Social Security Research Centre

KWSP EPF

SSRC Working Paper Series
No. 2017-6

An Exploratory Study on Social Protection in Selected ASEAN Countries: Malaysia, Singapore, Thailand, Philippines, Brunei and Indonesia

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December 2017

About Social Security Research Centre

The Social Security Research Centre (SSRC) was established in March 2011 at the Faculty of Economics and Administration (FEA), University of Malaya to initiate and carry out research, teaching and dissemination of evidence-based knowledge in the area of social security, including old age financial protection in order to enhance the understanding of this critical topic to promote economic development and social cohesion in Malaysia.

The interest in social security and old-age financial protection is ever growing in view of an ageing population. Malaysia is also subjected to rising life expectancy and falling fertility rates, the perceived inadequacy of current social security provisions, coupled with the added fear that simply more expenditure may not be conducive to the development and growth objectives of the society. This calls for innovative policy solutions that may be inspired by international experience based on an empirical grounding in national data and analysis.

To support the research in social security in general and old-age financial protection in particular the Employees Provident Fund (EPF) of Malaysia has graciously provided an endowment fund to create the nation's first endowed Chair in Old Age Financial Protection (OAFPC) at University of Malaya. OAFPC has the over-riding objectives to help formulate policies to promote better social security and improve old age financial protection, and to also formulate policies to promote economic growth in an aging society for consideration by the Government of Malaysia.

An Exploratory Study on Social Protection Floor in Selected ASEAN Countries: Malaysia, Singapore, Thailand, Philippines, Brunei and Indonesia

Abstract

Strengthening social protection has become a key element of the new development agenda among the Association of Southeast Asian Nations (ASEAN) member countries, particularly with the introduction of Sustainable Development Goals (SDGs) in 2015. A Declaration on Strengthening Social Protection was signed in 2013 by 10 ASEAN country leaders to express their own commitment towards ensuring social protection for the people. This initiative signifies a growing concern in the region of the importance of providing protection against economic, social and environment risks as well as a tool to fight poverty and reducing inequality. Each member state is guided by different political history that shaped the variations in terms of the level of economic structure and development. This in turn has resulted in the different priorities with regards to social protection goals and the extent of social protection coverage.

This article explores existing social protection systems in selected ASEAN member states; namely Singapore, Philippines, Thailand, Indonesia, Brunei and Malaysia. The focus of this article is on the three out of the four components of the social protection floor. They are health care, housing and income security.

Keywords: ASEAN, healthcare, housing, income security, social protection.

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Chapter 1 - Introduction

1.1 Introduction

While the Declaration on Strengthening Social Protection 2013 signalled the intent of ASEAN member states to improve access to basic social services for citizens, most of the countries in South East Asia had included the provision of education and basic health care services in the formulation and planning of their national development policies since the early days of their establishment as nations. However, progresses gained during economic growth of the 1980s were halted when the Asian Financial Crisis (AFC) hit the region in 1997. In the aftermath of the crisis, governments were struck by the fact that their economies were vulnerable and the severe impact of the crisis such as high unemployment, indebtedness and poverty. Many families were unable to provide basic necessities for their children, such as basic education, health care services and were struggling with basic shelter.

Moreover, the current trend in demographic structure shows declining birth rate and increasing life expectancy across the region. This poses a new challenge for the governments where rapid demographic change in population will negatively impact the national economic and social development, and will be more acute and prominent during economic crisis. Therefore, to face off economic uncertainties and rapid demographic change, it is imperative for governments to reform its existing social protection coverage to prevent more segments of the population from falling into poverty and protect the vulnerable from economic and social risks. Also, countries are now more exposed to severe environmental calamities

In view of these recent developments the study aims to investigate the type of policy response by each government to these changes. ASEAN countries are varied in the level of economic development and economic structure, institutional capacity and priorities vis-a-vis social protection goals hence, the extent of coverage differs. Currently, evidence suggests that ASEAN countries have started to reform their social protection system. Several social protection areas seem to be the focus of these reforms; the informality of the labour market, fiscal space to finance public pensions, professionalism among the organization of social protection and social regulatory capacity to oversee protection organization, based on a good pension economics and policies principles and practices.

This article gives an overview of the existing social protection system in selected ASEAN Member States; namely Singapore, Philippines, Thailand, Indonesia, Brunei and Malaysia by examining the social protection floor i.e. healthcare, housing and income security. It also attempts to highlight some of the reformed undertaken in these countries.

1.2 Background of the Study

Social Protection in the ASEAN region has been extended from a single focus on risk to a broader focus on basic needs and capabilities. This is reflected in practice, with a rapid scaling up of programmes and policies that combine income transfers with basic services, employment guarantees or moved on to asset formation. There has been rapid increase in terms of coverage and it has also been made a cornerstone of development efforts.

Social protection has come to the fore among the ASEAN member countries since the 1997 AFC. The main reasons for these are economic and demographic changes, the ongoing impact of the economic crisis and the 2004 tsunami (Suharto et al., 2006, Mansor et al., 2015). The welfare of children and adolescents has been hit hard by the crisis and subsequent natural disasters. During the crisis, many families are left vulnerable, unable to provide basic necessities for their children, such as primary education and health care services.

Social protection helps to reduce the impact of poverty and misery among the population including children. However, social protection is not only an initiative to reduce poverty. There have been a lot of evidence showing, to achieve a sustainable and inclusive development, effective social protection should be implemented in combination with other approaches, such as the provision of social and economic services for the overall socio-economic growth and development. Many studies show a positive relationship between the provision of social protection and basic social protection for the poor and economic growth (Shepherd et al., 2004).

About more than 60 percent of the ASEAN population live in rural areas, where poverty remain prevalent and urban poverty has also increasingly worsened. The economic development in the region has widened income disparity, between the urban and rural, between formal and informal worker and between the public and private sectors (ILO, 2014). Thus, employment

creation is a key driver for every member country. The provision of basic social protection for the less active poor would therefore positively impact the economy; it will impact the aggregate national development goals of the respective country (ILO, 2014) and plays a crucial role in cushioning both the workforce and businesses against main contingencies.

The ASEAN countries are varied in the level of economic development and economic structure, economic and institutional capacity, and the priority with regards to social protection goals. Hence, intuitively, the extent of coverage differs. Five countries have statutory schemes that cover at least six social security policy areas while several are still in the process of developing their social protection systems. Several social protection areas seem to be of concern are: the informality of the labour market, fiscal space to finance public pensions, professionalism among the organization of social protection and social regulatory capacity to oversee protection organization, based on a good pension economics and policy principles and practices.

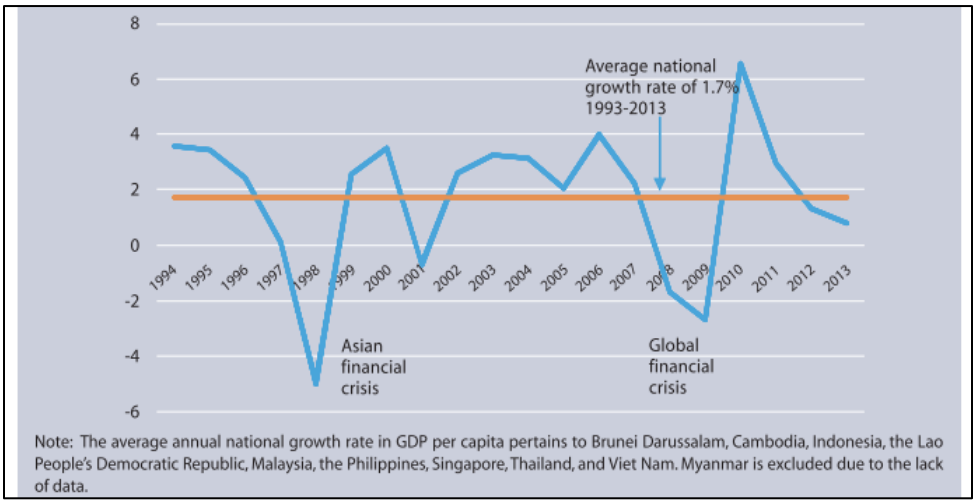
1.3 ASEAN Development at a Glance

Indonesia, the Philippines and Thailand are considered as emerging countries where they have generally enjoyed economic growth and relatively widespread distribution of its benefit in the early part of the 1990s. These countries have had strong previous records in providing coverage of basic health and education services to their respective populations. This factor combined with national policies that favour growth was the foundation behind their success in economic growth. Nevertheless, the income distribution was not efficient enough such that the economic growth was also accompanied by widening disparity between the rich and the poor.

Meanwhile, Brunei, Malaysia and Singapore are the most advanced economic countries in the region. These countries built development policies through active public or public/private interventions in many areas of development. From the beginning of their development path, investing in social development has become the priority and the pillar of their modernisation programmes. Their high economic growth and increasing domestic demand enabled these countries to experience higher level of social protection as well as high productivity gains in the workforce.

In a recent study by ILO-ADB (2014), it is estimated that 92 million people in the ASEAN region do not earn enough to escape poverty. Of the poor in the ASEAN region, majority are unemployed urban dwellers, landless labourers, small-scale farmers, fishermen and low-income earners struggling to survive in the rural areas. Furthermore, the financial crisis in 1997 and 2008 together with simultaneous food and fuel price shocks have caused the majority of its population that live below and just above the poverty line to be exposed to vulnerabilities. The real GDP per capita mostly has decreased for all countries in the region and among the countries to be most adversely affected are Thailand and Indonesia. For two consecutive years since 1997, both countries experienced negative change in real GDP per capita.

Figure 1: Average annual national growth rate in GDP per capita for ASEAN



Source: ADB (2015)

It has been highlighted that the economic growth period that followed had not been accompanied with equivalent progress at the social protection front that could have helped mitigate and reverse the adverse effects of the crisis (ILO 2016). Important information such as vital statistics on those affected, severity of the effects of the crisis and references regarding effective social protection schemes and available service delivery mechanisms were unavailable. The situation was made worse with the fact that the ASEAN region is also one that is most vulnerable to natural calamities. Various factors such as geophysical characteristics, high population density,

poverty, and ill-equipped infrastructure caused the region to suffer high costs in terms of human mortality, physical destruction, and economic loss.

1.4 Social Protection in Selected ASEAN Countries

The financial crisis along with the incidence of natural disasters in recent years brought social policy and the capacity of welfare systems to provide social protection to the forefront of public debate in ASEAN countries. For the majority of the ASEAN Member Countries, their social protection system still does not cover large shares of the population. Specifically, they are 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 like in many developing countries, the coverage of the any particular scheme is primarily linked to employment in the formal economy.

