JICA Thematic Guideline

Social Protection

（Social Health Protection・Income Security (Pension)・Social Welfare）

（September 2014）

Japan International Cooperation Agency

Preface

■ Purpose of the Thematic Guideline

The JICA Thematic Guideline is a reference document targeting the wide ranging internal and external stakeholders in social protection. The purpose of the Guideline is to provide basic information and knowledge about social protection such as an overview of social protection around the world, trends in international assistance, effective approaches and JICA's assistance directions. It serves as an aid when planning, implementing, monitoring and evaluating JICA projects. This Guideline is publicly accessible on the JICA Knowledge Site in order to promote JICA's activities in social protection to a wider range of stakeholders.

■ Rationale for the revision

JICA launched the first version in December 2006. The last version was published in March 2009 to respond to changes in society. The revision this time is to identify JICA's assistance directions in response to the following emerging issues in development.

(a) In recent years, economic growth in many low-income countries has made it possible for them to make the transition to middle-income countries,[1] where policy priorities have shifted from a response to basic needs, such as food security, public health, and basic education, to the improvement of quality of life including access to health care and income security. Policies have been initiated in many countries toward achieving universal health coverage and establishing contributory or non-contributory income security, in the form of pensions.

(b) Population ageing is occurring in many regions and countries at various levels of development. The population in some countries of Southeast Asia, especially, is expected to age at an unprecedented rate. Therefore, addressing the increased needs of health and long-term care as well as income security is an important policy agenda in these developing countries, many of which already have health care and pension programs in place. However, reforms to existing programs are needed in order to respond to the changing balance between the working population and beneficiaries.

(c) Establishing a more stable society is an important objective for the promotion of further economic development from the viewpoint of inclusive growth, by which the benefits of economic growth are distributed among a wider portion of the population, while at the same time, employment opportunities are expanded. The building and rebuilding of social protection systems are considered significant policy priorities.

[1] According to the World Bank classification, while the number of low-income countries decreased from 61 to 40 between 2003 and 2011, the number of middle-income countries increased from 93 to 104.

■ Revision points

The revision points are as follows.

- Changing social circumstances have been added to understand why social protection is emerging as an important policy priority.
- Historical development of social protection and its roles and functions have been included to understand what social protection is.
- Various definitions of social protection and social security[2] have been added to define social protection as the meaning varies among international development agencies.
- The following have also been taken into account: a human rights approach of international assistance to social protection; a connection between social protection and financial management; an explanation of new emerging mechanisms, such as, Conditional Cash Transfers (CCT); roles of the private sector; and the link between social protection and growth strategy.
- The need for policies to address ageing issues is clearly stated.
- The findings of the ASEAN 7 countries' study and lessons learned from the Thai technical project "The Project on the Development of a Community Based Integrated Health Care and Social Welfare Services Model for Older Persons (CTOP)"[3] have been considered in terms of their importance in assisting governments to coordinate community efforts to provide services with informal resources, as well as in assisting governments to establish and manage formal social protection programs, such as public insurance.
- Effective approaches have been structured around income levels, from three key perspectives: (a) suitability of program design, b) efficient and effective program management, and c) essential facilities, human resources, and systems to manage social protection.

[2] The term "Social Protection" is often used by the UN, the World Bank and others. The usage of social protection and social security will be discussed later.
[3] Refer to Annex 1-2, technical assistance project section, for details of the CTOP.

Contents

BOX

FIGURE

TABLE

The Development Objective Chart

From this Guideline a development objective chart (see the extract below) has been developed to show the effective approaches in the three areas of social health protection, income security and social welfare services according to the level of a country's economic development in a cross-section manner[4]. This chart can be used as an instrument when considering assistance directions and assistance approaches in response to development issues. (See next page for the complete chart.)

〈Development Objective Chart（extract)〉

Mid-term Goal	Least Developed Countries (GNI per capita below US$1,005)	Low- and Middle-Income Countries (GNI per capita US$1,006-3,975)	Upper Middle-Income Countries (GNI per capita US$3,976-6,925) and Higher
Suitability of Program Design	• Establish foundations to provide basic health services • Ensure financial sustainability of non-contributory programs and close collaboration with donors ＊snip＊	• Coverage expansion to include non-communicable diseases and more advanced medical services • Coverage expansion to the informal sector • Ensure financial sustainability ＊snip＊	• Ensure financial sustainability (controlling medical costs) • Address issues relating to an ageing society ＊snip＊
JICA's Priority Areas	• Establish foundations to provide basic health services (within the framework of the health sector cooperation) • Consider a co-financing or collaboration program of action with donors such as the World Bank and ADB in the case of ODA loans and grant aid schemes for non-contributory health care programs • Assist government officials by providing the necessary information in design through knowledge-sharing and advice for contributory health care programs ＊snip＊	• Coverage expansion to the informal sector: assist the countries with contributory schemes in designing and improving the program and sub-systems • Medical fees: Establishing a medical fee mechanism that ensures the quality of medical services and controls medical costs. • Establishment of a reliable information management system: management of insured persons' identification and information, the examination and payments of medical fees ＊snip＊	• Medical costs control: the improvement of the medical fee system and the processing of medical fees, the establishment/improvement of the medical information system, and in the cost-share mechanism for medical costs of the elderly population ＊snip＊

[4] In reality, causal relationships with development issues are interlinked unlike the linear-structured development objective chart. The chart is structured to understand the overview of development issues.

The Development Objective Chart for Social Protection (Social Health Protection・Income Security (Pensions)・Social Welfare)

Development Strategic Objective 1 ：Establishment of social health protection			
Mid-term Goal	**Least Developed Countries (GNI per capita below US$1,005)**	**Low- and Middle-Income Countries (GNI per capita US$1,006-3,975)**	**Upper Middle-Income Countries (GNI per capita US$3,976-6,925) and Higher**
Suitability of Program Design	• Establish foundations to provide basic health services • Ensure financial sustainability of non-contributory programs and close collaboration with donors	• Coverage expansion to include non-communicable diseases and more advanced medical services • Coverage expansion to the informal sector • Ensure financial sustainability	• Ensure financial sustainability (control medical costs) • Address issues relating to an ageing society
Efficient and Effective Program Management	• Develop a targeting system for a non-contributory scheme and coordinating with ministries (to ensure consistency with other poverty programs)	• For a contributory health insurance program covering the informal sector, establish a mechanism for collecting insurance premiums and manage information on the insured • Develop a targeting system to identify eligible beneficiaries when public funds are used to provide social health protection for those with low-incomes • Develop a reliable information system to manage information on the insured, ascertain patients' medical information and pay medical institutions.	Same as that on the left (improve existing systems)
Infrastructure, Personnel and Systems	• Establish basic medical service delivery (training of medical personnel, establishment of public health centers and hospitals)	• Correct regional disparities in medical service delivery	• Improve the quality of medical services (quality improvement in public medical institutions, inclusion of private medical institutions into public health insurance)
JICA's Priority Area	• Establish foundations to provide basic health services (within the framework of the health sector cooperation) • Consider a co-financing or collaboration program of action with donors such as the World Bank and ADB in the case of ODA loans and grant aid schemes for non-contributory schemes • Assist government officials by providing the necessary information in design through knowledge-sharing and advice for contributory schemes	• Expand coverage to the informal sector: assist the countries with contributory schemes in designing and improving the program and sub-systems • Medical fees: Establish a medical fee mechanism that ensures the quality of medical services and controls medical cost. • Establish a reliable information management system: management of the insured persons' identification and information, the examination and payments of medical fees	• Medical costs management: improve the medical fee system and the processing medical fees, establish/improve the medical information system, and the cost sharing mechanism for medical costs of the elderly population • Initiate quality development and management of medical services such as the establishment or improvement of the medical information system and the improvement of the medical fee system

