Box 2.3:

Old-Age Social Protection in ASEAN+3 Economies

Old-age social protection systems across ASEAN+3 economies are very diverse and characterized by distinct stages of maturity and institutional arrangements. While the definition of "social protection" varies across economies, the term usually refers to three pillars that a society provides to protect its population against economic and social distress: (1) social assistance, (2) social insurance, and (3) labour market programs (OECD 2018). Social protection aims to promote aging with dignity by providing income security and access to essential social services for seniors, including to essential health services and long-term care. In ASEAN+3, legal frameworks across these three areas—old-age pension, universal health coverage (UHC), and long-term care (LTC) insurance—exist in varying degrees, with Japan, Korea, and Singapore having the most comprehensive scope of legal coverage (Table 2.3.1).

The structure and design of ASEAN+3 pension systems vary across economies, requiring care when undertaking a regional comparison (Figure 2.3.1).

Except for Lao PDR, all economies in the region offer some form of pension floor (Tier 0), which guarantees minimum income security for seniors.[1] The schemes can be categorized into (1) universal, (2) means-tested, and (3) pension-tested to determine recipient eligibility.[2] In terms of pension floor financing, Japan and China rely on a mixed financing arrangement (financed by member contributions and tax) while the rest rely on a tax-financed non-contributory scheme.

Tier 1 schemes, which aim to provide income replacement in old age, are either provident savings fund or pension funds with defined contribution or defined benefit schemes. At present, Myanmar is the only ASEAN+3 economy that has yet to introduce a national pension scheme for formal private sector workers, although legal provisions are in place. In terms of financing, China, Japan, and Korea—which have larger elderly populations—resort to a mix of fiscal subsidy and member contributions to finance Tier 1 schemes while member contributions finance the rest.

Table 2.3.1. ASEAN+3: Social Protection Systems for Seniors

	Existence of Legal Framework		
	Old-age pension	Universal health coverage	Long-term care insurance
Brunei	✓	✓	None
Cambodia	✓	✓	None
China	✓	o	◊
Hong Kong	✓	o	None
Indonesia	✓	o	None
Japan	✓	✓	✓
Korea	✓	✓	✓
Lao PDR	✓	o	None
Malaysia	✓	o	None
Myanmar	●	o	None
Philippines	✓	✓	None
Singapore	✓	✓	✓
Thailand	✓	✓	None
Vietnam	✓	o	None

✓ Program is anchored in national legislation
o Backed by a national plan instead of legislation
● Program is yet to be fully implemented
◊ Program is under pilot trial

Source: World Health Organization; International Labour Organization; AMRO staff compilation based on officially published national documents.
Note: For universal health coverage (UHC), this refers to whether economies have an explicit UHC law.

This box was written by Dek Joe Sum.

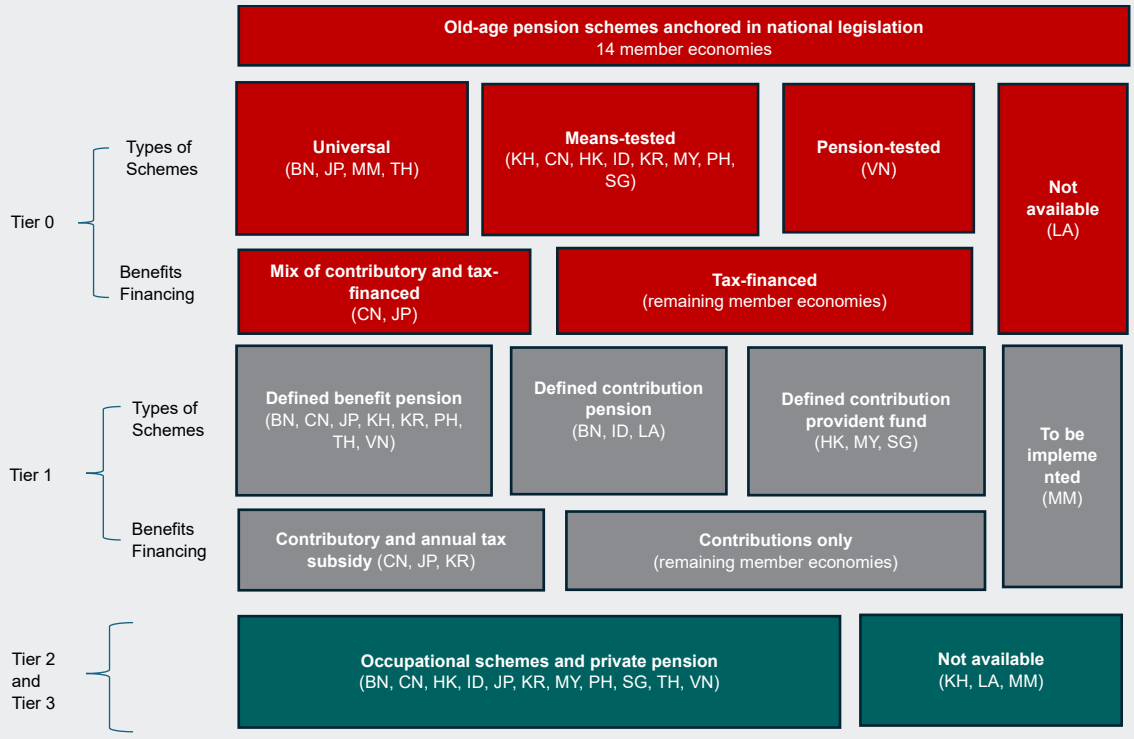
1/ This box considers the term "multi-tier" and "multi-pillar" to be broadly synonymous. The term "multi-tier" is used throughout rather than "multi-pillar" as the former better represents the overlapping nature of pension system components.