The ASEAN workforce is largely considered to be in "vulnerable employment" as they are less likely to benefit from proper employment conditions, social protection coverage, and effective representation. The growth in proportion of wage and salary workers in the ASEAN region has been slow at the expense of contributing family workers and own-account workers to a lesser extent. Based on more recent estimates, as many as 179 million or 58.8 per cent of the ASEAN workforce is vulnerably employed (ILO and ADB, 2014).

Evidence shows that social protection coverage in majority of countries in the Asia Pacific region appear to be underperforming, especially among the middle-income countries, where too little were spent on social protection (ADB, 2013). Table 1 below compares the social protection expenditure.

Table 1: Social Protection Expenditures as Percentage of GDP, 2015

Country	Percentage of Social Protection Expenditure out of Total Government Expenditure
Brunei Darussalam	3.4%*
Singapore	10.87%**
Malaysia	4.46%
Thailand	10.03%
Philippines	9.46%
Indonesia	-

Note: * Data from 2012, ** Data from 2014, Recent data from Indonesia not available
Sources: ADB Statistical Database System, various years.

The ASEAN countries coverage focuses mostly on increasing the number of individuals 'protected' under the statutory programme and the various risks protected. This is usually referred to as the protection of the law. It has been reported that there is universal health care coverage legislation in all countries except Indonesia and Vietnam but these programmes do not provide an adequate level of benefits (Asher & Zen, 2015). For a pension plan, the Philippines, Singapore, and Thailand have between two and three quarters of the current work age population covered by social security legislation, while the ratio is smaller for Indonesia, Malaysia, and Vietnam. Asher and Bali (2010) found a large variation in the proportion of the elderly population that receive pension. The proportion is high in Thailand, but less than 40 per cent for other ASEAN countries which implies that there is room for improving the effective coverage. Low effective coverage indicates that a significant share of expenditure for retirement savings and health care will be financed from individual and household savings.

1.5 Theoretical Framework & Methodology

Social protection refers to a protection scheme that society provides for its members through a series of public and private measures. It guarantees basic standard of living for citizens in need of assistance from the state, local municipalities, and the private sector in areas of welfare, health care, education, employment, housing, culture and environment and more. It also serves as a mechanism that integrates elements of welfare and safety net

to protect citizens from economic and social distress caused by the absence or reduction of income from work as a result of contingencies. These contingencies may occur due to illness, maternity, employment injury, unemployment, invalidity, old age, and death of breadwinner.

International agencies such as the International Labour Organisation (ILO), the World Bank and others have increased their appeals to governments to improve social welfare or further protect their people. Several countries have made provisions for social protection policy as priority to increase protection for the vulnerable and to prevent more segment of the population from falling into poverty. Review of literatures on social protection agrees on a protection framework to cover all vulnerable groups (Holzmann and Jorgensen 2000; Garcia and Gruat 2003; ILO, 2004). The ILO (2004) proposed a framework to guide policy makers formulate and plan for comprehensive and adequate social security standards.

ASEAN countries vary in terms of level of economic development and economic structures, economic and institution capacities and in priority given to social protection goals (Asher and Zen, 2015). The mix of programmes or instruments is reflective of historical legacies, institutional choices and country-specific administrative and fiscal capacities.

The focus of the working paper is to stock take existing social protection schemes in selected ASEAN Member Countries; namely Singapore, Philippines, Thailand, Indonesia, Brunei and Malaysia from the angle of the three guarantees of the social protection which are health care, housing, and income security .

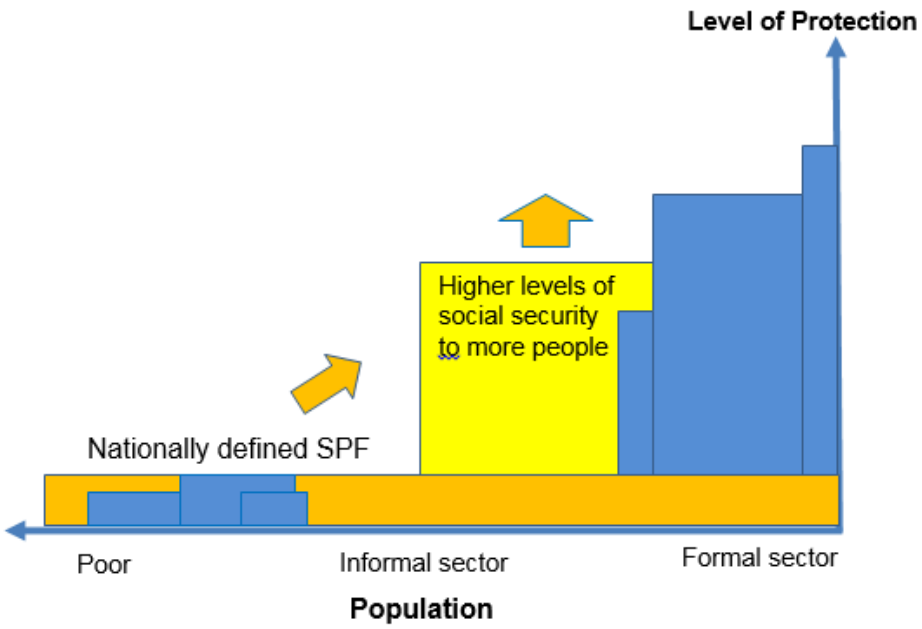
1.5.1 Social Protection Floor

The social protection floor is essentially the first step towards a higher level of protection. The floor can stimulate virtuous circle of development, which can begin once the floor is in place and it can provide an exit route out of poverty and inequality. In addition, it gravitates towards a long-term economic resilience and inclusive growth. The principle is to propagate self-propelling mechanisms which anchor on human development progress in a virtuous circle created by social protection. According to ILO, the Social

Protection Floor should include at least four essential social security guarantees:

I. Guaranteed access to goods and services constituting essential healthcare, education and other social services;
II. Basic income security for children with the aim of facilitating access to nutrition, health, education care and any other necessary goods and services;
III. Basic income security for persons in active age unable to earn sufficient income;
IV. Basic income security for people in old age

Figure 2. Social protection floor coverage



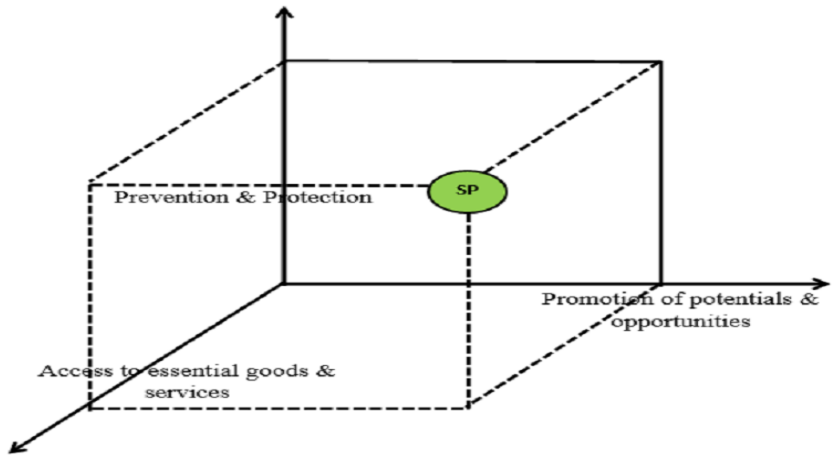
Source: ILO, 2012

Every social protection floor is context specific and has to be formulated and translated to fit a country's needs (ILO, 2012). Using an integrated and interconnected way, it addresses multidimensional vulnerabilities by providing a framework to develop coherent and coordinated approaches to social protection and employment policies. Aiming towards achieving minimum standards as a first step towards higher level of social protection is a particularly strong case. Figure 2 illustrates how a nationally defined social protection floor could fill social protection gaps by providing universal

coverage of basic social protection. Following the extension of social protection on the "horizontal dimension" (towards universal coverage), ideally social protection should be extended along the "vertical dimension", that is towards higher level of protection whether in terms of level of benefit or number of contingencies covered. Correspondingly, this initiates an expansion of contributory schemes along with the fiscal and policy space of a country.

This study will employ the three-dimensional framework as proposed by Garcia and Gruat (2003) and ILO (2014). The first dimension relates to access to essential goods and services - the social protection floor, while the second is prevention and protection against various risks and the third is promotion of potentials and opportunities in order to break vicious poverty cycles and pervasive tendencies. Thus, people would less likely depend on assistance and at the same time less vulnerable to risks. This would involve developing, promoting and providing opportunities to disadvantaged groups in society through targeted programmes which include education and training, active labour market policies or micro-credit strategies (Garcia & Gruat, 2003; Holzmann & Jørgensen, 2001).

Figure 3. The Three Dimensions of Social protection



Source: Garcia & Gruat (2003); ILO (2004)

The horizontal dimension should target the rapid implementation of national social protection floors, which contain basic social security guarantees ensuring that all in need can afford and have access to essential health care and have income security at least at a nationally defined minimum level throughout the life cycle. The social protection floor policies should aim to

facilitate effective access to essential goods and services and to promote productive economic activity. They should also be implemented in close coordination with other policies thus improving employability, reducing informality and precariousness, creating decent jobs and promoting entrepreneurship.

1.5.2 Healthcare

Every country in ASEAN provides some form of provision for social health protection which enables the citizens to have access to at least basic healthcare services. These either include access to free public health care services or to services financed through health insurance for certain population groups. Access to affordable and quality health services is an important dimension in evaluating healthcare provisions. Besides its effects on health outcomes, quality and equity of services can also affect access and service utilization.

Lack of access to quality and affordable services could lead to low service utilization among the poor and vulnerable, and/or high out-of-pocket health expenditure. Physical barriers to health care access afflict many ASEAN communities where there is still a substantial proportion of the population living in remote, difficult-to-access areas. Besides monetary cost coverage, equally important are supply-side provisions and regulatory mechanisms such as accessible health services in rural areas, medical staff training and price control of drugs and services.

1.5.3 Housing

Housing has a significant impact on standards of living and the extent of poverty among older persons. Home ownership is usually much lower among lower-income households, and thus has only limited impact on the risk of poverty. According to OECD (2013), the inclusion of estimates of “imputed rent” or rent that house owners do not pay because they own their house) decrease the relative risk of poverty incidence by only 3.5 percent.

In terms of social protection, housing by definition may refer to housing support, housing assistance programme, low-cost housing or housing subsidies. Eurostat (1996) further extended that definition and includes

housing and rent subsidies in the definition. Social protection means to prevent deprivation and vulnerability to deprivation, which means protect against falling living standards, not deprived of food or undernourished, live in substandard housing and access to water supply and sanitation to improve health status.

