforce is forecasted to continue. Higher wages abroad being the key 'pull' factor, one key 'push' factor is the lack of decent employment opportunities and skill mismatch as growth in labour supply remains unmet by lower growth in domestic labour demands.

Recent and ongoing reforms

- To improve inter-agency coordination, the Social Protection Operational Framework and Strategy was approved in May 2012.
- In 2013, the Philippine government enacted the Domestic Workers Act (Batas Kasambahay) to formalize employment conditions of domestic workers in the country and enhance their access to social protection schemes such as SSS and PhilHealth.
- During 2000–14, natural calamities affected 135 million – predominantly the poor and vulnerable – with annual socioeconomic damages of US\$1.1 billion.⁴ The emergency employment, cash- or food-for-work schemes, and livelihood programmes are implemented for displaced workers and survivors.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- Coverage**
Social security coverage remains limited to the formal sector, excluding most of the informal economy. One of the targets of the Social Protection Operational Framework and Strategy is to achieve universal coverage for social insurance by 2016. The AlkanSSSy initiative under the SSS acts as a micro saving mechanism but coverage remains limited with 102,765 members from 1,028 informal sector groups and local government units as of November 2014.
- Employment**
Unemployment and vulnerable employment are enduring concerns with ramifications on the feasibility and sustainability of social protection schemes.
- Migration**
Given the large emigrant labour population from the Philippines, social protection for this subgroup can be enhanced through bilateral or multilateral social security agreements that promote social protection in the receiving countries and portability of social security rights.

Examples of ILO work

- The ILO provides technical and financial assistance to the country's assessment based national dialogue (ABND) on social protection, employment promotion and disaster management that was launched in May 2014.
- Working closely with the Department of Labour and Employment (DOLE), donor governments, NGOs, and those affected on the ground, the ILO supported the initiative of an emergency employment programme which also provided health and social insurance coverage to the victims of Typhoon Haiyan in 2013.
- The ILO is supporting DOLE and the Domestic Work Technical Working Group to promote the implementation of the Domestic Workers Act.

³ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

⁴ D. Guha-Sapir et al.: *P. EM-DAT: International Disaster Database*, www.emdat.be [Accessed: 29 April 2015].



The State of Social Protection in ASEAN 2015



ILO/Japan
Multi-bilateral
Programme



International
Labour
Organization

Singapore

Singapore Country Fact Sheet | 2015

Key indicators

Socio-demography and economy		Year
Population (million)	5.5	2014
Population age structure		
0-14 years (%)	15.7	2014
15-59 years (%)	67.9	2014
60+ years (%)	16.4	2014
Dependency ratio	35.8	2014
Labour force participation rate (%)	66.7	2013
Female labour force participation rate (%)	58.1	2013
Unemployment rate (%)	3.9	2013
Average monthly wage (US\$)	3 547	2012
Poverty rate (% less than US\$2 a day)	...	
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	58.6	2012
Primary school net enrolment rate (%)	94.0	2001
Primary school completion rate (%)	98.7	2008
Legal coverage for work injury (% working age)	72.6	2012
Active pension contributors (% working age)	...	
Old-age pension beneficiaries (% population above statutory pensionable age)	0.00	2011
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	2.83	2011
Public health care expenditure	1.20	2011
Public SPE for children	0.01	2011
Sickness, maternity, work injury, disability	0.89	2011
Public SPE for older persons	0.70	2011
General social assistance	0.01	2011

Sources: ADB, ILO, UNDESA, UNESCO, WHO.

Social protection context

Singapore's social protection system is anchored on its Central Provident Fund (CPF) which acts as a savings and investment fund for directly financing health care, retirement, education, and housing, alongside indirect financing of benefits via social insurance and government-regulated private insurance schemes such as Medishield for health care, Eldershield for old-age disability, and the Dependents' Protection Scheme (DPS) for permanent incapacitation and death. Participation of CPF is compulsory for all wage workers with citizenship and permanent resident status, and voluntary for the self-employed.