2/ Vietnam uses a pension-tested scheme, where seniors aged 80 years and above who do not have access to the Vietnamese Social Security (VSS) system are qualified for a defined benefit and a non-contributory pension floor. It is called as such because qualification depends on access to the VSS.

Tier 2 and 3 schemes, which are fully-funded occupational and private schemes, are available in every economy except Cambodia, Lao PDR, and Myanmar. In terms of effective old-age coverage, the ratio is broadly higher in economies that are projected to become aged and super-aged societies by 2030 (Figure 2.39 in this chapter). Brunei stands out, however, as it is likely to achieve 100 percent old-age coverage by 2030 despite having a much slower pace of aging than Japan, Korea, and China. Similarly, fiscal spending on pension and other old-age related benefits is higher in economies with a larger elderly population (Figure 2.38 in this chapter). A notable exception is Hong Kong. Its significantly lower level of spending compared to ASEAN+3 peers with a similar demographic pattern is because the pension system receives no government subsidies.[3]

Social protection for seniors also requires easy access to publicly provided, affordable social services, such as health care. In line with the objective of UHC, social protection systems are "expected to guarantee access to health care without hardship by satisfying the criteria of availability, accessibility, acceptability, and quality" (ILO 2022). However, given budgetary restrictions, governments often face a dilemma involving competing demands from expanding the population and service coverages and providing quality medical care. This underscores the importance of health financing policies. A balanced and well-designed system for financing health care can deliver quality health services, equitable utilization of resources, and financial protection for the vulnerable population, while achieving long-term financial sustainability. According to the World Health Organization (2021a), the success of health financing systems depends on the performance of three important functions: (1) revenue collection, (2) pooling and management of resources, and (3) purchasing of services and interventions. Hence, careful consideration needs to be given to budgeting frameworks of social protection and health insurance schemes to improve the sustainability and impact of health financing.

Figure 2.3.1. ASEAN+3: Multi-tier Pension Systems



Source: International Labour Organization; AMRO staff compilation based on officially published national documents.
Note: BN = Brunei; CN = China; HK = Hong Kong; ID = Indonesia; JP = Japan; KH = Cambodia; KR = Korea; LA = Lao PDR; MY = Malaysia; MM = Myanmar; PH = the Philippines; SG = Singapore; TH = Thailand; VN = Vietnam. This regional comparison excludes civil servant pension, including for military personnel, for brevity. Tier 2 refers to complementary schemes and Tier 3 refers to voluntary personal pension. Both are usually fully and privately funded, with limited exceptions, and as such are lumped together in this box.

3/ This is attributed to the fact that old-age pensions in Hong Kong, China are mainly financed through the Mandatory Provident Fund.

In ASEAN+3, most economies have developed some form of contribution-based scheme to finance their health systems, either through social health insurance or a mix of social and community-based health insurance (Table 2.3.2). A contribution-based financing scheme brings the benefits of risk-pooling, stable revenue flows, and access to a broader range of services and products. However, administrative complexity can also make it challenging to manage. For example, the World Bank (2020) found that the fragmented intergovernmental transfers in Indonesia's decentralized system have created a fundamental disconnect between the level and geographic distribution of public health financing and the benefits offered, leading to implicit rationing and inequities in the incidence of social health expenditure. Contribution-based financing schemes are also vulnerable to exclusion and resource gaps, especially in economies with large informal sectors. For example, in Cambodia, Lao PDR, and Myanmar, out-of-pocket (OOP) payments—a modality considered inefficient and inequitable—remain the dominant source for current health expenditure financing, despite the existence of other various contributory schemes (Figure 2.3.2).