Studies of slum demolition in major cities in India shows that the dwellers lose their livelihood in wake of losing their housing, children drop out of school for a short period and some never go back, deteriorating quality of life as consequences of losing access to water supplies, health conditions deteriorate, stop work due to uncertainties caused by loss of house, change in their employment, equipment and assets.

International law recognizes housing as a fundamental right, expressing it as the right to adequate housing. The discussion of adequate housing is mostly with respect to physical environment where the availability of safe, health and sanitary conditions are of concern. Other interpretations of the right to adequate housing relates to the security of possession and tenure.

1.5.4 Income Security

Full productive and decent employment is the most important source of income security. A well-designed income security that is linked to other policies would enhance productivity, employability and support economic development. As an effective automatic stabilizer in time of crisis, income security and social security as a whole contributes to mitigate the economic and social impact of economic downturns and environmental risks, to enhancing resilience and achieving faster recovery towards inclusive growth.

The Income Security Recommendation, 1944 (No. 67), of ILO states that, income security schemes should relieve wants and prevent destitution by restoring, up to a reasonable level, income that is lost due to the incapability to work (including old age) or to obtain remunerative work, or due to the death of the breadwinner. Income security should be organized as far as possible on the basis of mandatory social insurance, and allocation for those not covered by mandatory social insurance is to be made by social assistance.

It is agreed by most analysts that the system which provides the greatest long-term income security is one that is multi-tiered, characterized by diversification of financing and benefit mechanisms. Generally there is consensus about a minimum guarantee for the poor (the first tier) and voluntary retirement saving (the third tier). It is generally also agreed that a better contribution-benefit linkage and proper incentives for contributions and transparency are required in the intermediate, mandatory insurance scheme (the second tier). The debate usually concerns the institutional setting of the second tier: the method of financing (pay as you go or funded) and the type of management (public or private). The interlinkages between these tiers are strong. For instance, if a country's bottom tier is well-developed and sustained, the size of the mandatory, contributory tier may be relatively smaller, and more emphasis can be directed to voluntary arrangements.

2.0 Introduction

Every country allocates some form of provision towards social health protection. Theoretically, this enables access to at least a limited range of health care services which include access to free public health care services or to services financed through health insurance for certain low income groups.

Besides universal health coverage, an equally important element in evaluating access to essential health care is the quality of health services. In addition to its effects on health outcomes, quality of services may affect access and service utilization too. In a two-tier health care system, equity between households becomes a key concern where basic public health care is mainly utilized by the poor and the marginalized lacking other options, while higher quality private health care is accessible only for the socially advantaged.

In low-income countries, not more than 5 to 10 per cent of the population are covered by statutory social health insurance schemes. Moreover, governments generally do not provide free or subsidized access to basic health care. This has resulted in the emergence of community-based health insurance schemes. The main advantage of such schemes is that they improve health expenditure efficiency, or the relation between quality and costs of health services. While the degree of success of these community based schemes have depended greatly on the characteristics of the organizations (for instance, based on occupation, gender, area or religious affiliation), on the design of the scheme and on the context in which they operate.

The next section of this paper gives a brief overview of the existing health care coverage in individual ASEAN member countries.

2.1 Singapore

The health insurance system in Singapore is not comprehensive, social protection for the sick is provided in the form of government subsidies for the masses and risk pooling for catastrophic illnesses. As with other aspects of social protection in Singapore, social protection for the sick also puts

emphasis on individual responsibility together with family responsibility and community support. Healthcare financing is an integrated system of a compulsory medical savings account (Medisave), a catastrophic medical insurance scheme (Medishield) and a means-tested medical expense assistance scheme (Medifund). For details, see Chia and Tsui (2005a). To deliver more targeted social protection for the disabled, the Eldershield was implemented as a disability insurance scheme. Currently, the Eldershield is the only scheme that covers a portion of long-term care costs.

Medisave account assist labours for hospitalization during their working life and retirement. The government supports Medishield system for Medisave members to enable coverage of major medical costs. Additionally, the government tries to subsidise the Medishield scheme for low and middle-income people, to make medical cost affordable for them (Central Provident Fund Board, 2013). Under the Central Provident Fund (CPF) savings, Singaporeans healthcare benefit depends on the contribution of employers and employees, wages base saving and interest rate. In most cases, 8 percent of an employee's monthly wage goes to their Medisave account (Asher, 1995). In 2014, Singapore government announced to raise CPF contribution of employers into Medisave account by one percentage for all employees to assist in healthcare expenses. The announcement came with a one year temporary employment credit substitutes by government to assist employers in adjusting their financial allocation. Three fourths of Singapore's labour force is covered by social security through CPF savings. Therefore, such an established scheme strengthens workers' confidence in the social protection system regardless of economic conditions in the future.

To ensure all Singaporeans have access to medical care, the government opens Medifund to assist the poor and the needy (Mohandas & Loh, 2014; EY 2014). Medifund is established by annual contribution of government as a safety net for the poor and the needy. If low income workers cannot afford to pay for their medical expense, Medifund assists to cover the cost for them. For senior citizens with low income, Eldershield assists in terms of payment for long term care. Due to surplus in national economy, government supports financially to each citizen account. Mostly, USD 2, 090[*] reward given to low income family earning under USD 697 salary per month and USD 348 for high income family earning over USD 13, 938 (Dong, 2006; Loong, 2012).

[*] Currency exchange at USD 1.00 = SGD 1.44 as of 3 January, 2017
Currency exchange at USD 1.00 = INR 13340.00 as of 18 January 2017

2.2 Philippines

Very little is known about the Philippine health care system and in particular its experience with social health insurance (SHI). Having initiated a SHI programme 35 years ago, the Philippines hold many lessons for the development of such schemes in other low and middle-income countries.

In 1969, Republic Act (RA) 6111 was approved, creating the Philippine Medical Care Commission (PMCC), charged with implementing the Philippine Medical Care Plan (Medicare). Medicare comprised of two programmes; Phase I targeted to those in formal employment, and Phase II aimed to reach informal sector workers, particularly the poor. The PMCC was largely successful in enrolling workers in regular employment. With respect to Phase II, the PMCC was far less successful. From the beginning, there was a view that universal coverage would be very difficult to achieve due to the culture and attitude of Filipinos (Soriano, Dror, Ampalay and Bayugo, 2002).

The focus of Medicare benefits was on hospital care. If the patient was confined in a private hospital, treatment was paid only up to the benefit limits, after that the patient is to be transferred to a government hospital. This reimbursement concept (the ‘‘first-peso approach’’) is being practiced until today (Gamboa, Bautista and Beringuela, 1993).

The passage of the RA 7875 (National Health Insurance Act) in 1995 created Philippine Health Insurance Corporation (PhilHealth), responsible for managing and developing the National Health Insurance Programme (NHIP), thereby replacing the PMCC (Hindle et al., 2001).

PhilHealth was formed in 1995 as a successor to the Medicare programme and was given a mandate to achieve universal health coverage for the Philippine by 2010. It is a tax-exempt, government-owned and government-controlled corporation (GOCC) of the Philippines, and is attached to the Department of Health. To date, PhilHealth has been quite successful in some areas (e.g. enrolment), but lags behind in others (e.g. quality and price control).

Funding varies based on the population covered, although the majority of funds flow from general taxation. Premiums for the formal sector reach up to 3% of monthly income. Premiums for both the poor and the informal sector

are USD 24[†] annually. However, the cost of insurance for the poor is fully subsidized by the central and local governments. The National government allocates more than 9 billion pesos annually to meet its target.

2.3 Thailand

For public healthcare schemes for the elderly, there is the Civil Servant Medical Benefit Scheme (CSMBS) or state enterprise scheme, Social Security Scheme (SSS) and Universal Healthcare Coverage (UC). The CSMBS is a non-contributory scheme for civil servants, their dependents (children and parents) and pensioners. This scheme is the most preferred compared to the rest because of its wide coverage and benefits. The SSS is available for private employees and is made accessible through their contributions to the Social Security Fund (SSF). For this scheme, employees, employers and the government are required to each contribute 1.5% of insured wage for illnesses, disability, maternity and death. The UC scheme is a free healthcare system financed by general tax revenues. It was created for those who are not covered in the other two categories and since its implementation in 2001, 79% of the Thai elderly are covered by UC.

For healthcare, under the UC scheme, there is the Low Income Health Card targeted at children under the age of 12 years, poor adults between 13-59 years with income of USD 56[‡] a month and below or USD 78 per month for a family, elderly aged 60 years and above, disabled, war veterans and monks (Pongsapich et al., 2002). There is also the Voluntary Health Card for the near poor and those without mandatory insurance. The other UC scheme is the 30 Baht UC Programme that gives access to the public who are not in civil service or private sector.

2.4 Indonesia

Healthcare for the Poor (*Jaminan Kesehatan Masyarakat Miskin, Askeskin - Jaminan Kesehatan Masyarakat, Jamkesmas*) has been implemented since January 2005 for 74.6 million of the poor and the near poor to cover free-of-charge primary healthcare services including maternity at public health centre (PUSKESMAS) and inpatient treatment in third-class hospital wards. PT

[†] Currency exchange at USD 1 = PHP 49.46 as of 3 January 2017.
[‡] Currency exchange at USD 1 = THB 35.81 as of 3 January 2017

ASKES was given responsibility to run this scheme until 2007. The Ministry of Health has taken over the implementation since 2008 to directly distribute the funds to PUSKESMAS and hospitals.

Through reforms, social health insurance coverage was expanded to the informal sector and the poor. The introduction of nationwide social health insurance for the poor known as *Askeskin* (*Asuransi Kesehatan untuk Keluarga Miskin*) is intended to complement social health insurance schemes for public and formal private sector employees. Unlike for the formal sector schemes where the premiums are based on mandatory earnings-related contributions, the premiums for *Askeskin* were fully subsidised by a government health fund. This programme provides comprehensive insurance coverage for public health care, including inpatient and outpatient services. Sparrow et al. (2013) investigated targeting and impact of the *Askeskin* programme using panel data for household observed in 2005 and 2006. They concluded that the programme indeed targeted the poor and those most vulnerable to catastrophic out-of-pocket health payments, and therefore improves access to health care among the poor. To date 50% of Indonesian population or 130 million are covered under health insurance scheme. (The Economist, October 2017)

2.5 Brunei

Brunei Darussalam has well-developed health facilities. A primary healthcare system is in place. Medical care in rural areas includes a “flying-doctor” service to the villages, outdoor clinics, and mobile dispensaries, while the capital has a large, modern hospital and a smaller modern one is located in each district in the country. Provision of universal health services is available to all Bruneians.