The Workfare Income Supplement and Workfare Training Support schemes aim to provide training and income security to older, low-income earners. Additionally for manual workers and non-manual workers earning 1,600 Singapore dollars (SGD) a month, work injury compensation is provided by employer's liability via mandatory private insurance coverage. Likewise, sickness and maternity benefits are provided by employer's liability as stipulated under Employment Act 1968 (Revised 2009). The government also finances at least (depending on the child's birth order) eight weeks of maternity benefit for all (including self-employed) married workers bearing Singaporean citizens with a minimum of three months' employment.

The national health system is multi-tiered beginning with the first tier of subsidized basic health care costs of up to 80 per cent depending on choice of service, means-testing, and citizenship or residence status. The second tier is provided by a mandatory savings account, Medisave which is part of the CPF. The social health insurance scheme against catastrophic health expenditures, Medishield forms the last tier. As a last-resort, the social safety net scheme, Medifund, caters to the most vulnerable groups.

Conditional to citizenship, childcare is partially subsidized and subsidy level varies according to family means. Other citizenship and means-tested social assistance interventions include "ComCare" subsidies for children, persons with disability, elderly who are unable to work, and the actively unemployed.

Economic and social trends

- Singapore has an ageing population due to increased life expectancy and decline in fertility. Between 2010 and 2025, the proportion of elderly is forecasted to almost double from 9.0 per cent to 17.3 per cent.
- Persistent gender wage gap where women earn on average 26.5 per cent less than men.

ILO-ADB report: Impact of economic integration¹

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises economic growth and job gains to Singapore. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Like other advanced economies, Singapore has high labour productivity and high wages (average wage of US\$3,547 a month). Collective bargaining agreements cover 17.3 per cent of private sector employees. Wage inequality is also the highest in the region. Workers in some sectors still earn very low wages relative to the high cost of living. Statutory minimum wage setting is largely absent with the exception of the cleaning service sector: licensed cleaning companies are obliged to comply with the Progressive Wage Model (PWM) which recommends a minimum monthly wage of SGD1,000 for entry-level workers.

Skills development: Singapore accounts for around half of ASEAN's high-skill manufacturing exports while most employment – 80.1 per cent in 2013 – is found in the service sector. Graduates appear to be well-equipped with the relevant skills needed by firms – more than 80 per cent of employer respondents agreed that technical and vocational training (TVET) and tertiary education graduates have the relevant skills required by the firms.

Intraregional migration: As the highest income country in the region, Singapore is one of the main hubs in intraregional migration. In 2013, 52.9 per cent of immigrants originated from other ASEAN countries. Of this share, Malaysian nationals make up the largest group at 85.0 per cent.

Recent and ongoing reforms

- Medishield will be replaced by a more “universal” coverage scheme, Medishield Life at the end of 2015. Government subsidies would facilitate the full coverage of all citizens and permanent residents, in particular those overage, low-income, and have pre-existing conditions who do not qualify for Medishield coverage.²
- The CPF Lifelong Income for the Elderly scheme (CPF Life) was introduced in 2009 to provide lifelong monthly pension benefits.

- The Singapore government introduced paid weekly rest day for domestic workers from January 2013.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- (i) **Ageing population**
An ageing population increases the risk of pension inadequacy and costs of health and elderly care. The CPF relies on individual savings with a limited risk-pooling component, Medishield, and the new life annuity scheme, CPF Life. Risk-pooling within Medishield and CPF Life is constrained by age-based (and gender-based for CPF Life) premiums while participation under CPF Life is conditional upon minimum retirement savings.
- (ii) **Out-of-pocket health expenditure**
Despite the high quality and multi-tiered health care system, average household out-of-pocket health expenditure is high: 58.6 per cent. The reliance on personal savings and expenditure can impoverish and exacerbate social inequality. For instance, the lowest income quintile spends more on health care as a proportion of household expenditure compared to the higher income quintiles.³
- (iii) **Migrant workers**
Social protection for migrant workers without permanent residence status is limited. They are excluded from CPF coverage and government subsidy for basic health care. Domestic workers who are predominantly migrant workers also lack labour protection such as sickness and maternity benefits.