Other economies—Brunei, Hong Kong, and Malaysia—use a tax-based national health system as their financing method. While this method provides universal legal coverage and risk-pooling for the entire population, it is prone to unstable funding due to competing priorities for public expenditure. Malaysia's one-size-fits-all fee structure and reliance on a single source of tax financing have contributed to prolonged underinvestment in health and a health budget that no longer matches the reality of its changing demographics (Malaysia Ministry of Health 2023). These outcomes underscore the challenge of achieving UHC across the ASEAN+3 region, and the need to undertake necessary policy reforms to provide adequate social health protection. Currently, the region's aged and super-aged societies generally enjoy a higher coverage in essential health services and tend to implement larger public health-related spending (Figures 2.3.3 and 2.3.4).

Increased longevity and decreased fertility rates in ASEAN+3 have raised concerns about who will provide care for the growing number of older people (who will have more long-term and complex care needs) and how to finance this long-term care. Japan and Korea are the early movers, having institutionalised LTC insurance schemes more than a decade ago, while China is undertaking a pilot trial for LTC insurance in 49 cities. In the ASEAN, Singapore is the only economy to have institutionalised LTC insurance through the CareShield Life and LTC Bill in 2019. The differing speeds in LTC institutionalization reflect demographic patterns across the region, as well as the speed of aging, and different levels of social protection development. While there has been no systematic data collection or estimates on how much informal care costs, the majority of LTC financing in ASEAN is from private financing—including through family care, unpaid family labor, and volunteer care—and OOP expenditure for health and social care services, or the employment of domestic workers to provide care (Wyse and Walker 2021).

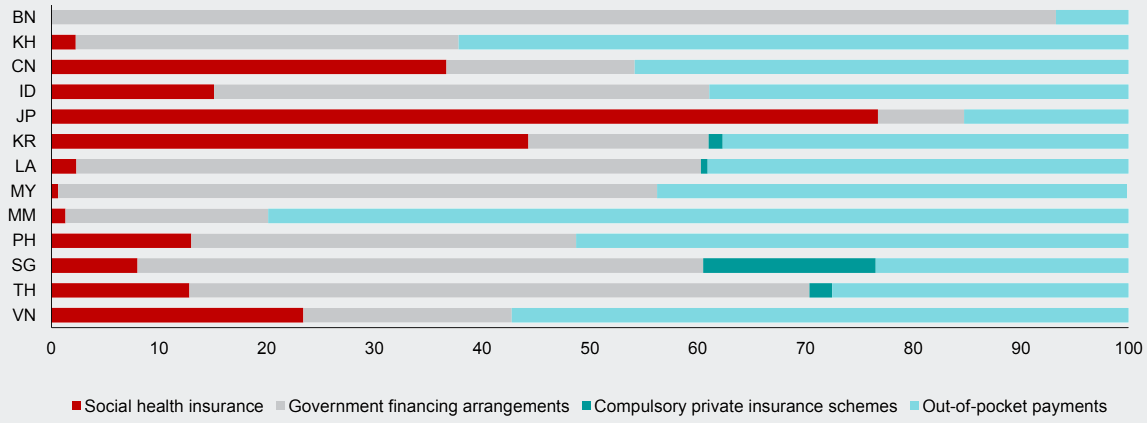
Moving forward, the spectrum of maturity and institutional features of old-age social protection systems in ASEAN+3 will remain highly diverse, especially as each economy is confronted with unique challenges arising from population aging.