Additionally, the decentralization of health services from central hospitals in each district into residential zones located in central villages as satellite centres catering to a much larger public within their own vicinities has taken place. For example, services from the RIPAS hospital in the Brunei-Muara District have been transferred to such satellite centres.

The quality of health and medical services is reflected in the life expectancy at birth of 78.2 and the death rate of 2.7 per 1,000 persons in 2008. The virtually free immunization programmes have resulted in positive health

outcomes. Children are also given the basic WHO immunizations such as BCG, Rubella and Polio. Health and medical services are provided for all citizens and permanent residents at a highly subsidized minimal rate of USD 0.70[§] registration fee and USD 3 for foreigners. For example, vaccination against the H1N1 influenza is currently provided free to citizens and residents of Brunei Darussalam.

2.6 Malaysia

The healthcare system in Malaysia is divided into the public and private sector. The public healthcare service is universal, heavily funded by tax revenue and administered by the Ministry of Health Malaysia (MOH), the largest healthcare provider. This medical service, which includes both out and inpatient treatment, is available to all citizens. Foreigners, however, are required to pay for the service, considered by many as cheap. The MOH has a free immunization scheme for all children accessed through hospitals, health clinics, and primary schools. Dental treatment is also provided through the public hospitals.

Supplementing the government hospital system is the emergence of private hospitals, which provide specialist services as well as regular medical services. The rate charged by the hospitals are not controlled but mutually agreed through consultations by the parties involved.

A number of private insurance companies provide schemes to cover individuals and families with coverage for medical expenses. Those who can economically afford the coverage, purchase the type of cover suitable for their needs.

The government has established a Medical Assistance Fund with the development of private medical services and specialists providing medical treatment not available in government hospitals. This Fund was designed to provide full or partial payment for medical costs, facilities and medication, which are needed by the individual and not available in government hospitals. Malaysians who are poor or registered as disabled with the Department of

[§] Currency exchange at USD 1.00 = BND 1.44 as of 3 January 2017.

Welfare, or persons referred by hospitals and certified by the Department of Welfare, are entitled to receive the benefits.

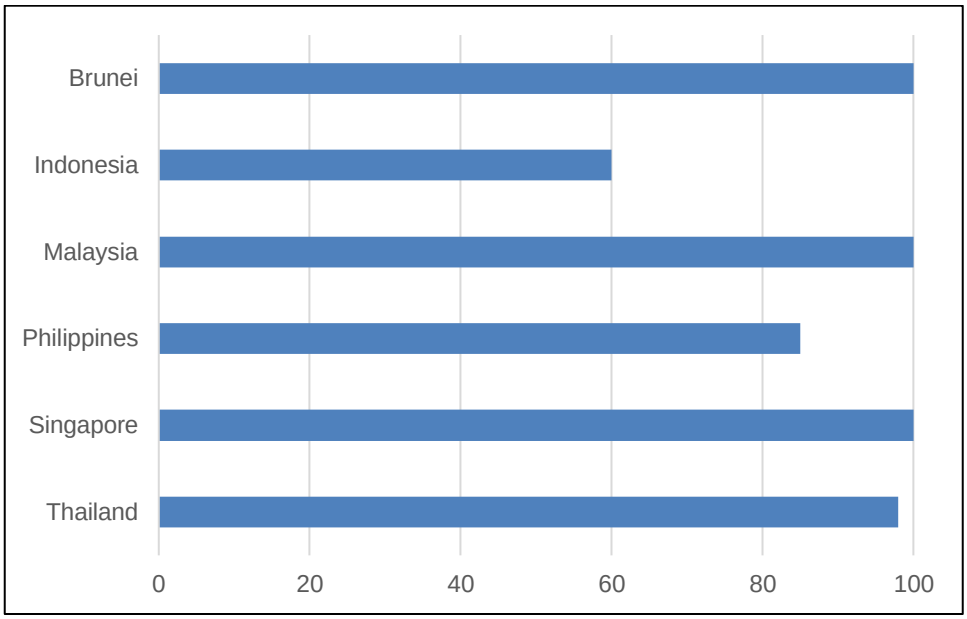
Also under the present Prime Minister, 1Malaysia Clinics were established to deliver healthcare to the urban poor. They are managed by medical assistants and staff nurses with weekly visits from medical officers. The treatment charges are USD 0.22[**] for Malaysians and USD 3 for non-Malaysians. These clinics provide treatment for minor ailments such as flu, cough, minor surgical procedures and simple laboratory tests.

Health care plays a crucial role in poverty reduction and the provision of access to essential health care. At least four ASEAN Member Countries have achieved (near) universal health coverage through a tax-financed general 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 member countries on the other hand have set specific targets for achieving universal coverage: Vietnam (2014), the Philippines (2016) and Indonesia (2019).

Even with "nominal" health coverage, the lack of access to quality and affordable services can discourage service utilization among the poor and the vulnerable, and/or increase out-of-pocket health expenditure. Physical barriers to health care access afflict many ASEAN communities where there is still a substantial proportion of the population living in remote, difficult-to-access areas. Besides monetary cost coverage, equally important are supply-side provisions and regulatory mechanisms such as accessible health services in rural areas, medical staff training and price control of drugs and services.

[**] Currency exchange at USD 1.00 = MYR 4.49 as of 3 January 2017

Figure 4. Percentage of Health coverage in selected ASEAN countries



Note: 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, 2014.

Table 2: Health financial system and health expenditure for selected ASEAN countries, 2014

	Brunei	Indonesia	Malaysia	Philippines	Singapore	Thailand
Main health financing system	Tax-based national health system	Social health insurance	Tax-based national health system	Social health system	Social health system	Tax-based national health system and social health insurance
General government expenditure on health as a percentage of total expenditure on health	93.86	37.78	55.18	34.28	41.74	77.83
Private expenditure on health as a percentage of total expenditure on health	6.14	62.22	44.82	65.72	58.26	22.17
General government expenditure on health as a percentage of total government expenditure	6.47	5.73	6.45	10.01	14.15	13.28
Out-of-pocket expenditure as a percentage of private expenditure on health	97.83	75.32	78.75	81.69	94.11	53.79

Source: Global Health Observatory data, WHO (2014)

Table 2 shows the health financing system and break down of health expenditure for selected ASEAN countries. It is observed that for Brunei, Malaysia and Thailand, the majority of health expenditure is funded by their respective governments through taxation. While the majority of health expenditure for Indonesia, Philippines and Singapore come from private expenditure reflecting the nature of their healthcare system which is through a contribution based health system with a social assistance component for the needy.

Despite successful health insurance enrolment, service utilization among the poor and vulnerable is still low. This is indicative of the existence of other barriers to effective health coverage. Among those identified are high out-of-pocket payments as shown in Table 2 where such payments represent a large share of private expenditure on health. Non-monetary factors include under-utilization of health care among insured migrant workers and stateless or displaced persons in Thailand.

3.0 Introduction

Housing has a significant impact on standards of living and the extent of poverty among older persons. Home ownership is usually much lower among lower-income households, and thus has only limited impact on the risk of poverty. According to OECD (2013), the inclusion of estimates of “imputed rent” or rent that house owners do not pay because they own their house) decrease the relative risk of poverty incidence by only 3.5 percent.

In terms of social protection, housing by definition may refer to housing support, housing assistance programme, or low-cost housing and housing subsidies. Eurostat (1996) further extend that definition and includes housing and rent subsidies in the definition. Social means to prevent deprivation and vulnerability to deprivation, which means protect against falling living standards, not deprived of food or undernourished, live in substandard housing and access to water supply and sanitation to improve health status.

Studies of slum demolition in major cities in India shows that the dwellers lose their livelihood in wake of losing their housing, children drop out of school for a short period and some never went back, deteriorating quality of life as consequences of losing access to water supplies, health conditions deteriorate, stopped working due to uncertainties caused due to loss of house, change in their employment, equipment and assets.

International law recognizes housing as a fundamental right, expressing it as the right to adequate housing. The discussion of adequate housing is mostly with respect to physical environment where the availability of safe, health and sanitary conditions are of concern. Other interpretations of the right to adequate housing relates to the security of possession and tenure.

3.1 Singapore

Singapore’s public housing price decline gradually every year in view of government loans, mortgage and investment in construction sector, in comparison with Hong Kong and Taiwan, similar countries with limited land. Even low income citizens of Singapore are able to buy a public flat in 25 years (Beng, 2012).

Employers have to contribute 16% to CPF and employees save 20% of their income. This CPF savings can be used for purchase of other properties after

having owned Housing and Development Board (HDP)'s public housing. For example, Dependents' Poverty Scheme (DPS) assists families and dependents with financial need for members that are permanently handicapped or passed away before age of 60 (CPF, 2014).

In Asia, having houses and lands represents the social status of individuals. Singapore government deeply emphasizes on house ownership. Therefore, in order to protect the members of families who are using CPF to purchase public housing, government set up The Home Protection Scheme (HPS), a compulsory mortgage reducing insurance scheme to shield from losing ownership in case of death or permanent incapacity (CPF, 2014). This scheme eases the problem of rising housing cost for Singaporeans as can be seen in several cities such as London, Tokyo, Hong Kong, Sydney and New York. Shaila Dewan reported that the world major cities face housing crisis for the new generation and lower and middle income classes to own affordable houses (Dewan, 2014). The provision of large scale welfare spending for housing by Singapore pointed to the style of welfare spending and designs in East Asia. Extensive housing projects are a Singapore's successful welfare plan and contribute towards improving the living standard and economic growth of citizens. Over three decades, this housing strategy has provided improvement of urbanization and livelihood of people. However, the qualification of applying for public housing is complex and sometimes exclusive for single mothers and single citizens. The government tries to control social and family institution through public housing scheme (Phang, 2012).

3.2 Philippines

Resettlement in Philippines involves the relocation of informal families on government and public lands into developed sites with housing component. The National Housing Authority (NHA) has implemented resettlement projects since the 1970s as a major housing programme for the low-income sector.

The NHA is the sole central government agency mandated to engage in direct shelter production for the lowest 30% of income earners. In line with this mandate, the NHA implements five housing development programmes, which are: resettlement, slum upgrading, sites and services, core housing and medium rise housing (MRBs). In the last decade, NHA focused on the

resettlement programme in line with the relocation need of the North and South Rail Infrastructure Project, which required the relocation of close to 100,000 families. Moreover, intense typhoons (Reming, Pepeng, and Ondoy) hit the country during this period causing major disasters specifically in the Bicol region and Metro Manila. The affected families specifically those left homeless were among the beneficiaries of NHA resettlement projects. Between 2001 and 2011, the resettlement programme received the largest budget and accounted for about 75% of NHA production outputs for the period.