Development Strategic Objective 2 : Establishment of Income Security such as Pensions			
Mid-term Goal	**Least Developed Countries (GNI per capita below US$1,005)**	**Low- and Middle-Income Countries (GNI per capita US$1,006-3,975)**	**Upper Middle-Income Countries (GNI per capita US$3,976-6,925) and Higher**
Suitability of program design	• Minimum level of public assistance for the socially vulnerable • Ensure financial sustainability for non-contributory programs and collaborate with donors	• Ensure coverage of employees in contributory income security programs • Ensure financial sustainability of income security for employees • Ensure coverage of the socially vulnerable in non-contributory income security programs • Ensure the financial sustainability of non-contributory income security programs	• Ensure effective income security for old age • Expand contributory income security programs to the informal sector • Improve the income replacement rate for contributory income security programs • Ensure financial sustainability
Efficient and Effective Program Management	• Develop a targeting system for non-contributory programs and coordinate with ministries (to ensure consistency with other poverty programs)	• Ensure governance of contributory income security programs for employees and monitor implementation • Develop reliable information systems for contributory income security programs for employees • Develop a targeting system for non-contributory income security programs	• Improve sub-systems such as accurate information management of the insured, contribution correction and smooth payouts in contributory programs • Enhance governance for asset management
JICA's Priority Areas	• Consider a co-financing or collaboration program of action with donors such as the World Bank and ADB in the case of ODA loans and grant aid schemes for non-contributory programs • Provide technical assistance to increase the sustainability of financial resources for non-contributory programs in a framework of public finance management assistance • Assist government officials by providing the necessary information and key points in design through knowledge-sharing and advice for contributory programs	• Ensure the program's financial sustainability, and establish or improve the related sub-systems for employee-based income security	• Expand the coverage to the informal sector in a contributory income security program through: a) choosing financial models, b) information management of the insured, c) contribution collection, d) contribution setting, and e) benefit setting in case of pay-as-you-go pensions

Development Strategic Objective 3 : Establishment of Social Welfare Services			
Mid-term Goal	**Least Developed Countries (GNI per capita below US$1,005)**	**Low- and Middle-Income Countries (GNI per capita US$1,006-3,975)**	**Upper Middle-Income Countries (GNI per capita US$3,976-6,925) and Higher**
Suitability of program design	• Delivery of the bare minimum of public social welfare services for orphans, persons with disabilities who need specialized care, the elderly with no relatives, victims of disasters, and others	• Develop sustainable programs for children and adults with disabilities and the elderly	• Augment service types such as long-term care and childcare (expanding beneficiaries) • Ensure financial sustainability
Efficient and Effective Program Management	• Coordinate at various levels such as between the central government and local governments, between the central and local governments and NGOs, volunteers and community associations, and donors	• Develop mechanisms for social welfare service delivery such as setting up an assistance consultation counter and assigning assistance consultants • Develop standards for social welfare services to ensure the quality of the services	• Provide stronger collaboration between government agencies, central and local governments, and governments and the private sector
Infrastructure, Personnel and Systems	• Establish infrastructure for minimum level social welfare services (establishing institutions for the care of orphans and residences for the elderly with no family and hiring the personnel to work in these institutions)	• Train social welfare service personnel • Train volunteers, develop mechanisms for promoting the activities of NGOs and volunteers	• Establish infrastructure for social welfare services such as childcare and long-term care • Train social welfare professionals such as social workers
JICA's Priority Areas	• Assist those affected by natural disasters and the vulnerable: JICA's emergency disaster relief (emergency humanitarian aid) for disasters, dispatch of Japan Overseas Cooperation Volunteers (JOCV) and NGOs under JICA Partnership Programs for grass-roots assistance for the socially vulnerable • Develop social welfare services and human resources: provide necessary information in design, types of services needed and roles of professionals, through knowledge-sharing and advice.	• Develop a system for social welfare services such as a human resource development program for social workers, and to set up standards for social welfare institutions • For welfare needs at the grass-roots level, JOCV Programs and JICA Partnership Programs will be utilized.	• Assist the following for long-term care for the elderly: development of long-term care services and long-term care professionals, capacity development of professionals, families and volunteers as caregivers, policy development for a sustainable long-term care system within the fiscal constraints • Ensure financial sustainability of social welfare services: cost analysis of the services and analysis of financial resources • Share knowledge about various actions to address the ageing of society • Strengthen partnerships among relevant ministries at the central level, between central and local governments as well as between public and private sectors

Executive Summary

■ Organization of this Guideline

The Guideline is organized in three chapters. Chapter One is an overview of social protection based on available facts such as societal changes affecting social protection, actual global situation of social protection programs, historical development of social protection, its roles and functions, definitions, and international and Japanese assistance trends. Chapter Two describes effective approaches to social protection according to the level of a country's economic development. Chapter Three describes JICA's assistance direction based on the discussions of Chapters One and Two, rationale of JICA's support, JICA's priority areas, assistance approaches, points to remember when providing assistance, and the challenges ahead.

■ Scope of Social Protection in this Guideline

Although the term "social protection" is widely used, there is no unified definition. The scope and contents vary according to country and institutions. This Guideline covers (a) social health protection (non-contributory health care packages and contributory public health insurance), (b) income security (cash transfers and public pension insurance), and (c) social welfare (provision of social welfare services). As to social health protection, the Guideline focuses on funding for medical costs although the provision of health services is important as well. The provision of services is covered in a separate Guideline in JICA's health sector. As to income security and social welfare, separate guidelines have been developed for such areas as education, poverty reduction, agriculture development, public financial management, and disability. Therefore, this Guideline does not cover these areas. Active labor market policies, which are also important for inclusive growth, need different interventions and resources than other social protection programs. Developing a separate Guideline on labor is to be considered.

■ Global Situation of Social Protection Systems

Today, developing countries are experiencing the effects of modernization and industrialization, that is, a weakened sense of community and in the near future the ageing of their population. Although steady economic growth has been achieved in many developing countries, uneven distribution of the benefits of economic growth and expanding inequality are contributing to social instability. According to the ILO, only 20 percent of the world's population has effective access to comprehensive social protection. Furthermore, only one third of the world's countries have implemented all three systems: medical care, old-age income benefits, and unemployment benefits. In regard to health care programs, nearly one third of the world's population cannot access any medical facilities or medical services. WHO reported that more than 1 million people fall into poverty annually due to sickness or the high cost of medical services. Furthermore, poverty among the elderly is high. The informal sectors, on the other hand, are excluded in most cases despite their employment of a large portion of the population.

■ Historical Development and Goals and Functions of Social Protection

The history of modern social protection systems began in late 19th Century Germany when Chancellor Bismarck initiated social insurance legislation. Social protection developed to substitute informal mutual assistance within traditional communities (agricultural communities or religious organizations) with state involvement after new challenges or demands emerged. The new challenges were, for example, a weakened sense of community due to the development of modern societies (modernization and industrialization), the growth in the number of urban workers, and loss of income due to accidents, illness, unemployment or retirement. After the Second World War, “the right to social security” was proclaimed in the Universal Declaration of Human Rights adopted in 1948. Social protection came to be recognized as a human right as well as a measure to maintain social stability and to create effective demand, which were instrumental for the economic growth after the Second World War.

Today, social protection has various functions relating to individuals and society. For individuals, it guarantees a minimum standard of living, provides financial protection and necessary services. For society, it fosters a sense of security and equality among citizens, as it promotes economic activities and has redistributive effects.

■Trends in International and Japanese Assistance

International assistance was first implemented in the early 1950’s, when the ILO supported the social protection systems in Southeast Asia. The World Bank began its assistance in the 1970s, and in the 1980s in particular, social protection programs were established to alleviate the hardships caused by reduced social welfare services under the structural adjustment policies implemented in developing countries. In the 1990s, social protection programs were set up in the former communist countries to reduce the shock market-oriented economic reforms were having on the citizens’ lives. After the 1997 Asia Financial Crisis and in response to the rapidly changing socio-economic environment in its aftermath, the institutionalization of comprehensive and sustainable social protection programs that address various needs is becoming a global social policy priority. Some major aid organizations are becoming leading donors, for example, the ILO, the World Bank, ADB, UNICEF, GIZ, DFID. In particular, in FY2009 through FY2011, largely in response to the global economic crisis, the World Bank’s social protection and labor lending increased fivefold, representing the largest sectoral increase in World Bank lending over this period. In 2009, the ILO launched the social protection floor initiative with the UN aiming for universal coverage.