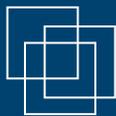
Examples of ILO work

- In June 2014, the ILO and the Ministry of Manpower renewed their Partnership Agreement to improve labour and workplace practices in South East Asia. It supports issues concerning occupational safety and health, productivity, tripartism, and social dialogue.
- With the support of the ILO and tripartite partners, Singapore has ratified the ILO Maritime Labour Convention, 2006 (MLC, 2006) in 2011 to protect the rights and minimum standards in work and living conditions of seafarers.

¹ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

² Ministry of Health: *MediShield Life*, 2015, https://www.moh.gov.sg/content/moh_web/medishield-life/ [Accessed: 10 March 2015].

³ Ministry of Health: *Consumer Price Indices (CPI) & Household healthcare Expenditure*, 2015, https://www.moh.gov.sg/content/moh_web/home/statistics/Health_Facts_Singapore/Consumer_Price_Indices_CPI_and_Household_healthcare_Expenditure.html [Accessed: 29 May 2015].



The State of Social Protection in ASEAN 2015



ILO/Japan
Multi-bilateral
Programme



International
Labour
Organization

Thailand

Thailand Country Fact Sheet | 2015

Key indicators

Socio-demography and economy		Year
Population (million)	67.2	2014
Population age structure		
0-14 years (%)	17.8	2014
15-59 years (%)	67.1	2014
60+ years (%)	15.1	2014
Dependency ratio	38.6	2014
Labour force participation rate (%)	71.6	2013
Female labour force participation rate (%)	63.3	2013
Unemployment rate (%)	0.8	2013
Average monthly wage (US\$)	357	2012
Poverty rate (% less than US\$2 a day)	3.5	2010
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	13.1	2012
Primary school net enrolment rate (%)	95.6	2009
Primary school completion rate (%)	93.6	2000
Legal coverage for work injury (% working age)	26.2	2012
Active pension contributors (% working age)	21.4	2012
Old-age pension beneficiaries (% population above statutory pensionable age)	81.7	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	7.24	2011
Public health care expenditure	2.27	2011
Public SPE for children	0.45	2011
Sickness, maternity, work injury, disability	0.20	2011
Public SPE for older persons	4.20	2011
General social assistance	0.01	2011

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

Thailand's social protection floor is anchored on two universal coverage schemes: the Universal Coverage Scheme (UCS) introduced in 2001 to provide health care access to the remaining majority who were not covered by existing social health schemes, and the Non-contributory Allowance for Older People (or the "500 baht" Universal Pension Scheme) established in 2008 to provide income security to the elderly over 60 years of age who do not receive any form of retirement income from public schemes. The flat-rate pension was changed to an age-based pension in 2011.

There is a fragmented social protection system apart from the two schemes. The health care system consists of the UCS, the Civil Servants Medical Benefit Scheme (CSMBS), the Health Branch of the Social Security Fund (SSF) for those covered under Sections 33 and 39, and the Compulsory Migrant Health Insurance (CMHI) for migrant workers from Myanmar, the Lao People's Democratic Republic, and Cambodia.

Likewise, the social security system is scattered across different funds such as the SSF, the Workmen's Compensation Fund, the Government Pension Fund (GPF), the Private School Teachers' Welfare Fund (PSTWF), and several provident funds. Within the SSF, benefit packages vary depending on one's employment status, contribution history, and choice: Section 33 for formal sector workers, Section 39 for those formerly insured under Section 33, and Section 40 for workers aged between 15 and 60 years who are not insured under Sections 33 or 39 (the self-employed and informal economy workers). The Section 40 voluntary contribution scheme is partially subsidized by the Government, offering separate and mixed benefit packages for sickness, invalidity, death, and/or old-age (via a lump sum grant and/or pension).

Other notable social protection schemes include the Universal Non-contributory Allowance for People with Disabilities, the Universal Non-contributory Allowance for People with HIV/AIDS, and the Education for All Policy which provides 12 years of free education as enshrined under the Thai Constitution, B.E. 2550 (2007).