The NHA classifies its housing programmes as follows:

1) Resettlement programme - involves the acquisition and development of large tracts of raw land to generate serviced lots and/or housing units for families displaced from sites earmarked for government infrastructure projects and those occupying danger areas such as waterways, esteros, and railroad tracks.

2) Slum upgrading programme - an on-site housing development programme where NHA acquire occupied lands and provides on-site improvement through introduction of roads or alleys and basic services such as water and power. Land tenure issue is resolved through sale of home lots to bonafide occupants.

3) Sites and Services - involves the development of raw land into service home lots to serve as catchment area for informal settlements. The intent is to help families acquire housing on an incremental basis. This programme can be tied up with resettlement programme.

4) Completed/Core housing - this programme provides service lots with core housing specifically targeted to low-salaried government and private sector employees. The projects are implemented under joint venture arrangement with private sector or LGUs.

5) Medium rise housing - an in-city housing programme that entails the construction of 2 to 5 storey buildings utilizing funds allocated under Republic Act No. 7835 or the Comprehensive and Integrated Shelter Financing Act of 1994 (CISFA). The units are made available under lease or lease to own arrangements. Standard unit cost is about USD 9, 800 to USD 11, 720 for a 4-storey and 5-storey building,

respectively. This amount excludes the cost of land. Lease rates per month range from USD 15 to USD 80.

Resettlement projects are undertaken in four phases. Phases I to III covers the project development stage while Phase IV is monitoring and estate management. Resettlement projects are implemented by NHA through different modalities. Classification by modalities maybe distinguished in terms of method of location. By method, there are basically three approaches: (1) Completed Housing Resettlement Projects or Developer-Constructed projects; (2) Home Material Loan Project or Incremental Housing Project; (3) the LGU-NHA joint venture scheme or RAP-LGU. By location, resettlement projects may be classified as: (1) In-City projects; and (2) Off-City Projects. In City refers to a resettlement site within the same LGU while off-city refers to resettlement sites outside of the administrative boundaries of the LGU and is usually considered distant relocation (possibly 20 to 30 kilometres from original settlement). Resettlement by location may involve either completed housing or incremental housing strategies or both.

3.3 Thailand

Housing delivery system in Thailand can be divided into three types: “owned housing sector”, “public housing sector”, and “private housing sector”. National Housing Authority (NHA) was established in 1973 to afford and provide an accessible public housing for low to middle income group. The largest group of low income is still the priority since it is a challenging issue in social development to enhance the quality of life of the citizen.

Public housing has been provided in Thailand for low income group for more than 40 years especially in urban area such as Bangkok. There are more than thirty public housing projects built under different schemes. Most importantly the projects aim to satisfactorily enhance the quality of living of the low income sector. Thus, affordable public housing programme for the low income in Thailand has been an ongoing effort. Nevertheless, ensuring affordable public housing for all in the low income sector in the urban areas is a challenge because of land speculation, housing unit price, and other social issues.

Public housing vision and policy have been in line with the National Development Plan since the 3rd National Plan until the present (11th National

Plan, 2011 - 2016) under the welfare equality policy. Housing development particularly determines human and social security as a milestone policy of the country to establish housing security for all.

3.4 Indonesia

Indonesia has been implementing three housing policies including self-help housing policy such as the *Kampung* Improvement Programme (KIP), Community-based Housing Development (P2BPK) and Self-help Housing Assistance (BSPS); the PERUMNAS Programme which is the national programme for public housing development; and the cross subsidy housing policy (Tunas and Peresthu, 2010).

The public housing programme in Indonesia started in the 1950s when a few government ministries and housing cooperatives created by local governments built low-cost housings. This approach generated a handful of new housing units and only targeted the civil service corps (Silver, 2008). Following a National Housing Workshop in 1974, the Government of Indonesia established three key institutions to address housing problems including the National Housing Authority (*Badan Kebijaksanaan Perumahan Nasional*) which is responsible for formulating the national housing policy, the PERUMNAS Corporation which is responsible for providing low-cost housing in the urban areas; and the State Savings Bank (Silver, 2008; Tunas and Peresthu, 2010; UN Habitat, 2008).

The PERUMNAS programme is the national public housing programme run by the PERUMNAS Corporation. The programme is supported and subsidized by the State Savings Bank, locally known as BTN. The BTN first offered loans for house purchases in 1976 and in the 1980s became central to the housing finance market particularly for low- and middle-income households. Two-thirds of the BTN's lending funds are derived from the Ministry of Finance and the Bank of Indonesia at rates well below market levels (Lee, 1996).

The PERUMNAS programme through the BTN offered loans up to 20 years with low interest rates of 8.5% to 14% with a 10% down payment (Tunas and Peresthu, 2010). The programme is aimed to provide low-cost housing units for low- and middle-class-income households with a monthly income of less

than USD 125[6]. The PERUMNAS programme built housing units on different size lots from 18 square meters to 36 square meters. The dimensions of the house are based on the minimum requirements for individual space, good lighting and air circulation. The PERUMNAS programme also offers a ready-to-build land parcel on different size lots from 54 square meters to 72 square meters for people who prefer to build a house on their own (Tunas and Peresthu, 2010).

Those who are eligible for loans from the BTN are those who have formal collateral (Sastrosasmita and Amin, 1990). About 80 % of BTN borrowers are government employees. Civil servants can provide formal collateral and are considered better risk. Those who are working in informal sectors and cannot show any formal collateral are not eligible for loans from the PERUMNAS programme.

3.5 Brunei

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

Since the mid-1970s, the government has supported an ongoing housing programme through the National Development Plan to encourage and support home ownership for all citizens. Since the mid-1980s, citizens of Brunei Darussalam have been eligible for the National Housing Schemes upon reaching the age of 18 although eligibility may depend on criteria such as family eligibility.

As of 2000, interest-free home loans have been available to all citizens although this policy may change as the government reconsiders the sustainability of its oil-based economy. Two national housing schemes that

[6] Currency exchange at USD 1.00 = INR 13,337.00 as of 18 January 2016

should be mentioned are the landless citizen scheme and the resettlement scheme. Formerly, these schemes were administered by the Land Department and the Housing Development Department, respectively. In recent years, however, both of these schemes have come under the auspices of the Housing Development Department and the development projects are under the National Development Plan. Low cost housings on state land with infrastructure fully subsidized by the government are allocated to low income citizens on a 99-year lease while higher income citizens are provided with a plot of land at USD 9, 055. The ownership is transferable to next of kin. Through the Landless Indigenous Citizens Housing Schemes, the government has constructed at least eight housing project sites to offer affordable, modern housing to low-income residents. From 1972 - 2009, over 6,000 new homes were built. More new houses would be completed in the near future to meet the vision 2035.

3.6 Malaysia

Since independence, Malaysia housing policy is geared towards the provision of adequate and decent housing especially for the lower income categories, to access adequate, decent and affordable housing. The policy emphasises that there must be constant adequate supply of houses affordable to Malaysians especially to the poorer households. Government intervention in housing can be seen in the Five Year Malaysian Plan setting out target of housing planned since the First Malaysia Plan (MP) in 1966 until the Eleventh Malaysia Plan (2011 - 2015). Policies relating to housing development are outlined in the five-year Malaysia Plans and the longer-term Outline Perspective Plans. The key players involved in the housing industry include the Government, state governments and private organisations, i.e. housing developers. The Government is represented by various ministries and agencies such as the Ministry of Urban Wellbeing, Housing and Local Government (MHLG) while at the state level, some of the more prominent state economic development corporations are also involved in housing programmes, such as the Penang Development Corporation, the Selangor State Development Corporation were directly responsible in providing housing for the poor in urban areas through establishment of the State Economic Development Corporations and various urban developments.

During the Tenth Plan, the Government implemented various housing programmes to provide sufficient and affordable housing for the poor as well as for the low- and middle income households. The *Program Bantuan Rumah*

(PBR) was implemented to provide comfortable homes in the rural areas, while The *Program Perumahan Rakyat (PPR)* was implemented to address the increasing demand for affordable housing among the low- income household, particularly in urban areas. Government has subsidised between USD 3, 344 and USD 4, 459 for the low income households to build houses priced between USD 10, 033 to USD 14, 493 per unit on land owned by the recipients under *Rumah Mesra Rakyat 1Malaysia* (RMR1M*)* programme.

As the government's commitment to provide housing for low income group through allocations for public housing, the Malaysian government has also introduced several housing programmes for low and middle income households such as *The Perumahan Rakyat 1Malaysia* (PR1MA*)* which provide affordable homes to middle-income household in urban areas with monthly household income between USD 557 – USD 2,229. 1Malaysia Civil Servants Housing (PPA1M) to assist civil servants to own a house, particularly in major cities, *Rumah Wilayah Persekutuan* (RUMAWIP) to provide housing to the residents of Federal Territories and *Skim Perumahan Mampu Milik Swasta* (MyHome) with a subsidy of USD 6,689 per unit to enable the first time buyer with households income of USD 669 to own a house.

4.0 Introduction

Full productive and decent employment is the most important source of income security. A well-designed income security that is linked to other policies would enhance productivity, employability and support economic development. As an effective automatic stabilizer in time of crisis, income security and social security as a whole contributes to mitigate the economic and social impact of economic downturns and environmental risks, to enhancing resilience and achieving faster recovery towards inclusive growth.

The Income Security Recommendation, 1944 (No. 67), of ILO states that, income security schemes should relieve wants and prevent destitution by restoring, up to a reasonable level, income that is lost due to the incapability to work (including old age) or to obtain remunerative work, or due to the death of the breadwinner. Income security should be organized as far as possible on the basis of mandatory social insurance, and allocation for those not covered by mandatory social insurance is to be made by social assistance.

It is agreed by most analysts that the system which provides the greatest long-term income security is one that is multi-tiered, characterized by diversification of financing and benefit mechanisms. Generally there is consensus about a minimum guarantee for the poor (the first tier) and voluntary retirement saving (the third tier). It is generally also agreed that a better contribution-benefit linkage and proper incentives for contributions and transparency are wanted in the intermediate, mandatory insurance scheme (the second tier). The debate usually concerns the institutional setting of the second tier: the method of financing (pay as you go or funded) and the type of management (public or private). The interlinkages between these tiers are strong. For instance, if a country’s bottom tier is well-developed and sustained, the size of the mandatory, contributory tier may be relatively smaller, and more emphasis can be directed to voluntary arrangements.