The Japanese government provides human resources to JICA projects, accepts technical trainees, and undertakes and supports projects by Japanese organizations in international cooperation. It also provides funds to international organizations such as WHO and the ILO for their programs related social protection. With ASEAN countries in particular, the Japanese government exchanges views with ministers through the “ASEAN+3 Health Ministers and Senior Officials Meetings”, convenes annual meetings of the “ASEAN and Japan High Level Officials Meeting on Caring Societies”, and collaborates with the ILO through the ILO/Japan Multi-bilateral Project.

From 2000, JICA’s assistance in social protection has been expanding through its dispatch of long-term experts to Southeast Asian countries and by initiating projects and surveys. In

Central and South America, JICA implemented technical assistance for social welfare programs for the elderly and children.

■Perspectives to Consider

The government has the primary responsibility for providing social protection. The objective of JICA's cooperation in social protection is to provide support, primarily to the governments of developing countries, in developing and implementing effective social protection programs. From the perspective of the government officials who draft and implement policies, three perspectives must be considered when establishing a social protection program: (a) the suitability of the program design, (b) the effective and efficient administration of the program and (c) the infrastructure, personnel and systems supporting the program.

The suitability of social protection programs is assessed in terms of whether the program's design is consistent with the citizens' needs, whether the program is matched with the country's economic and fiscal conditions and whether the program is financially sustainable. A social protection program's design must be considered in terms of its components, specifically (a) the population eligible for the social protection program, the range of services or payments offered (i.e., the program's "coverage") and (b) how the program will be funded.

From the perspective of efficient and effective program management, a number of factors must be taken into consideration, such as, targeting systems, information management of the insured, contribution collection in a contributory system; provision of service benefits; asset investment conditions in the asset management of reverse funds; the capacity of administrators; governance; system compliance; monitoring and evaluation; and coordination and collaboration between stakeholders.

From the perspective of infrastructure, personnel and systems supporting the program the following must be considered: for social health protection, medical institutions such as public health centers, medical clinics and hospitals, medical personnel, systems for the procurement and management of pharmaceuticals and medical supplies; for income security within a contributory system, experts such as pension actuaries and fund managers, personnel and systems for managing individual subscribers' information and remittances; for income security within a non-contributory system, a certification system for beneficiaries, information management systems and systems for remittances; for social welfare services, childcare facilities, long-term care facilities for the elderly, and the human resources to provide these services.

■ Effective Approaches According to the Country's Economic Development Level

When a developing country is designing a social protection program, there are three effective approaches that are necessary to consider and they are based on the level of economic development in that country.

In the least developed countries (GNI per capita below US$1,005): As for suitability of program design, expanding coverage of basic medical services, ensuring financial sustainability of non-contributory programs, and providing a minimum level of income security and public assistance for the socially vulnerable are important. As for efficient and effective program management, developing a targeting system for non-contributory schemes in health protection and income security, coordinating with relevant ministries, and coordination at

various levels for social welfare services are essential. As for infrastructure, personnel and systems, establishing basic medical service delivery (training of medical personnel, establishment of public health centers and hospitals), and establishing infrastructure for a minimum level of social welfare services are high priorities.

In low- and middle-income countries (GNI per capita US$1,006-3,975): As for suitability of program design, the following are important: coverage expansion to include non-communicable diseases and more advanced medical services, coverage expansion to the informal sector, coverage expansion of a contributory income security and a non-contributory income security system for the socially vulnerable, and financial sustainability whether in social health protection or income security. As for efficient and effective program management, the following are important: establishing a mechanism for collecting insurance premiums and managing information on the insured; improving governance for an employees' based contributory income security program and monitoring it; establishing an information management system whether in social health protection or income security; establishing targeting systems for a non-contributory income security program; and developing a system that provides social welfare services. As for infrastructure, personnel and systems, correcting regional disparities in medical service delivery and training human resources for social welfare services are important.

In upper middle-income countries (GNI per capita US$3,976-6,925) and higher: As for suitability of program design, the following are important: managing medical costs, addressing the health issues of an ageing society; effective income security for old age; expansion of contributory income security programs to the informal sector; improving the income replacement rate for contributory income security programs; augmenting service types of social welfare services; and maintaining financial suitability in all the related systems. As for efficient and effective program management, improvement of sub-systems and governance in income security and stronger collaboration between government agencies, central and local governments, and governments and the private sector are needed. As for infrastructure, personnel and systems, improving the quality of medical care, and establishing infrastructure for social welfare services such as childcare and long-term care are needed.

■Why Does JICA Support Social Protection?

The rationale for JICA's assistance in social protection is: a) the realization of fundamental human rights (access to social protection) and human security, b) the realization of inclusive and sustainable development, c) the contribution to global peace and stability, d) the response to imminent urgent issues such as the rapid ageing of the population, e) the raising of the quality of life and the sharing of the benefits of economic growth, e) and, mutual learning as part of Japan's ongoing agenda which includes the ageing society and reforming its social protection system.

■JICA's Priority Areas in Social Protection

One of the characteristics of Japan's experience in social protection is that Japan established its social protection system through contributory schemes based on the western social protection model at a relatively early stage of economic growth and when there was still a very large agricultural population. The development of a rapidly ageing society and the

policies undertaken to respond to this situation are also one of the characteristics. When planning JICA's activities, these characteristics should be considered as comparative advantages. JICA's priority areas are listed below and in reference to a country's stage of development.

Least developed countries

Social Health Protection	● **Establish foundations to provide basic health services** (within the framework of the health sector cooperation) ● **Support for a non-contributory scheme**: Consider a co-financing or collaboration program of action with donors such as the World Bank and ADB when supporting the scheme through ODA loans and grant aid schemes. ● **Support for a contributory scheme**: Respond to government officials' needs to identify the necessary information and key points in design through knowledge-sharing and consultation
Income Security such as Pensions	● **Support for a non-contributory scheme**: Consider a co-financing or collaboration program of action with donors such as the World Bank and ADB when supporting the scheme though ODA loans and grant aid schemes. Provide technical assistance to increase the sustainability of financial resources in a framework of public finance management assistance ● **Support for a contributory scheme**: Respond to government officials' needs by providing the necessary information and key points in design through knowledge-sharing and consultation
Social Welfare Services	● **Relief activities for those affected by natural disasters and support for the socially vulnerable**: Emergency humanitarian aid by Japan Disaster Relief Team in great disasters. Japan Overseas Cooperation Volunteer Program and JICA Partnership Program for the grass-root assistance for the vulnerable people ● **Assistance for development of social welfare services and human resources**: Responding to government officials' needs, provide necessary information in design, types of services needed and roles of professionals, through knowledge-sharing and advice.

Low- and Middle-Income Countries

Social Health Protection	● **Support for coverage expansion to the informal sector**: Assist the countries with contributory schemes in designing and improving the program and sub-systems. Japan's experiences for universal health coverage can be utilized. ● **Support for a medical fee mechanism**: Establish a medical fee mechanism that ensures the quality of medical services and controls medical costs. ● **Support toward a reliable information management system**: Establish and improve a system to manage beneficiary identification and information and promote a smooth examination and reimbursement process. Skills and experiences of social insurance specialists and private service providers will be utilized.
Income Security such as Pension	● **Support for an employee-based income security scheme**: Ensure the program's financial sustainability, and establish or improve the related sub-systems, for instance, carry out actuarial studies to set the levels of premiums and benefits, asset management and investment mechanisms and methods. Aid resources include academics, social insurance specialists and actuarial professionals.
Social Welfare Services	● **Support for the development of mechanisms to provide social welfare services**: Development of a human resource development program for social workers who assess needs, coordinate on service delivery and provide consultation services, and set up the standards of social welfare institutions. For welfare needs at the grass-roots level, Japan Overseas Cooperation Volunteer Program and JICA Partnership Programs for grass-root assistance will be utilized.