Economic and social trends

- Between 2010 and 2025, the proportion of elderly is forecasted to almost double from 8.9 per cent to 16.1 per cent.
- Labour force growth is projected to slow down and contract by 1.1 per cent between 2010 and 2025.
- Persistent vulnerable employment with own account and contributing family workers making up 56.1 per cent of total employment in 2013.

ILO-ADB report: Impact of economic integration¹

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises economic growth and job gains to Thailand. Three critical intersections between the AEC and social protection have been identified:

Wage setting: Wage setting is important with wage workers making up 41.4 per cent of total employment. The lack of effective collective bargaining mechanisms and low unionization has led to the use of statutory minimum wage setting (US\$237 a month) for real wages to catch up with productivity gains.

Skills development: Thailand accounts for 19.6 per cent of ASEAN's high-skill manufacturing exports. To meet the growth in demand for skilled workforce, Thailand will have to address its current skills mismatch. An estimated 80 per cent of firms have experienced hiring difficulties due to graduates lacking relevant technical skills despite the high tertiary education gross enrolment rate of 51.4 per cent.

Intraregional migration: Spurred by regional wage disparities, Thailand is one of the main receiving countries in Intraregional migration. In 2013, almost all of its immigrants (96.2 per cent) originated from other ASEAN countries, in particular Myanmar, Lao People's Democratic Republic, and Cambodia. Labour immigrants are disproportionately low- and medium-skilled.

Recent and ongoing reforms

- The National Savings Fund was legislated in 2011 as a voluntary retirement savings programme for approximately 35 million workers – mainly self-employed and informal sector workers – who are not covered by any pension schemes. Its implementation is planned for mid-2015.
- Ministerial Regulation No. 14 (B.E. 2555) issued in 2012 offers domestic workers a weekly rest day and additional paid leave provisions (including for sickness) in a year.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- (i) Fragmentation
The present coexistence of many contributory and non-contributory social protection schemes can be

inequitable, inefficient, and ineffective, especially if benefits are not portable across schemes.

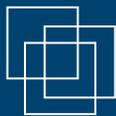
- (ii) Ageing population
Ageing population places a growing fiscal burden with general tax-financed schemes such as the UCS. Most workers are still excluded from contributory pension (including provident fund) schemes and the non-contributory universal pension benefit is very low relative to the poverty line.
- (iii) Coverage
Social protection gaps persist, among others, in the form of the exclusion of domestic workers from SSA and Workmen's Compensation Act and the exclusion of stateless persons, ethnic minorities, and migrant workers from the UCS. Despite legal provisions, only 2.5 per cent of informal economy workers (62.4 per cent of the labour force) were covered under Section 40 of SSA in 2010.² The extension of social protection will necessitate removal of barriers to access, for example by simplifying enrolment and contribution payment mechanisms, formalizing domestic employment, and by regularizing undocumented migrant workers.

Examples of ILO work

- The ILO has conducted actuarial reviews, including assessment of reform options, of the Social Security Fund.
- From June 2011 to October 2012, the Assessment Based National Dialogue (ABND) on social protection was conducted to assess the social protection situation, identify policy gaps and implementation issues, and draw appropriate policy recommendations for the achievement of a comprehensive social protection floor.
- Thailand is one of the main destination countries covered under ILO's GMS TRIANGLE project to protect migrants within and from the Greater Mekong Sub-region from labour exploitation.
- Together with the government and social partners, the ILO-IPEC project aims to combat child labour and forced labour while creating decent work conditions in the fisheries industry.

¹ This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

² V. Schmitt, et al.: *Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Thailand* (Bangkok, ILO, 2013).