Table 2.3.2. ASEAN+3: Health System Financing Mechanisms

	Health system	Long-term care
Brunei	Tax-based national health system	N/A
Cambodia	Limited social/community-based health insurance coverage and social assistance	N/A
China	Social health insurance	N/A
Hong Kong	Tax-based national health system	N/A
Indonesia	Social health insurance	N/A
Japan	Social health insurance	Social long-term care insurance
Korea	Social health insurance	Social long-term care insurance
Lao PDR	Limited social/community-based health insurance coverage and social assistance	N/A
Malaysia	Tax-based national health system	N/A
Myanmar	Limited social health insurance coverage and social assistance	N/A
Philippines	Social health insurance	N/A
Singapore	Tax-based public health system and social health insurance	Social long-term care insurance
Thailand	Tax-based national health system and social health insurance	N/A
Vietnam	Social health insurance	N/A

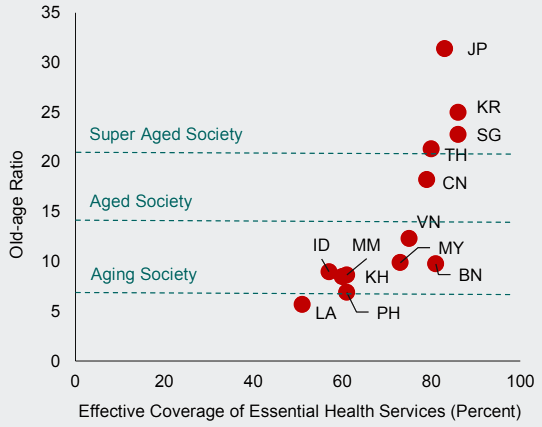
Source: World Health Organization; International Labour Organization; AMRO staff compilation based on officially published national documents.
Note: The information refers to the scheme each member economy uses to finance its statutory health system and long-term care program. It is important to note that the statutory financing arrangement may not necessarily be the dominant source of financing. The classification of health system financing scheme used in this box follows ILO (2015) and OECD/WHO/Eurostat (2011), with necessary adjustments to reflect the latest arrangement in ASEAN+3 member economies. N/A = not available.

Figure 2.3.2. ASEAN+3: Sources of Current Health Expenditure Financing, 2021
(Percent of current health expenditure)



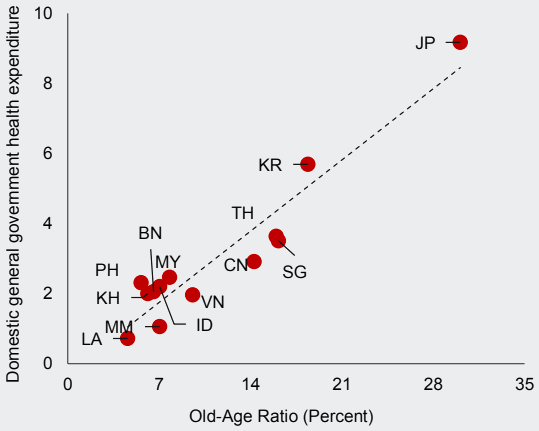
Source: World Health Organization (2021a); national authorities.
Note: BN = Brunei; CN = China; ID = Indonesia; JP = Japan; KH = Cambodia; KR = Korea; LA = Lao PDR; MY = Malaysia; MM = Myanmar; PH = the Philippines; SG = Singapore; TH = Thailand; VN = Vietnam. Data for Hong Kong are not available. For further details on financing sources, refer to WHO (2021a).

Figure 2.3.3. ASEAN+3: Old-age Ratios and Effective Coverage of Essential Health Services, 2030
(Percent)



Source: United Nations via Haver Analytics; International Labour Organization.
Note: BN = Brunei; CN = China; HK = Hong Kong; ID = Indonesia; JP = Japan; KH = Cambodia; KR = Korea; LA = Lao PDR; MY = Malaysia; MM = Myanmar; PH = the Philippines; SG = Singapore; TH = Thailand; VN = Vietnam. The old-age ratio is defined as the share of people of ages 65 years and above in the total population. Coverage of essential health services is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases, and service capacity and access, among the general and the most disadvantaged population.

Figure 2.3.4. ASEAN+3: Domestic General Government Health Expenditure and Old-age Ratios
(Percent of GDP)



Source: United Nations via Haver Analytics and International Labour Organization.
Note: BN = Brunei; CN = China; HK = Hong Kong; ID = Indonesia; JP = Japan; KH = Cambodia; KR = Korea; LA = Lao PDR; MY = Malaysia; MM = Myanmar; PH = the Philippines; SG = Singapore; TH = Thailand; VN = Vietnam. The old-age ratio is defined as the share of people of ages 65 years and above in the total population, and the data are as of 2023. General government expenditure on health—with data as of 2021—includes all public sources for health system such as domestic revenue (internal transfers and grants, transfers); subsidies to voluntary health insurance beneficiaries; nonprofit institutions serving households or enterprise financing schemes; as well as compulsory prepayment and social health insurance contributions.