Upper Middle-Income Countries

Social Health Protection	● **Support for medical costs control**: Improve the medical fee system and the decision-making process on medical fees, establish/improve the medical information system, assist to establish appropriate sharing mechanism for the medical costs for the elderly ● **Support toward higher quality medical services**: Establish/improve the medical

	information system, improve the medical fee system
Income Security such as Pension	● **Support toward coverage expansion to the informal sector in a contributory income security**: a) choosing financial models (funded or pay-as-you-go), b) information management of the insured, c) contribution collection, d) contribution setting, and e) benefit setting in case of a pay-as-you-go pension. Knowledge and skills of social insurance specialists and actuarial professionals will be utilized.
Social Welfare Services	● **Support for a long-term care for the elderly**: Develop long-term care services and long-term care professionals, capacity development of professionals, families and volunteers as caregivers, policy development for sustainable long-term care system under the fiscal constraints. Knowledge and experiences of local government officials and long-term care providers will be fully utilized. ● **Support for ensuring financial sustainability of social welfare services**: The cost analysis of the services and the analysis of financial resources especially for long-term care services for the elderly. ● **Support on policy interventions in various issues regarding ageing**: Knowledge-sharing for various activities in the ageing society including age-friendly environments in housing and urban areas, ensuring the livelihood of the elderly, establishing employment services for the elderly; developing products that take into consideration the physical conditions of the elderly (universal design); and disaster and violence prevention for the elderly as well as medical services, pension and long-term care services. ● **Strengthening the partnerships between central governments and ministries, central and local government partnerships, and public and private sector partnerships**: Strengthen the coordination among health, welfare and housing sectors, clarify respective roles of central and local governments, build capacity of local officials, and foster partnership between government and private sectors (profit and non-profit) regarding the long-term care for the elderly.

■Assistance Approach

JICA adopts an approach that will strengthen the capacities of policy makers and implementers. Effective assistance will be pursued through the appropriate selection and combination of various aid schemes. (For example, a combination of official loan aid, aimed at assisting financial gaps, and technical assistance, aimed at the development of social protection policies and programs; a combination of technical assistance in designing information systems for health care and income security programs; and official aid loans upon introduction of the system). Furthermore, promoting knowledge exchanges and policy advice through training programs, symposiums and seminars is effective in designing a project and in increasing Japan's contribution to the establishment of social protection systems. It is essential that meetings and training programs such as the ASEAN and Japan High Level Officials Meeting on Caring Societies organized annually by the Ministry of Health, Labor and Welfare as well as JICA training programs for social insurance administrators be utilized effectively. In addition to introducing Japan's experience, promoting south-south cooperation is also an important form of assistance.

■Points to Remember When Providing Assistance

When providing support to establish systems, it is necessary, first, to know and understand the different situations of a country and invent possible and innovative solutions that address particular challenges and opportunities under administrative, financial and economic constrains without adhering to the experiences or current systems of developed countries. At the same time, the sovereignty of nation-states must be respected when establishing social protection systems. A thoughtless intervention could be risky because it may be taken as interference in the domestic affairs of the state. If informal human resources such as

neighbors, relatives and acquaintances in communities or existing traditional indigenous organizations function fully in developing countries, it is necessary to give consideration to how to maintain harmony with these services when providing assistance. Long-term and continuous political dialogues are very important to assist countries according to their needs and a “running partner approach” is desired for implementers. JICA will give advice on policy, however, it is equally important to build trusting relationships with countries as a dialogue partner.

■The Challenges Ahead

The challenges ahead are: a) Ensuring human resources and documenting Japan′s experience in social protection, b) Multisectoral coordination、c) Systematic knowledge and evidence collection. As for a) above, ensuring specialists in the social protection sector, who are experts in social protection systems and able to undertake assignments in foreign languages, is an urgent task. Ensuring human resources in developing countries is also important. Documentation in English regarding Japan’s experience (successes and failures) in social protection is also essential. As for b) above, it is very important to strengthen multisectoral coordination and collaboration in such fields as education, health, employment and labor, rural development, regional development, agricultural technology development, public finance management, and poverty reduction within JICA. As for c) above, conducting academic research based on hands on experience, that is JICA’s strength, generating global knowledge which is widely applicable to assistance operation, and disseminating it are important. Systematic knowledge, evidence collection and building on past experience lead to more compelling policy advice.

Chapter 1. Overview of Social Protection

In recent years, a great deal of attention has been given to social protection. Historically, social protection developed according to changing needs. Therefore, in this chapter, we will first attempt to understand why social protection is one of the emerging priorities in development while taking into consideration current social conditions, such as livelihood, family, population, employment as well as the economic environments. Secondly, in order to understand what social protection is and why assistance for social protection is important, we will look at their historical development in the western world and their roles and functions.

1-1. Global Status of Social Protection

1-1-1. Societal Changes Affecting Social Protection[5]

Societal changes and society's needs for protection have become more sophisticated, diverse and complicated. These changes have increased the relevance of social protection worldwide, and the need to establish effective social protection systems that respond to changes in society is quite high.

Local communities are greatly transforming amid ongoing industrialization and urbanization. For example, not only in urban areas but also in rural areas, women and the elderly have assumed a greater role in community work than before while young and middle-aged men leave home for work during the daytime. This transformation has weakened traditional family and community functions which have supported its members in times of difficulty, such as sickness, disability, unemployment and child rearing.[6] Recent demographic trends show that the ageing of populations is expected to occur in all regions and countries and will call for greater attention to long-term care and income security for the elderly. Furthermore, declining birthrates are expected to result in a shrinking labor force, which supports not only social protection but also economic development.

In recent years, steady economic growth has been achieved in many developing countries and many low-income countries have made the transition to middle-income countries. On the other hand, most of the poor have been left behind without reaping the benefits of economic growth. Crisis and instability have often disproportionately affected those who are already vulnerable and so have inequality and the uneven distribution of the benefits of

[5] As socioeconomic indicators, the transition of urban population and the population ageing rate are reported in Annex 3.
[6] See ADB (2012)

economic growth. Today, three quarters of the world's poor live in middle-income countries.[7] The recent turbulent situation in the Middle East can be attributed to a sense of unfairness which has led to further social instability.[8,9,10] Social protection for the increasing number of immigrant workers around the world has also become a challenge.

Adding to the above situation is the deterioration of the employment situation. According to the International Labor Organization (ILO), global unemployment was projected to be 196 million by the end of 2011 and expected to increase to 220 million in 2012.[11] The increase in long-term unemployment and in unemployment of those under 25 years of age remains a major challenge.

Box.1-1. 【Ageing in developing countries】

Life expectancy at birth has risen worldwide. The rapid progression of population ageing in developing countries is raising the priority of social protection for the elderly population in development agendas. The United Nations projects that the majority of older people (60 percent of those aged 60 or over) live in low- or middle-income countries. It is expected that this number will have increased to 80% by 2050. Chile, China and Iran will have an especially high percentage of elderly citizens. Among the world's regions, Asia is experiencing the most rapid ageing of their populations as well as a declining birthrate. It is predicted that Thailand and Vietnam will experience ageing at a more accelerated pace than Japan. Furthermore, the reduced size of households, due to rapid urbanization and migration from rural to urban areas, has affected the family's capacity to care for the elderly.

What is making ageing and declining birthrates more problematic in developing countries is that they have to respond to these new challenges before sufficient economic growth. This situation was not experienced by developed countries. Moreover, the occurrence of rapid ageing in rural areas is worsening the situation. As the birthrate decreases and the younger generation moves to urban areas, the ability for the rural area to increase income levels diminishes. These changes in the demographics of urban and rural areas will require governments to respond accordingly. In recent years, for example, non-contributory social pensions covering the vulnerable elderly have been implemented in over 100 countries, according to HelpAge International's Social Pensions database.

Ageing also has a gender dimension. In general, women live to a more advanced age than men and their later stage in life is longer. Women have a higher probability of losing their spouse, and their chances for re-marriage are lower than that for men. This indicates that there is a higher need for income security for older women. Receiving a pension, however, is a privilege that few of them enjoy, as the majority of older women are employed in the informal sector, which is excluded from formal contributory pension schemes when they are in their productive age. As widows, they rarely receive the benefits of survivor pensions because many income security programs do not cover the informal sectors.