4.1 Singapore

4.1.1 Singapore Central Provident Fund

Comparing with regional countries, Singapore provides mainly National Provident Fund and Employer liability measure, while other South East Asia countries practice social insurance scheme. Since the British colonial government, Singapore has instituted a social security retirement system named as The Central Provident Fund (CPF) under the Ministry of Manpower. Unlike other welfare states, Singaporeans need to finance their social security and social protection by themselves. This system is based on contribution rather than benefits for welfare assistance from the state. The scheme is designed for contributions from both employees and employers, meant only to serve as retirement pensions and therefore forbidding withdrawals before retirement. However, since the late 1960s, government allows the usage of CPF savings for purchase of public housing under the Public Housing Scheme (PHS).

In 2011, 173,450 members of Singapore PHS withdrew USD 1.68 billion to buy flats and obtained bank loans for housing. Under private properties Scheme, Singaporeans can purchase private properties, condominiums and housing loan instalment. There are three types of saving accounts in CPF. Almost 30% of CPF is in the form of ordinary account for retirement, education, long term investment and buying houses. 6% of savings known as Medisave account goes for medical insurance and 4%, the third account for old age contingencies (Asher, 1995). In 2016, 37% of total output of Singaporean is saved into social security funds made up of 20% contribution from employees and 17% from employers. Singapore savings rate to GDP ratio is nearly 50% of national income. Up to 36% of the incomes of labours are invested in the Central Provident Fund (CPF) as savings and pursuing housing ownership for the purpose of social security. When a member of CPF reaches 55, the account holder is allowed to withdraw all the money except a certain amount deposit to be left in account. CPF will pay a fixed monthly wage to a member from the age of 60. Unlike other private or public pension systems, CPF scheme accommodates employees to transfer jobs. If there is an emergency need by a family member, subject to a limit, account owners can share cost for social protection (Asher, 1995; Trading Economic, 2014). Government guarantees all individual saving accounts a minimum interest rate of 2.5% and additional 1.5% for long term ordinary and special savings account (Lee and Vasoo, 2008).

4.1.2 Public Assistance Scheme

Public assistance is administered by the Community Development Council (CDC), which is responsible for the constituency in which the applicants reside. The programme offers financial aid on a long term basis. A person is entitled to this assistance as long as he/ she proves to be unable to work (because of old age, illness and disability) and therefore unable to generate any income. Furthermore, he/she does not receive any other subsistence scheme and obtain hardly any support from his or her family member. Assistance comes in three forms: monthly cash grants to provide for basic necessities, medical assistance which offers free treatment in public clinics and hospitals, and education assistance which eases the financial burden of children's schooling expenses. Cash relief is distributed on a per household basis with rates varying from USD 140 to a maximum of USD 398 per month per household.

4.1.3 Interim Financial Assistance

Interim (short term) financial assistance is under the governance of the Community Development Council (CDC). The eligibility criteria of the scheme may vary according to the individual CDC. It provides temporary assistance in terms of cash grants or food vouchers. Being an interim assistance, it only lasts for 3 months. Recipients can reapply to be reviewed for renewal; however, they may only obtain this assistance for a maximum period of a year. The cash grant to individuals or households for each month range from USD 98 to USD 419.

4.1.4 Rent and Utilities Assistance Scheme

This program is administered by the National Council of Social Service. It is meant for poor families who are still indebted in areas of rent, utility expenses or conservancy charges. The eligibility criteria includes family members suffering from old age, illness or disability, family's breadwinner being detained or imprisoned and some other adverse situations that are justifiable for assistance. The monthly amount a household can obtain ranges from USD 168 to a maximum of USD 496.

4.1.5 Work-Support Programme

The Work support programme provides aid to people who are jobless in the short term. This programme, lasting from 6 to 12 months, is means tested. It is for low household income worker (less than USD 1, 047 per month) without any other support. In addition, the unemployed should show his/ her determination to become financially independent. The work-support programme also offers grants for selected training courses so that individuals may have a better chance to secure a job.

4.1.6 ComCare – An Integrated Care System

MCYS also administers an integrated programme under the ComCare Fund, which was launched in 2005 as an endowment fund from the government budget. As in other endowment fund scheme, the government will top up the fund when there is a budget surplus. The three programmes under ComCare targeted at the unemployed, the children in need, the elderly and the disabled. *ComCare Self-Reliance* provides a safety net for the needy and serves as a springboard for them to become self-reliant and to "bounce back". The *ComCare Grow* is targeted at children from needy families to help them break out of the poverty cycle. The *ComCare EnAble* assists those who need long term assistance (such as the needy elderly and people with disabilities) to integrate into the community.

4.2 Philippines

4.2.1 Philippines Social Security System

The passage of Republic Act No. 76412 has provided for mandated payment of retirement benefits. All private sector employees regardless of their position, designation or status and irrespective of the method by which their wages are paid are entitled to retirement benefits upon compulsory retirement at the age of 65 or upon optional retirement at 60 or more but before 65. The minimum retirement pay to covered employees shall be equivalent to one-half month salary for every year of service, a fraction of at least 6 months being considered as one whole year. The benefits accorded under this law are other than those granted by the Social Security System.

Any employee may retire or be retired by his employer upon reaching the retirement age established in the CBA or other tax-qualified applicable agreement contract and shall receive the retirement benefits granted therein: provided, however, that such retirement benefits shall not be less than the retirement pay required by RA 7641 and provided further that if such retirement benefits under the agreement are less, the employer shall pay the difference.

Voluntary personal pension funds are offered by pre-need and life insurance companies. Pre-need companies are plan issuers authorized under Republic Act No. 87993 to sell or offer for sale to the public any pre-need plan in accordance with rules and regulations which the Securities and Exchange Commission has prescribed. Pre-need plans pertain to contracts which provide for the performance of future services or the payment of future monetary considerations at the time of actual need, for which plan holders pay in cash or instalment at stated prices, with or without interest or insurance coverage and includes pension plans. Other dominant plan types are life, education and internment plans.

On the other hand, the Philippine Insurance Code allows insurance companies to offer endowment and annuity contracts which are classified as life insurance contracts for purposes of said law. Old age and regular endowments are availed by those who want guaranteed retirement income without however, entirely losing the protection element of the plans.

4.2.2 Labour Market Programmes

The labour market programmes including several measures to improve employment opportunities by establishing more jobs and ways to improve the skills of the people. These programmes aimed to protect the rights and welfare of workers as well, specifically in terms of compensation, benefits, and health and safety.
In the Philippines, there are some programmes for the labour market such as:

- Skills trainings through TESDA (Technical Education and Skills Development Authority)
- Special Programme for Employment of Students
- Save Child Worker (*Sagip Batang Manggagawa*)
- DOLE Integrated Livelihood Programme

- Private education student financial assistance
- Reintegration programme

4.2.3 Social Insurance

Under social insurance, the main concern is to mitigate risks by pooling of resources to "spread risk across time and classes," (SDC Resolution No. 1, 2007). Commonly, the beneficiaries pay a premium over a given period of time to cover or protect them from loss of income and unemployment as a result of illness, injury, disability, retrenchment, harvest failure, maternity, old age, etc. This component includes micro- and area-based schemes to address vulnerability at the community level (such as micro-insurance and social support funds).

In the Philippines, social insurance can be found in the following programmes:

- Philippine Health Insurance Corporation (PhilHealth)
- Philippine Crop insurance Corporation
- Government Service Insurance System

4.2.4 Social Welfare

Social welfare and assistance programmes usually comprise direct assistance in the form of cash or in-kind transfers to the poorest and marginalized groups, as well as social services including family and community support, alternative care and referral services.
The following are the social welfare programmes in the Philippines

- *Pantawid Pamilyang Pilipino Programme* (4Ps)
- Education assistance programme
- National Housing Authority (NHA) Resettlement programme
- Philippine Charity Sweepstakes Office (PCSO) Individual medical assistance programme

4.2.5 Social Safety Nets

These measures aim to address the impacts of economic shocks, disasters and calamities on specific vulnerable groups. The purpose of social safety nets is to provide relief to the vulnerable groups, such as subsidies, emergency assistance, emergency loans, and employment programmes.

- Price subsidy programmes
- Emergency employment
- Disaster management programme

4.3 Thailand

4.3.1 Thai Provident Fund

For those in the private sector, old aged benefits are available for those who has contributed 3% of their wages to the Social Security Fund (SSF) and in addition the employers also contributed 3% of the insured wages into the fund (Pongsapich, Leechanawanichphan and Bunjongjit, 2002). The latest policy enacted by the government is the National Savings Fund (NSF), formed to promote savings for retirement specifically targeted for the self-employed and do not fall in the civil servant and private employee categories. The contribution can be as minimum as USD 1 and the government contributes between 50% to 100% of individual savings to individual account according to the individual's age (Chandoevwit, 2013).

The Social Security Fund (SSF) was established under the Social Security Act B.E. 2533 to bring about security and stability of livelihood for Thai citizens.

The Social Security Office, established by virtue of the Act, has duty to manage the SSF for the best interest of all members. The coverage is divided into seven types: sickness, maternity, disability, death, child allowance, old age and unemployment.

Table 3: Contribution Rate in Thailand

Conditions	Government	Employers	Employees
Sickness	Every party made a contribution of 1.5% of wage		
Maternity			
Disability			
Death			
Child allowance	1% of wage	3% of wage	3% of wage
Old-age			
Unemployment	0.25% of wage	0.5% of wage	0.5% of wage

Categorized under the Defined Benefit System, the SSF regulates member benefits at the very outset regardless of the amount of contributions or returns on investment of any parties. Every employer with at least one employee and all workers except those exempted by the Act such as civil servants, state enterprise employees and private school teachers are required to make equal contributions while the government subsidizes additional levy to the fund.

Whenever wages are paid, employers must submit the contributed sums to the Social Security Office within the 15th day of the month following the month when the contribution is deducted.

4.3.2 Social Assistance for the Elderly

Social assistance for the elderly includes cash benefits and benefits in-kind (food, clothes, groceries or accommodation). The social assistance is available only for those 60 years of age and above and at present, the cash benefits is between USD 17 to USD 28 according to their age category. The benefit in-kind is a low budget fund allocated mainly to Thai elderly who are really poor, homeless or abandoned by family.

A long term care system for the elderly is critical as the country's percentage of elderly surpasses the percentage of children. As life expectancy increases, the long term care for the elderly will also escalate. With the decreasing number of spending needed for education due to declining number of children, the portion used for education expenditure can be used for expanding the long term care facilities for old age (Chandoevwit, 2013).

4.4 Indonesia

4.4.1 Indonesia National Social Security System

In terms of the development of the social security programmes, in 2004, Indonesian government introduced a new law on the National Social Security System. Through the new law, a number of social security schemes will be created for citizens. The schemes include old-age pension, old-age savings, national health insurance as well as death benefits for survivors of deceased workers.