The State of Social Protection in ASEAN 2015



ILO/Japan
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International
Labour
Organization

Viet Nam

Viet Nam Country Fact Sheet | 2015

Key indicators

Socio-demography and economy	Year	
Population (million)	92.5	2014
Population age structure		
0-14 years (%)	22.6	2014
15-59 years (%)	67.4	2014
60+ years (%)	10.0	2014
Dependency ratio	41.3	2014
Labour force participation rate (%)	77.5	2013
Female labour force participation rate (%)	73.2	2013
Unemployment rate (%)	2.2	2013
Average monthly wage (US\$)	181	2012
Poverty rate (% less than US\$2 a day)	12.5	2012
Social protection coverage		
Out-of-pocket payment (% total health expenditure)	48.8	2012
Primary school net enrolment rate (%)	98.1	2012
Primary school completion rate (%)	97.5	2011
Legal coverage for work injury (% working age)	30.4	2012
Active pension contributors (% working age)	17.3	2010
Old-age pension beneficiaries (% population above statutory pensionable age)	34.5	2010
Social Protection Expenditure, SPE (% GDP)		
Total social protection expenditure	6.28	2010
Public health care expenditure	2.54	2010
Public SPE for children	0.02	2010
Sickness, maternity, work injury, disability	0.33	2010
Public SPE for older persons	3.13	2010
General social assistance	0.09	2010

Sources: ADB, ILO, UNDESA, UNESCO, World Bank, WHO.

Social protection context

The Social Insurance Law passed in June 2006 covers public and private employees with contracts of at least 3 months in the event of disability, sickness, maternity, work injury, and old-age. The contractual length criterion has limited the legal coverage of its working population, allowing some employers to evade social contribution payments through short-term contracts (although recent reforms partially address this issue). Amidst the global financial crisis in 2008–09, an unemployment insurance (UI) scheme was introduced to replace the existing severance pay system in 2009.

Domestic workers, recognized under the Labour Code since 2012, are obliged to have work contracts under Decree 27/2014/ND-CP issued in April 2014. Depending on the contract's length, this makes them eligible for compulsory social insurance coverage. In contrast, informal economy workers are still largely excluded from social insurance coverage except for the voluntary retirement and survivor pension scheme introduced in January 2008.

The Law on Health Insurance of 2008 aimed to achieve universal health insurance by 2014. The extension of coverage exceeded 60 per cent by 2011 but national targets were revised to 70 per cent by 2015 and 80 per cent by 2020. Besides automatic enrolment with full subsidies of premium for the most vulnerable and voluntary enrolment with partial subsidies for others, the government has relied on a series of laws to extend compulsory health insurance coverage. The 2014 amendments stipulate mandatory health insurance for the various insured groups and their dependents.

Viet Nam has several social assistance programmes targeting nine vulnerable groups defined under Decree 67/2007/ND-CP, among others: orphans, the elderly aged at least 85 years who are not recipients of other benefits, incapacitated adults, elderly, or AIDS/HIV-infected children who live in poor households and/or do not receive any support.

Economic and social trends

- Increased life expectancy and decline in fertility have given Viet Nam one of the fastest ageing rate in the world: doubling from 7 per cent of the population aged 65 and older in 2011 to 14 per cent in 2030. The National Statistics Office predicts ageing population challenges by 2017.
- Continual high rural-urban migration especially to the two largest cities, Ho Chi Minh City and Hanoi, and the most industrialized provinces.¹

¹ B. D. Le et al.: "Social Protection for Rural-Urban Migrants in Vietnam: Current Situation, Challenges and Opportunities", in *Centre for Social Protection (CSP) Research Report* (2011, No. 08, January).

ILO-ADB report: Impact of economic integration²

With the importance of trade as part of its national economy, the ASEAN Economic Community (AEC) promises economic growth and job gains to Viet Nam. Three critical intersections between the AEC and social protection have been identified:

Wage setting: The weakness of collective bargaining in wage setting have led Viet Nam to rely on minimum wage setting. Regional minimum wages range from US\$90 to US\$128. Strengthening collective bargaining mechanisms could assist in bringing about productivity-linked wage gains while reducing the reliance on minimum wage setting for this purpose.