Reference：UNFPA and HelpAge International (2012) Ageing in the Twenty-First Century: A Celebration and A Challenge

[7] Sumner (2010)

[8] It is reported that income inequality affects effective poverty reduction even when the economy has grown. See Ravallion (2005)

[9] In many ASEAN member countries, the Gini coefficient has not changed in 10 years or rather has increased. Thailand：41.5(1998)→40.0(2009), Indonesia：29.0(1999)→34.0(2005), Malaysia：49.2(1997)→46.2(2009).Source：WB (http://data.worldbank.org/indicator/SI.POV.GINI/). The average in the mid 2000s in 30 OECD countries is 31.1, Japan 32.1(OECD (2008)). It is reported that the higher the Gini coefficient is, the shorter the sustainability of economic growth tends to be. See Berg, A. et al.(2011)

[10] Analysis shows that inequality prevents a country from economic growth and development. See Easterly (2007)

[11] ILO (2011a)

1-1-2. Global Situation of Social Protection Systems

As discussed in 1-1-1, there is a growing demand for government intervention to establish social protection systems that respond to the rapid social changes taking place. However, an ILO report in 2010 reveals that only 20 percent of the world's population have effective access to comprehensive social protection. Furthermore, only one third of the world's countries have implemented all three systems: medical care, old-age income benefits, and unemployment benefits.[12] Extending social protection coverage to the excluded majority[13] who have not been covered is a global concern. The excluded majority includes workers in informal sectors, non-regular workers, the self-employed, domestic workers, immigrant workers, unskilled workers, persons with disabilities,[14] patients with chronic diseases such as HIV/AIDS, the elderly, women, children, indigenous groups and minority ethnic groups. In many developing countries contributory health benefit programs for the formal sectors are already in place, though, the number of non-regular workers in the formal sectors not covered by any social protection programs is increasing.[15] The informal sectors, on the other hand, are excluded in most cases despite their employment of a large portion of the population. In Asian countries, the proportion of the population working in the informal sectors, such as agriculture, is still high[16]. The World Bank has reported that the number of workers worldwide exceeds 3 billion with almost half being farmers or the self-employed.[17] Therefore, the key to expanding social protection coverage is to extend it to the informal sectors.

In regard to health care programs, nearly one third of the world's population cannot access any medical facilities or medical services. The World Health Organization (WHO) reported that more than 100 million people fall into poverty annually due to sickness or the high cost of medical services.[18] Although 40 percent of countries worldwide have established old-age income security programs, the actual proportion covered by these programs is only 20 percent of the working population in Asia, the Middle East, and the North African Countries, and no more than 5 percent in Sub-Saharan Africa. In high-income countries, 75 percent of those over 65 years of age receive some form of pension, but in low- or middle-income countries, less than 20 percent do. Social protection for the elderly is also very limited in developing countries. Help Age International (an international NGO on ageing), reported that poverty among the elderly is high, particularly in countries where the majority of older persons are employed in the informal sector.

In the labor sector, statutory unemployment schemes exist in only 78 countries (42 per cent)

[12] ILO (2010c)
[13] ILO uses the term "the excluded majority". See ILO (1999)
[14] The 2011 World Report on Disability (WHO) reports that access to social protection among people with disabilities is limited.
[15] ILO (2012a) documents success stories of policies for non-regular workers
[16] The number of workers in the informal sector is expected to grow, which will contribute to the increased poverty. OECD (2009a)
[17] WB (2012c)
[18] WHO (2010)

out of a total of 184 ILO member countries, and if they exist, they often cover only a minority of the labor force. Regarding coverage for work-related accidents and diseases, globally, less than 30 per cent of the working-age population, which is less than 40 per cent of the economically active, receives coverage. Not many developing countries have social welfare services and social assistance, and when available, the coverage is very limited. Geographically, the Middle East, Asia and Africa are behind in terms of the development of social protection systems when compared to the countries in Latin America.[19]

The situation of social protection systems varies depending on a country's level of economic development. The differences in economic development will be further discussed in Chapter Two.

1-2. What is Social Protection?

1-2-1. Historical Development of Social Protection[20]

Informal mutual support among family and community members has always been an essential function since earliest times. The modern social protection system, in which the state became involved, began with the Poor Law implemented in the United Kingdom in the 17th century. This was the prototype of the current social assistance system but the main purpose was to maintain public order. It was in late 19th century Germany that a social protection system was institutionalized as one of the government's national policies. In the course of its industrialization as a developing country at that time, serious problems, such as the deterioration of workers' health and frequent labor disputes arose. Otto von Bismarck, the Chancellor at that time, enacted a series of social insurance programs for sickness, industrial injury, and old-age and disability pensions in order to ensure the productivity of the labor force and to stabilize and improve their livelihood. In Japan, after the occurrence of frequent labor disputes in the early 20th century, health insurance for blue-collar workers was legislated in the 1920's. Under the strong political backing of "Healthy people create healthy soldiers" during the war years of the 1930s and early '40s, a series of social insurance programs was enacted, including community-based health insurance for farmers and the self-employed (1938), health insurance for white-collar employees (1939) and the coverage extension of health insurance to dependent family members of employees (1942). In 1941, the employee's pension insurance scheme was legislated. In the United States, during the Great Depression of the 1930s, the Social Security Act was established as part of the New Deal program, resulting in the implementation of social protection systems such as public assistance to the elderly and persons with disabilities, unemployment insurance, and old-age pensions.

[19] The ILO Social Security (Minimum Standards) Convention (C102, 1952) has been ratified by only 47 countries (as of March 2013). The number of countries ratified by region is: only Japan in Asia, 5 countries in Africa, 9 countries in South America and none in the Middle East.

[20] Regarding historical development, Part I of "2012 Edition Annual Health, Labor and Welfare - think about social security" by the Ministry of Health, Labor and Welfare has a detailed explanation.

This history of social protection since the late 19th century shows that states have gradually assumed the mutual assistance role of traditional communities (agricultural communities and religious organizations) as new challenges and demands emerged. The new challenges included the dismantling of traditional society in the course of modernization and industrialization, the emergence of a great mass of urban workers and their risk of losing of earnings due to accidents, diseases, unemployment or retirement.

The Beveridge Report,[21] presented to the British parliament in 1942, had a great impact on social protection systems in the postwar world, including those in Japan. Under the slogan, "from the cradle to the grave," a new lifetime security system was developed in combination with the following three measures: (a) social insurance for basic services, (b) public assistance for special circumstances, and (c) voluntary insurance. After the Second World War, successive governments in the United Kingdom and other European countries, as well as in Japan, actively intervened in the domestic economy to create effective demand by filling the gap of private investment through which full employment is attained (Keynesianism). At the same time, they pursued a path to becoming welfare states, wherein social protection systems contribute to the creation of demand by maintaining a certain level of purchasing power in any economic circumstances. Social protection became indispensable to economic growth during the postwar era as a support mechanism for a state's economic policy.

In addition to these trends "the right to social security" was proclaimed in the Universal Declaration of Human Rights adopted in 1948. Social protection was recognized as a human right as well as a measure to maintain social stability and to create effective demand. Now social protection is an established human right enshrined in the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Rights of the Child (1989), and the Convention on the Rights of Persons with Disabilities (2006).

1-2-2. Goals and Functions of Social Protection

Having reviewed the historical development of various social protection systems, this section will discuss the fundamental objectives of social protection systems which are twofold: (a) to guarantee a citizen's minimum standard of living, and (b) to guarantee stability to their livelihood, which leads to social stability as a whole. Social protection has various functions relating to individuals and society in order to achieve these goals.

Table 1-1. Functions of Social Protection relating to Individuals and Society

Individual	Society
● guarantee a minimum standard of living ● provide financial protection ● provide necessary services	● foster a sense of security and equality among citizens ● promote economic activities ● redistribute wealth and income

[21] Inter-Departmental Committee on Social Insurance and Allied Services (1942)

A) Functions relating to individuals

To guarantee a minimum standard of living : In developed countries, social protection plays a role in guaranteeing a minimum standard of living to those who are facing financial hardship by providing necessary assistance depending on their level of deprivation. Not many developing countries are equipped with the same level of social assistance. However, one instrument being utilized mainly in Latin America and Asia is Conditional Cash Transfers (CCT), which plays an important role in ensuring a minimum standard of living for the poor.