All these schemes would be financed by imposing a payroll tax on worker's wages which will be collected equally from employers and workers. The implementation of the new law has resulted in the expansion of social security programmes coverage to cover all Indonesian citizens including those working in the informal sector. Arifianto (2006) pointed out a number of serious flaws of the newly imposed law. He suggested that the goals of the law are too ambitious. This is due to the fact that 70% of Indonesian citizens are working in the informal sector, where workers' employment and payroll records are not kept and therefore it would be difficult to collect contributions and pay out benefits.

4.4.2 Social Welfare Programme

Social Welfare Programme or *Bantuan Kesejahteraan Sosial Permanen* is the oldest among other social assistance programmes in Indonesia, which provides income support to neglected elderly, neglected children and poor disabled persons. A temporary scheme is targeted at the victim of natural disasters/social disasters and troubled migrant workers. The scheme is implemented by the Ministry of Social Affairs and Local Governments.

4.4.3 Cash Transfer

Cash transfer or *Bantuan Langsung Tunai* has been introduced in 2005. The unconditional cash transfer (*bantuan langsung tunai tidak bersyarat*) was implemented from October 2005 to December 2006 providing 19.2 million poor with income support. The unconditional cash transfer has been replaced by conditional cash transfer (*bantuan langsung tunai bersyarat*) since January 2007. In contrast to unconditional cash transfer, the conditional cash

transfer provides income support to very poor family conditionally upon investment in human capital – school attendance, healthcare, nutrition). The target groups of conditional cash transfer programme are very poor households with children between 0 and 15 years and/or a pregnant mother at the time of registration. Each family will receive funds for up to six years. During three years of implementation, in 2010 the conditional cash transfer namely *Program Keluarga Harapan*, was implemented in 20 provinces, 86 districts and 739 sub districts for 816,000 very poor households. The programme is targeted to reach 2.4 million poor households in 2014.

4.4.4 Maternity Benefit for Uninsured Persons

Maternity benefit for the uninsured persons *(Jaminan Persalinan)* has been implemented since 2011 for pregnant women who are not covered by any maternity scheme.

4.4.5 School Aid Programmes

These programmes provide operational aid to primary and secondary schools (*Bantuan Operasional Sekolah, BOS*) and scholarships for senior secondary school students (*Bantuan Khusus Murid, BKM*). The programmes have been implemented since 2005.

4.4.6 Social Welfare Insurance Programme

The Social Welfare Insurance Programme (*Asuransi Kesejahteran Sosial, ASKESOS*) has been implemented since 2003 by the Ministry of Social Affairs for the poor and near poor working in informal sector of the economy. The programme covers limited healthcare benefits and death benefits for maximum 3 years of membership.

4.5 Brunei

4.5.1 Brunei Retirement Income

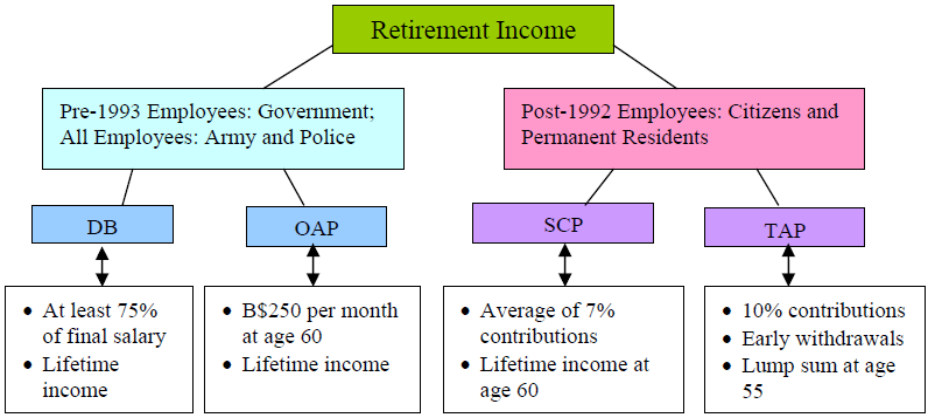
The local labour force is now provided with a mix of provident fund and employer liability legislation. Since 1993, the provident fund has been regulated by the Tabung Amanah Pekerja Act and Chapter 167 on employee trust funds and is under the responsibility of the Ministry of Finance. Both employers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

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

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

The SCP scheme requires an additional contribution of 3.5% from the employee. Employers are obliged to match this sum. The SCP scheme contribution should amount to 7%. If the employee's contribution is below USD 12, the government will make up the difference. In the case of a self-employed person, he or she contributes 3.5% while the government will shoulder the additional 3.5%.

Figure 5: Brunei Darussalam: Retirement Income for Economically Active Population



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

Source: Hajah Sainah binti Haji Saim (2010).

4.5.2 Brunei Islamic Council

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

4.5.3 Sultan Haji Hassanal Bolkiah Foundation

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

4.5.4 Other Schemes

Other arrangements are made by the private individual and the private sector. Private insurance companies provide protection over and above the protection by the state. Commercial banks in the country also provide

insurance coverage for their customers. In addition, the local private sector has also established corporate social responsibility sections or foundations. These institutions have been active in cleaning campaigns, tree planting campaigns, and other environmental issues.

4.6 Malaysia

4.6.1 Malaysia Employees Provident Fund

The Employees Provident Fund (EPF) is a compulsory savings scheme covering the private sector employees, the self-employed and certain employees in the public sector. All employees in the private sector who are employed under a contract of service must compulsorily contribute a certain percentage of their monthly wage according to wage categories to the Employees Provident Fund.

The public sector employees who have not been confirmed and do not qualify for the pension scheme are also required to contribute to the Employees Provident Fund. The self-employed person can contribute any sum in excess of a minimal amount. For contribution rates under the EPF system, the rates for an insured person are 11% of monthly earnings for members up to age 54, and 5.5% of monthly earnings for members aged 55 to 75.

Similarly, the employer is required to contribute 12% of monthly earnings for members up to age 54, and 6% of monthly earnings for members aged 55 to 75. The EPF savings is structured into two types of accounts namely, Account 1 and Account 2. Each account is designed to serve the different needs of contributors. Account 1 comprises 70% of member's savings for retirement in line with the primary objective of the scheme which is to ensure that members have sufficient cash savings for retirement. The savings from this account can only be withdrawn when members reach the age of 55. The balance under Account 2 can be utilised as pre-retirement withdrawals aimed at enhancing members' well-being.

4.6.2 Financial and Welfare Assistance

The financial and welfare assistance are meant for both productive and non-productive groups in society. The former include children, dependents of the sick, prisoners and detainees, poor families, single parent families and their dependents, ex-residents of welfare institutions, while the latter cover the sick, the elderly and the severely disabled. The major intention of the

coverage for the former group is to provide assistance until they become productive and independent while for the latter it is to help them to secure their basic needs for survival. Government has allocated different assistance to both the target group where for the Non-Productive group elderly, they are provided with the elderly activity centre, the elderly care unit, and financial assistance of USD 67 for those aged above 60 years old. A monthly allowance of USD 67 is also given to the carers if the aged is bed ridden, disabled or chronically ill.

4.6.3 Home-help Services

Home-help services was introduced as an alternative approach to assist the elderly poor and the disabled who live alone or those who live with family but in need of assistance. It is essentially a community support endeavour with the cooperation of volunteers who undertake to become caregivers to the elderly.

4.6.4 Zakat

As for the Muslims, there is another form of assistance that is based on Zakat or tithing through Islamic institutions such as the State Islamic religious councils (*Majlis Agama*) or Baitulmal. Principally, Zakat reaches out to needy people but faces limitations in scope and size since it is applicable to Muslims only.

On the other hand, social insurance (SI) is also a form of social protection (Devereux and Sabates-Wheeler, 2004). The components of social insurance consist of Public sector pension, *Lembaga Tabung Amanah Tentera* (LTAT), Social Security Organization (SOCSO), Workmen's Compensation Scheme, Sickness and Maternity Benefit, Healthcare, Private Retirement Scheme, Saving Scheme. However, out of nine SI listed below, only Social Security Organization (SOCSO) schemes are based on the principles of social insurance whereby contribution is compulsory for the covered groups – the scheme operates on social pooling of risks and benefits and a fund is created with no individual accounts.

Chapter 5 - Challenges and Conclusion

The 1997/98 financial crisis while a debacle of enormous proportion was also an eye opener in terms of awareness on the need for an effective and sustainable social protection measures and programmes for the elderly and the vulnerable. Social protection systems in existence then, were inadequate and did not cover a large part of the population of member countries and especially of those in the informal sector. The idea of providing basic education, health care and other basic social needs were of course considered by most countries in their national development plans way before the crisis but were proven ineffective in insulating the populace from unemployment, indebtedness and possible spiral into poverty and destitution.

Post crisis, saw leaders of member countries in consensus about the importance of social protection system as a means of assisting people to escape the clutches of the poverty and/or the demographic traps. Social protection measures properly designed and implemented would raise people's ability to deal and protect themselves against exposures to various risks such as instability of income, price volatility of consumer goods and natural calamities, since the ASEAN region is deemed to be the most prone to natural disasters. Efforts on improving social protection measures should also prove to be a worthwhile venture as the consequence from such endeavours would see more stable economic developments in member countries.

The current state of affairs in ASEAN, a region noted not only for its ethnic and cultural diversity but also for stage of developments the member countries are in, differs considerably. Therefore, while the social protection floor is common, the designs and approaches taken reflect the diversity, cultural preferences and needs as well as the wills, resources and capabilities of the governments of the day. Recently, we have also seen the up scaling of measures and policies adopted, a broader focus on basic needs and capabilities, a shift for multiple approaches such as promoting social and economic services for an overall socio-economic growth and development and a general desire to realize a more durable and adaptable social protection system to withstand and safeguard against the volatility of market forces and calamitous natural disasters.

The overdependence on the traditional social protection systems whilst pursuing a liberal market economy has proven to be fragile especially with the rapid erosion of family and community networks. It was also evident that the ineffective response to the crisis is due to the residual role played by the governments.

Moving forward, ASEAN countries have to ensure that the 'table' agreements do not remain a rhetorical commitment but should serve as a foundation for a solid implementation of an effective and workable social protection system in respective countries that is inclusive and scalable in reach to encompass all relevant groups. The social protection strategies undertaken should, subject to availability of resources and capacities of each member country, be in line with strategies advocated by the ILO and also be flexible enough to allow for mitigating steps to be made to suit changing environment and market demands. Innovative ways of creating good jobs, reducing financial constraints in the near and the long term and stimulation of trade and revenue are agents of growth and should be pursued relentlessly and continuously.