Skills development: Besides its near universal access to primary education (net enrolment rate at 98.1 per cent) and high literacy rate (93.4 per cent), Viet Nam still has to improve learning outcomes in post-primary education and skills training.

Intraregional migration: Though not one of the region's main receiving or sending countries, emigrating Vietnamese workers have traditionally targeted high-income Japan and South Korea. Recent growth in intra-ASEAN emigration is expected to remain with deeper economic integration.

Recent and ongoing reforms

- The Decree on Domestic Workers took effect on May 2014 to obligate the use of labour contracts that would enable social insurance coverage among domestic workers.
- Amendments to the Law on Health Insurance in 2014 were implemented from January 2015. They extend compulsory social health insurance coverage by moving from an individual-based to a household-based insurance system.
- A recent Decree on Unemployment Insurance (No. 28/2015/ND-CP) extends mandatory coverage to wage workers with a minimum three-month contract regardless of firm size from May 2015.
- To increase coverage and avoid social contribution evasion by employers, the new Social Insurance Law passed in November 2014 will, from January 2018, incorporate workers with shorter contracts of minimum one month, foreign employees with work permits, and part-time civil servants in communes, wards, townships.

Further challenges and way forward

For further advancements in social protection for all, these key areas deserve attention:

- Coverage**
Social security coverage remains limited to the small formal sector, excluding the large informal economy that is concentrated in rural areas and the agricultural sector. Out of the 52.2 million employed in 2013, only 34.8 per cent are wage workers, of which 60 per cent participate in the social insurance scheme.³ Voluntary coverage is also very low with 173,584 participants or 0.3 per cent of the workforce in 2014.⁴
- Institutional capacity**
The lack of institutional capacity remains a major impediment that resulted in the low compliance of employers to contribute to the social insurance schemes. This is particularly acute for internal migrant workers that have moved from rural areas to large cities and industrial zones.⁵
- Sustainability**
The current national pension scheme has been assessed by the ILO to be unsustainable: the pension fund is predicted to run out by 2034 at its present state. To bolster the funds, the government should consider increasing the retirement age to correspond to the extended average lifespan and equalizing the retirement ages for men and women.

Examples of ILO work

- In 2011, the ILO had produced a rapid assessment of the social protection situation, including a cost-calculation of various policy options to fill the social protection floor gap.
- Since 2009, the ILO has provided advice on unemployment insurance. An actuarial assessment of the scheme was conducted in 2014 with design recommendations to enhance its effectiveness and long-term sustainability.
- An actuarial assessment of the public pension system was performed in 2012 to evaluate its financial sustainability, adequacy of benefits, levels of coverage, and scheme policy design.
- The ILO provided technical inputs on the draft employment law and reform of the social insurance law.

² This section is based on ADB and ILO: *ASEAN Community 2015: Managing integration for better jobs and shared prosperity* (Bangkok, ILO and ADB, 2014).

³ M. Bédard: *Actuarial Report on the Unemployment Insurance Scheme of Viet Nam* (ILO, 2014), unpublished.

⁴ Hong Thuy: "Few sign up for voluntary insurance", in *Viet Nam News*, 13 July 2014.

⁵ W. Taylor: "Vietnam's 26 Million Migrant Workers: Greatest Advantage, Greatest Challenge" in *The Asia Foundation*, 28 September 2011.

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The state of social protection in ASEAN at the dawn of integration

The ASEAN economic integration has the potential to drive innovation, create new jobs, and accelerate growth. This will also be accompanied by necessary changes in skills and employment. Social protection is therefore a priority to smooth the transition and ensure that more men and women benefit from these changes, and that no vulnerable people would be left behind. With the adoption of the ASEAN Declaration on Strengthening Social Protection in 2013, the Member States recognized that building the ASEAN Socio-Cultural Community relies on solid social protection. ASEAN countries have made significant progress in extending social protection coverage. However, the report warns that social security remains a reality mainly for formal workers, excluding the majority in ASEAN from this fundamental human right. The reports discusses recommendations for effectively and adequately expanding social protection at this critical juncture of deepening regional integration.

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