Financial protection : Different supports are needed according to the needs of a population throughout an individual's life-cycle.[22] For instance, while the most important goal of social protection for the elderly is stability, promoting economic independence is important for the younger generation not only in terms of their well-being but also of the nation's economy. Some examples of the risks people may face throughout their life-cycle are: health at birth, illness or disability, or the loss of parents during childhood. As adults the risks may be temporary illness or disability, unemployment, loss of a breadwinner during their productive years, and illness, long-term care, or decrease in income in their later years. These risks inevitably lead to livelihood instability due to lost income or increased living costs. The role of cash transfers or pensions is to reduce financial burdens which will, to some extent, result in reducing the impact of those risks. The following programs play this role: old-age pensions, disability pensions, survivor pensions, child allowances for single-mother households, and sick pay covered by health insurance while unemployment insurance covers unemployment benefits or workers' accident compensation. Particularly, social protection through contributory schemes plays a role in reducing risks in society as a whole, as the insured pay contributions in preparation for unexpected events. Addressing any vulnerability caused by the risks mentioned above will contribute to mitigating the intergenerational transfer of poverty.

Providing necessary services : The appropriate social protection scheme will guarantee the necessary services required to provide different services for different needs, such as health care, housing, food, childcare, and long-term care. Health care services are needed in case of illness or disability, clothing, food, and housing services in case of impoverishment, and childcare services when orphans are concerned. Professional long-term care or childcare services are becoming necessary to an increasing extent due to the ageing population and the proliferation of nuclear families. These services are provided by either a government's general fund or public insurance funds.

B) Functions relating to society

Promotion of economic activities : Sustaining income levels helps to keep the overall labor markets active which in turn results in reducing the negative risks on societies as a whole. Furthermore, maintaining a certain living standard through social protection will support a proactive attitude in the economic activities of individuals, which will then lead to promoting further economic activity in society as a whole.

[22] ILO and OECD emphasize the importance of a life-cycle approach in designing social protection. ILO (2003), OECD (2009c)

Social stability and security improvement would offer incentives to lure foreign investment. Returning the benefits back to society is a source for establishing more comprehensive social protection systems that would then contribute to the improvement of an individual's economic situation. Thus, this ripple effect on the economy, society and the individual is anticipated.

Fostering a sense of security, alleviating a sense of inequality : As mentioned above, social protection offers a minimum standard of living and preparation for various risks individuals may face throughout their lives. It also fosters a sense of security in societies as a whole. The redistributive function (see below) is effective in reducing a sense of inequality, which in turn leads to social stability.

Redistribution of wealth and income : Social protection systems are viewed as redistributive systems. By working in conjunction with social and economic production systems they are expected to produce a virtuous cycle that brings stability and development to a society. This system is a mechanism for distributing funds to individuals from a pool of tax revenues or premiums collected from individuals or markets, in accordance with the priorities of each sector. Social protection programs do this by providing cash or in-kind benefits under the public assistance scheme, or services and allowances funded by the government's general revenues. Social insurance also has a redistributive effect when government subsidies are provided or the amount of health insurance premiums is determined according to the income level of the insured.

C) Global recognition of the effects of social protection

The ILO has analyzed the results of impact assessments of existing social transfer schemes in 30 countries as shown in figure 1-1. These schemes have had positive effects on strengthening human development and productivity, on stabilizing consumption, and on promoting social solidarity and inclusion. Social protection has also contributed to the reduction of poverty, inequality, and income disparity,[23] and to the promotion of economic growth,[24] pro-poor growth,[25] and sustainable and inclusive development by redistributing the benefits of economic growth as widely as possible[26]. Social protection has also been instrumental in promoting equal opportunity by addressing social exclusion[27] issues and unemployment. Nevertheless, it has been pointed out that government strengthening of

[23] In OECD countries, it is reported that tax-based cash transfers contributed greatly to reducing income disparities. Also in Latin America, similar outcomes have been reported. OECD (2009c), ODI (2011)

[24] See OECD (2009c)

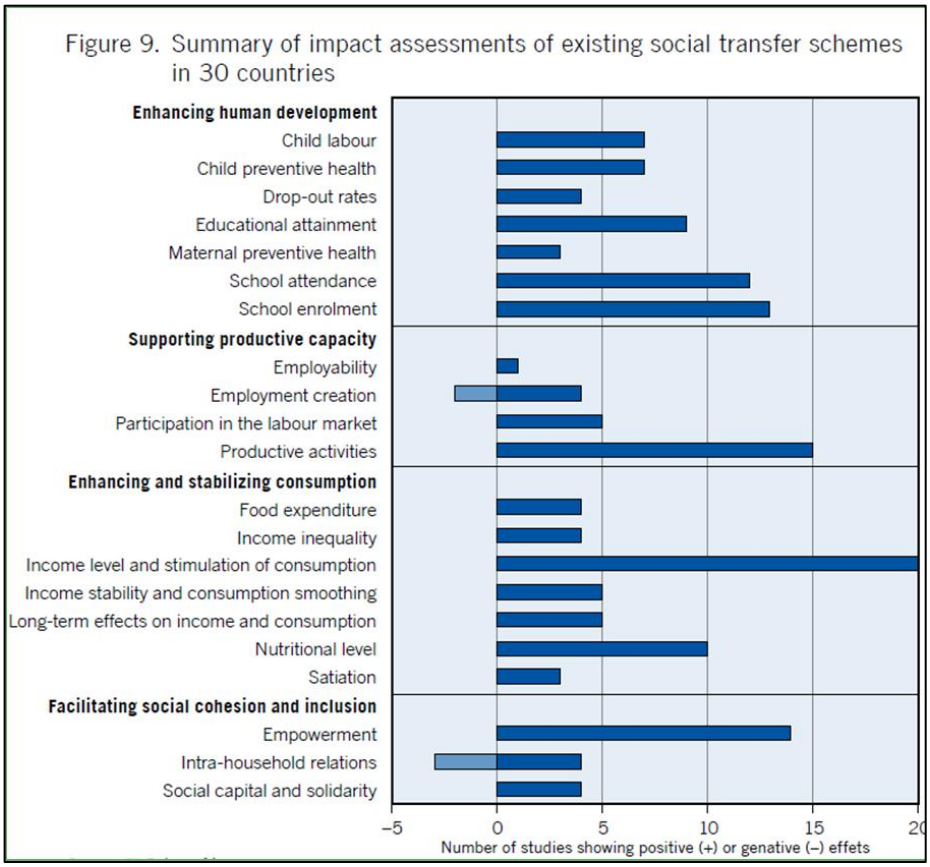
[25] OECD highlights the following five approaches for pro-poor growth: (a) investment in human capital, (b) risk management, (c) empowerment and livelihood, (d) macro-economic strategy, and (e) social cohesion and state building. OECD (2009c)

[26] See ILO (2011b) , OECD (2009c)

[27] It has been pointed out that it is important to promote affirmative action in social inclusion as a new direction of social protection. Social inclusion is a term referring to the reverse of social exclusion of individuals or groups in society. It promotes active integration of vulnerable individuals or groups in the population into mutual relationships within societies by restoring their connections with others and those excluded by societies due to poverty and unemployment.
UNICEF launched the Social Protection Strategic Framework in March 2012 establishing inclusive social protection as one of its principles. It discusses three specific dimensions of exclusion – gender, disability and ethnicity and also provides examples of instruments that specifically address exclusion and discrimination in accessing services and securing adequate standards of living. It also looks at how to mainstream inclusion in design and implementation. See UNICEF (2012) p81

redistribution systems is not enough to reduce inequality,[28] and that the role of social protection programs is shifting from maintaining stability in an individual's daily life to promoting economic and social independence.[29] In this context, the OECD emphasizes the importance of an integrated approach between social protection programs and labor policies.[30] Specifically, active labor market policies to improve skills are essential, for example, establishing job training programs to help the vulnerable become economically independent and creating an environment conducive to improving their economic situation in the medium- and long-term.