References

Ananta, A. & Siregar, R. (1999). Social Safety Net Policies in Indonesia: Objectives and Shortcomings. *ASEAN Economic Bulletin, 16*(3), 344-359.

Arifianto, A. (2006). The New Indonesian Social Security Law: A Blessing or Curse for Indonesians? *ASEAN Economic Bulletin, 23*(1), 57-74.

Asher M. G. & Rajan R. (2008). Social Protection in Singapore, in Lee H. G. ed. (2008). *Ageing In Southeast and East Asia: Family, Social Protection and Policy Challenges*, Singapore, ISEAS.

Asher, M. G. (1995). Compulsory savings in Singapore: An alternative to the welfare state', Dallas, TX: National Center for Policy Analysis, 1-5.

Asher, M., & Bali, A. S. (2010). Impact of Aging on Social Security and Pension Systems in Asia. Wilhelm Hofmeister et al., *Aging and Politics, Consequences for Asia and Europe*. Panorama Insights into Asian and European Affairs, Konrad-Adenauer-Stiftung, 47-72.

Asher, M., & Zen, F. (2015). Social Protection in ASEAN: Challenges and Initiatives for Post-2015 Vision. www.eria.org/ERIA-DP-2015-06.pdf

Baulch, B., Weber, A., & Wood, J. (2008). Social Protection Index for Committed Poverty Reduction: Volume 2: Asia.

Beng, C. S. (2012). Employment-based Social Protection in Singapore: Issues and Prospects, *ASEAN Economic Bulletin, 29*, 218-229.

Central Provident Fund (2014). Workfare Income Supplement (WIS) Scheme', Available from http://mycpf.cpf.gov.sg/Members/Gen-Info/WIS/WIS_Scheme.htm

Central Provident Fund Board 2013, Annual Report, Home Ownership, Available from, http://mycpf.cpf.gov.sg/NR/rdonlyres/6D9F644D-57D8-4CFC-ABA7- 0ACC8E566B1D/0/Home_Ownership.pdf

Chan, S., & Ear, S. (2004). Towards understanding social protection in Cambodia. *Cambodia Development Review, 8*(4), 9-13.

Chandoevwit, W. (2013). Social and Economic Aspects of the Elderly in Thailand. *Malaysian Journal of Economic Studies, 50*(2), 193-206.

Chia N. C. & Tsui, A. K. C. (2005a). Medical Savings Accounts in Singapore: How much is adequate? *Journal of Health Economics, 24*(5): 855-875.

Chia N. C. & Tsui, A. K. C. (2009). Monetizing Housing Equity to Generate Retirement Incomes. SCAPE Working Paper No. 2009/01, NUS Economics: Singapore Center for Applied Policy and Economics.

Choon, C. N. (2010), Social Protection in Singapore: Targeted Welfare and Asset-based Social Security, in Asher, M. G., S. Oum and F. Parulian (eds.), Social Protection in East Asia – Current State and Challenges. ERIA Research Project Report 2009-9, Jakarta: ERIA., 90-123.

Cook, S., & Kwon, H. J. (2007). Social Protection in East Asia. *Global Social Policy, 7*(2), 223-229.

Daly, A. & Fane, G. (2002). Anti-Poverty Programs in Indonesia. *Bulletin of Indonesian economics Studies, 38*(3), 309-329.

Dewan, S., (2014), 'Rent Too High? Move to Singapore', The New York Times, 29, April, 2014 Available from http://www.nytimes.com/2014/05/04/magazine/rent-too-damn-high-move-to-singapore.html?_r=1

Dong, W, 2006, 'Can health care financing policy be emulated? The Singaporean medical savings accounts model and its Shanghai replica', *Journal of Public Health 28*(3), 209-214

Ernst & Young Global Limited. (2014). Singapore Budget 2014, Personal income tax rate and rebate. Available from http://www.ey.com/SG/en/Services/Tax/EY-singapore-budget-2014-synopsis-personal-income- tax-rate-and-rebate

Esmara, H. Tjiptoherinto, P. & Islam. I. (1986). The Social Security System in Indonesia*. ASEAN Economic Bulletin, 3*(1), 53-69.

Fukuda-Parr, S. (2006) Millennium Development Goal 8: indicators for international human rights obligations? *Human Rights Quarterly 28*, 966–997.

Gamboa, R. M., Bautista, M. C. G., & Beringuela, M. L. I. (1993). Health insurance in the Philippines. Health Finance Development Project HFDP Monograph no. 6, Department of Health, Manila.

Garcia, A. B., & Gruat, J. (2003). Social Protection: A Life Cycle Continuum Investment for Social Justice. Poverty Reduction and Sustainable Development, Paper for the ILO.

Giang, T. L. (2013). Social Protection for Older People in Vietnam: Role, Challenges and Reform Options. *Malaysian Journal of Economic Studies, 50*(2), 207-219.

Haji Saim, H. S. (2010). Social Protection in Brunei Darusslam – Current State and Challenges, in Asher, M. G., S. Oum and F. Parulian (eds.), Social Protection in East Asia – Current State and Challenges. *ERIA Research Project Report 2009-9.*

Hindle, D., Acuin, L., & Valera, M. (2001). Health insurance in the Philippines: Bold policies and socio-economic realities. *Australian Health Review, 24*(2), 96-111.

Holzmann, R., & Jørgensen, S. (2001). Social Risk Management: A new conceptual framework for Social Protection, and beyond. *International Tax and Public Finance, 8*(4), 529-556.

ILO. (2004). A fair globalization: Creating opportunities for all: World Commission on the Social Dimension of Globalization.

ILO. (2014). World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice. Geneva.

ILO. (2015). The State of Social Protection in ASEAN at the Dawn of Integration. Bangkok.

Jones D. S. (2002). Welfare and Public Management in Singapore: A Study of State and Voluntary Sector Partnership. *Asian Journal of Public Administration, 24*(1), 57-85.

Lee, J. & Vasoo, S. (2008). Singapore: Social Investment, the State and Social Security, in J Midgley & K L Tang, eds. Social Security, the Economy and Development. Palgrave Macmillan, New York, 269-284.

Lee, M. (1996). The Evolution of Housing Finance in Indonesia: Innovative Responses to Opportunities'. *Habitat International, 20*(4): 583-594.

Loong, L. H. (2012). Singaporeans will always be top priority: PM", Straits Times, 2 May 2012, Available from http://www.straitstimes.com/premium/forum-letters/story/vwos-should-hire-beneficiaries-if-they-fit-the-bill-20130502

Mansor, N., Salleh, S., Nabilah, S., Tan, L. Y., Koutronas, E., & Aikanathan, S. (2014). *Social Security in Malaysia: Stock-Take on Players, Available Products and Databases.* SSRC Working Paper Series 2014-2, Kuala Lumpur: Social Security Research Centre.

Meessen, B., Pei, X., Criel, B., & Bloom, G. (2008). Health and social protection: experiences from Cambodia, China and Lao: ITGPress.

Mendes, P. (2009). An Australian Perspective on Singaporean Welfare Policy, *Social Work and Policy 7*(1), 33-45.

Mohandas, V. & Loh, D., 'Budget 2014: Employer CPF contribution rates to be raised', Channel News Asia, 2014 Available from http://www.channelnewsasia.com/news/singapore/budget- 2014-employer-cpf/1007674.html

Nishino, Y., & Koehler, G. (2011). Social protection in Myanmar: Making the case for holistic policy reform. IDS Working Papers, 2011(386), 1-27.

Phang, S. Y. (2007). The Singapore Model of Housing and the Welfare State. *Housing and the New Welfare State: Perspectives from East Asia and Europe*. 15-44. Research Collection School of Economics.

Pradhan, M., Saadah, F., & Sparrow, R. (2007). Did the health card program ensure access to medical care for the poor during Indonesia's economic crisis?. *The World Bank Economic Review, 21*(1), 125-150.

Sastrosasmita, S., & Amin, A. N. (1990). Housing needs of informal sector workers: The case of Yogyakarta, Indonesia. *Habitat International, 14*(4), 75-88.

Shepherd, A., Marcus, R., & Barrientos, A. (2004). Policy paper on social protection: DFID.

Shuid, S. (2004, February). Low medium cost housing in Malaysia: Issues and challenges. In *Asia Pacific Network for Housing Research Conference* (APNHR). Hong Kong.

Silver, C. (2008). Planning the Megacity: Jakarta in the Twentieth Century. New York: Routledge.

Sim, D., & Hamid, T. A. (2010). Social Protection in Malaysia-Current State and Challenges towards Practical and Sustainable Social Protection in East Asia: A Compassionate Community. *Social Protection in East Asia-Current State And Challenges*, 182.

Soriano, E. S., Dror, D. S., Ampalay, E., & Bayugo, Y. (2002). Attitudes towards solidarity, risk and insurance in the rural Philippines. In A. S. Preker, & D. M. Dror (Eds.), Social reinsurance: A new approach to sustainable community health financing (pp. 377–394). Washington: World Bank/ILO.

Sparrow, R., Suryadi, A. & Widyanti,W. (2013). Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Programme. *Social Science & Medicine, 96*, 264-271.

Suci, E. (2006). Child access to health services during the economic crisis: An Indonesian experience of the safety net programme. *Social Science & Medicine 63*, 2912-2925.

Suharto, E. (2009). Social protection systems in ASEAN: Social policy in a comparative analysis. Social Development Issues, 31(1), 1-26.

Suharto, E., Thamrin, J., Cuddy, M., & Moran, E. (2006). Strengthening social protection systems in ASEAN. Ireland: Galway Development Services International.

Suryadi, A., Suharso, Y. & Sumarto, S. (2001). Coverage and Targeting in the Indonesian Social Safety Net Programmes*. ASEAN Economic Bulletin, 18*(2), 161-175.

Tan, T. H. (2011). Sustainability and housing provision in Malaysia. *Journal of Strategic Innovation and Sustainability*, *7*(1), 62.

Trading Economy (2014). Singapore Social Security Rate, Available from http://www.tradingeconomics.com/singapore/social-security-rate

Tunas, D. & Peresthu, A. (2010). The self-help housing in Indonesia: The only option for the poor? *Habitat International, 34*(3): 315-22.

World Bank. (2011). Data and Statistics: Country Groups. http://go.worldbank.org/47F97HK2P0

Zin, R. H. M., Lee, H. A., & Abdul-Rahman, S. (2002). Social Protection in Malaysia. In Erfried A., Michael V. H. & Marei J. (Eds.), *Social Protection in Southeast and East Asia*, 119-170.

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