Figure 1-1. Summary of Impact Assessments of Existing Transfer Schemes in 30 Countries



Source : ILO (2011) Social Protection Floor for a Fair and Inclusive Globalization, p42

[28] Ihori (2009) P30

[29] See Itsuishi (2010)

[30] OECD (2009c)

BOX.1-2. Poverty reduction and social protection: Relationship with Millennium Development Goals (MDGs)

Social protection is gaining attention as an important instrument to achieve the United Nations Millennium Goals (MDGs). The MDGs are a common developmental framework agreed upon by the United Nations member states to eradicate poverty and hunger, to achieve universal primary education, to promote gender equality, to reduce infant mortality and to improve maternal health in the world's poorest countries. While efforts to achieve these goals have brought some results (the deadline is 2015), some reports have pointed out that benefits have not been distributed to the people who need them most. Now there is a growing awareness that economic growth and physical and social infrastructure alone are not enough to achieve the MDGs. Instead, supporting institutions should directly intervene in those areas that the poor would most benefit from and find the means to protect them from impoverishment in order to accelerate the achievement of the MDGs.[31,32] Although social protection measures are not explicitly included within the MDGs, almost all of the goals imply a strong connection and there is increasing evidence of the relationship between social protection and poverty reduction.[33] It has been reported that social protection contributes not only to poverty reduction, but also to improvements in nutrition, education, health, and to decreased infant mortality.[34]

Social protection in Brazil contributed to mitigating inequality, reducing poverty, while fostering economic growth and improvements in education and health. Between 1993 and 2008, the Gini coefficient was dramatically reduced from 59.4 to 54.2. The most notable program, Bolsa Familia, is a conditional cash transfer program that, between 2001 and 2004, reduced inequality by 30%. The purpose of the program is to improve governance, initiate related legislation, facilitate organizational reforms and invest in human capital. Examples of the results are that the Brazilian Congress passed the Basic Income Law in 2004, and that pension schemes have become embedded in the Constitution. Lessons learned are the following.

- Positive impacts of social assistance on poverty and inequality have been achieved as part of a broader social policy package, including investments in education, health and economic policies such as the minimum wage.
- Broad coverage and accurate targeting have contributed to the program's effectiveness in the reduction of inequality and poverty.
- High pension transfers linked to the minimum wage can ensure an increase in the real value of the transfers.

Source：ODI (2011) Brazil's story: Social protection in Brazil: Impacts on poverty, inequality and growth

[31] MDGs Summit in September 2010. For details see Annex 12

[32] The UN General Secretary highlighted that achieving the Millennium Development Goals will need accelerated interventions in key areas. These interventions should be framed within the broader developmental framework of national development strategies. See UNICEF（2010）

[33] See Barreintos and Hulme（2008）、ILO (2011b) , OECD (2009c)

[34] For programs to reduce the mortality rate among children, see Hypher (2011)

1-2-3. Definition of Social Protection

The definition[35], scope, goals, and roles of social protection vary from country to country and organization to organization, and the usage of terminology is also not uniform. Generally, the term 'social security' [36] is rarely used in Europe or by international development organizations. Instead, especially after the 1997 Asian Financial Crisis, 'social protection'[37] is often used. See Annex 5 and 6 for the usage of social security and social protection.

The scope of social protection in this Guideline

Social protection in this Guideline includes the following: a) public social assistance to guarantee a minimum standard of living, b) public non-contributory programs offering in kind or cash transfers, c) social insurance programs through contributions as citizens' mutual aid funds, d) public services for vulnerable groups such as the elderly, children, people with disabilities, and single-mother households, and e) programs to develop beneficiaries' coping skills. While a state has the primary responsibility for establishing and implementing social protection programs, the Guideline includes the state's support/coordination role for effective implementation by NGOs and community resources that offer informal services.

This thematic guideline addresses social health protection, income security and social welfare, which are categorized by the purpose and the function of the programs.[38] Another categorization is social insurance, social welfare services and social assistance, which is based on how the programs are designed. This guideline adopts the categorization based on the purpose and function of the programs, namely: social health protection, income security (including pension), and social welfare.

Social health protection consists of two aspects: service provision and finance. These two are significantly linked to each other. This Guideline focuses on health care financing because JICA's health sector has a separate Guideline for health care provision. Although education, poverty reduction, agriculture development, public finance management, disabilities and development overall are important for social protection, they will not be covered in this Guideline as these sectors have separate guidelines. For income security and inclusive growth, active labor market policies, which refer to the policies supporting unemployed people in order to find job opportunities by providing career guidance at public employment agencies or skills development at skills development institutions, are equally important and the assistance need from developing countries is quite high. However, this guideline does not include them as the aid approach and necessary resources are quite

[35] See ILO (2010c)

[36] The term "social security" ("Shakai-hosho" in Japanese) is relatively new. The term was coined from a combination of "social insurance" and "economic security" in the process of drafting the Social Security Act by the US Congress during the Depression of the 1930s , The term, later, became widely used, including Japan.

[37] "Social Protection" came to be used when the concept of the welfare state was first used in Europe and the purpose was to guarantee a minimum standard of living and respond to temporary poverty. In Japan, Social Protection is often translated as Shakaiteki-hogo. Looking at the historical development of social protection, what was called "social security" at the early stage of development means so-called social insurance now. In recent years the concept of social security has expanded though the scope of Social Security and Social Protection remains the same. Thus, in this Guideline, social protection is considered a more encompassing concept than social security and translated as Syakai-hosho.

[38] Hiroi・Yamazaki (2007)

different from those of health care and income security. Developing a separate guideline on labor is to be considered.

Definition of social protection per major international development agencies

This section looks closely at the definitions given by the ILO and the World Bank which are major donors to social protection.

The ILO's objectives are based on policies to promote social justice by improving labor conditions, supporting full employment and union-management cooperation, and promoting social protection. The ILO uses a human rights based approach[39] consisting of the three principles of universalism, solidarity and distribution. The World Bank, on the other hand, promotes the Social Risk Management Approach. The Social Risk Management Approach views social protection as part of a poverty reduction strategy, aiming for individual empowerment (especially among the poor) by supporting not only risk reduction, but also risk management. The advantage of a human rights based approach is to address equality issues to eliminate discrimination, whereas the advantage of a social risk management approach is that the concept is more encompassing than social security.

The ILO has adopted various social protection standards such as the Social Security (Minimum Standards) Convention, 1952 (No. 102), Social Protection Floors Recommendation, 2012 (No. 202). In the Social Security (Minimum Standards) Convention, 1952 (No. 102), the minimum standards of benefits in each program are set. (See Annex 4 for more details.) Recommendation 202 calls for ILO members to establish basic health care service and income security programs. (Social protection floors will be mentioned later.)

Table 1-2. Definitions and Approaches by ILO and the World Bank

	ILO	World Bank
Definition	Social security: it covers all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from (a) loss of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) lack of access or unaffordable access to health care; (c) insufficient family support, particularly for children and adult dependents; (d) general poverty and social exclusion	Social security is not used.
	Social Protection: It is often interpreted as having a broader character than social security (including, in particular, protection provided between members of the family or members of a local community), but is also used in some contexts with a narrower meaning than social security (understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of the society).	Social protection and labor systems, policies, and programs help individuals and societies manage risk and volatility and protect them from poverty and destitution – through instruments that improve resilience, equity, and opportunity.
Approach	Human rights approach Two dimensional approach	Social risk management
Goal	Social stability, fair growth, enhanced productivity Source: ILO (2010) Social Security Report	Resilience, Equity, Opportunity: prevention of individual risks, equity by income distribution, increased opportunities by labor policies Source: WB (2012) Social Protection and Labor Strategy

[39] According to Munro (2010), there are three approaches in social protection as basic principles: risks, needs and rights.

1-3. Trends in International and Japanese Assistance

1-3-1. Trends in International Assistance

1-3-1-1. Overview

International assistance was first implemented in the early 1950's, when the ILO supported the social protection systems in the Philippines, Thailand, and Indonesia with the objective of worker protection.[40] In the 1970s, the World Bank initiated the practical implementation of cooperation for institution-building in the fields of social funds, social safety nets and pensions.[41] In the 1980s, social protection programs were established to alleviate the hardship caused by reduced social welfare services under the structural adjustment policies implemented in developing countries. In the 1990s, social protection programs were set up in the former communist countries to reduce the shock market-oriented economic reforms were having on the citizens' lives.

After the 1997 Asia Financial Crisis and in response to the rapidly changing socio-economic environment in its aftermath, the institutionalization of comprehensive and sustainable social protection programs that address various needs and target the entire population is becoming a global social policy priority. The need for strengthening social protection assistance has been recognized at major international meetings, such as the G8 and G20 summits, and the High Level Forum on Aid Effectiveness.[42] Today, many donors such as the EU, bi-lateral donor organizations, and NGOs as well as the ILO, World Bank, and ADB are expanding the scope of assistance to incorporate the concept and term "social protection" in their development frameworks and regard it as a high priority. [43]

1-3-1-2. Importance of Medium- and Long-term Assistance

Since the 1997 Asian Financial Crisis, the trend of cooperation and support activities for social protection development by international agencies has shifted from short-term assistance (mainly social safety net programs) to medium-and long-term assistance.[44] Various social safety-net programs, [45] food assistance and temporary transfer of income programs targeting the poor and jobless were implemented by various donors responding to the crisis. These actions contributed to reducing the shock and prevented the situation from worsening in the short term. In the meantime, the international community became aware that in order to mitigate the impact caused by the crisis and to strengthen the capacity for countries' to deal with future risks, it was necessary to institutionalize these isolated and short-term social safety net programs. It also found that it was important to establish

[40] ILO (2008a)

[41] WB (2001)

[42] The recent G8 and G20 summits mentioned social protection. See Annex 12.

[43] See UN, ILO, World Bank, UNDP, UNICEF, WHO, WFP, ADB, AusAID, DFID, USAID, HAI (Help Age International)

[44] See Osawa (2004), Deacon (2011)

[45] For example, social safety net programs implemented in Indonesia focused mainly on ensuring access to health care and education for the poor, scholarship programs, foods assistance, public works to create employment, skills training or job matching programs for the unemployed, and to provide funds for economic stimulation. Source: Takeda (2002）

sustainable social protection systems that targeted poverty reduction. For example, the UK's Department for International Development (DFID) has been supporting Kenya financially and technically for 10 years in their efforts to build a social protection system.[46]

1-3-1-3. Importance of the Role of Government as Coordinator

Social protection is a mechanism whereby a state is responsible for securing the lives of its citizens. Although government intervention will continue to be indispensable, the state alone will not be enough to address the current issues discussed in Chapter 1. Assistance programs that engage stakeholders other than the state will need to be established.

The increasing role of the community is becoming a common trend not only in developing countries but in developed countries as well. Especially in the sector of health, long-term care and childcare reforms are underway to transfer the authority of service provision to local governments or to expand the service providers from state owned providers to the private sector including NGOs in the communities and for-profit organizations.[47] As governmental, human, institutional and financial capacities are limited in developing countries, it is difficult for states to provide all the necessary social welfare services. Organizing informal resources and volunteers in communities and strengthening collaboration between them and professional services can lead to efficient and effective implementation of social welfare service provisions, which in turn can lead to increased financial sustainability. Asian countries cannot expect to see high economic growth like that of 1960s' Japan and will therefore need to build social protection systems within their financial constraints. This can be done by utilizing informal resources in the community, for example, private organizations with community participation that will provide certain services.[48] Without limiting their actions to formulating systems, international donor entities such as the World Bank, have started to support the activities of local governments, private organizations or NGOs for the purpose of valuing and strengthening traditional mutual assistance mechanisms within families and communities.[49] It has to be noted, though, that there are no concrete solutions for how to utilize traditional mutual assistance mechanisms and for how to maintain and strengthen community ties weakened by modernization.[50]

[46] For example cash transfers for orphans and vulnerable children. More on DFID's website www.efid.gov.uk

[47] Hiroi/Yamazaki (2007)

[48] For example, international instruments supporting informal carers are: Madrid International Plan of Action on Ageing 2002、UN Convention on the Rights of Persons with Disabilities (2006)、and Long-term Care in European Union (2008). EC funded research has found that public support and policies supporting informal social resources are not sufficient in EU countries. Triantafillou et al (2010)

[49] Oizumi（2006）

[50] Aratame (2006)

BOX.1-3.【Micro health insurance for those excluded from formal insurance】

In developing countries, micro health insurance schemes have been implemented in rural areas and among workers in the informal sector where there is no public insurance available. Although this is still in the exploratory stage, positive results have been reported to some extent. Those involved are organizations based on profession or ethnic group, women, NGOs, churches, hospitals and others. In India, it is reported that there are 370 million working in the informal sector, of which only 8 percent (30 million people) are covered by health insurance schemes.[51]

One example of success in India is the micro health insurance covering members of the Self Employed Women's Association, which is now a labor union.[52] The Self Employed Women's Association was established in 1972 for women working in the informal sector. The number of members covered by the insurance was 32,000 in the beginning but has now expanded to 200,000 across 4 states where Gujarat is the core (as of 2010). Subsidies from the state government contributed to the increase in membership. In the beginning, the beneficiaries were only association members but this was later expanded to include family members and children. There are different provisions in the insurance. The premium for women is US$4 (175 INR), for their dependents US$3 (125 INR), and for their children US$2 (100 INR)(as of 2010). Outpatient treatment is not covered by the insurance but cash benefits will be provided for hospitalization. The benefits are US$222 for death (for death by accident US$888), hospitalization (incl. childbirth) US$44.4, and loss of assets US$222. In the future, membership will expand to 350,000 people when states other than the current 4 are included.

In Ghana, the Mutual Health Insurance Organization (MHO) established a micro health insurance plan at the beginning of the 1990s.[53] The voluntary, community based MHOs, started out at the local level, pooling risk for their members, and by 2003 numbered in excess of 250, but on average covered no more than 1,000 people. With the passage of the National Health Insurance Act in Ghana, only district-level schemes were allowed, and MHOs were incorporated into the public health insurance program. The MHOs were allowed to retain a degree of operational autonomy as long as they charged the premiums set by the NHIS, and offered the benefit package that was determined at the national level. To make the membership for national health insurance more affordable, most of the costs are funded by taxes. There are no out of pocket payments, and elderly members are exempted from paying premiums. A major source of funding for the NHIS is a 2.5% levy, called the National Health Insurance Levy, which comprises four thirds of the fund, premium contributions account for 5%, and the remaining by a payroll tax of 2.5% paid by employers. Issues of sustainability and coverage extension remain. (Currently the coverage rate is 34%).

Micro health insurance and UHC：Micro health insurance is usually small scale and does not target the poorest. Thus, it has been pointed out that the issue of coverage remains. To solve this, it is suggested that there is a need for measures that contributions from the poorest should partially or entirely be paid by subsidies from governments.[54] Ghana's case shows us a path to achieving UHC by expanding public health insurance coverage by utilizing an existing micro health insurance program.[55]

[51] ILO (2001) (2009)
[52] ILO (2008c)
[53] WHO (2011b)
[54] Jacobs et al (2007)
[55] ILO's project "Innovative facilities for micro insurance" presents information about micro health insurance from over 40 countries on the website http://www.microinsurancefacility.org/en/hwg/products

BOX.1-4.【Community-based Mutual Assistance in Indonesia】

In Indonesia, there is a tax-based public social health protection program for impoverished households. However, his program does not cover the costs of transportation or attendants. In some regions where the access to health care is difficult due to the lack of nearby medical institutions, community-based mutual assistance mechanisms have appeared. For example, health volunteers perform daily public health promotion activities in collaboration with village leaders, such as a village chief, and residents contribute some money or food to be used when other residents become sick or to maintain their minimum standard of living. Unlike this kind of voluntary contribution, residents are reluctant to join a contributory program which requires them to pay a set monthly amount. This point is very important when deciding what kind of health protection is suitable through social insurance can be promoted in Indonesia.

Source： JICA (2012) Survey report on social protection in Indonesia

1-3-1-4. Major Donors

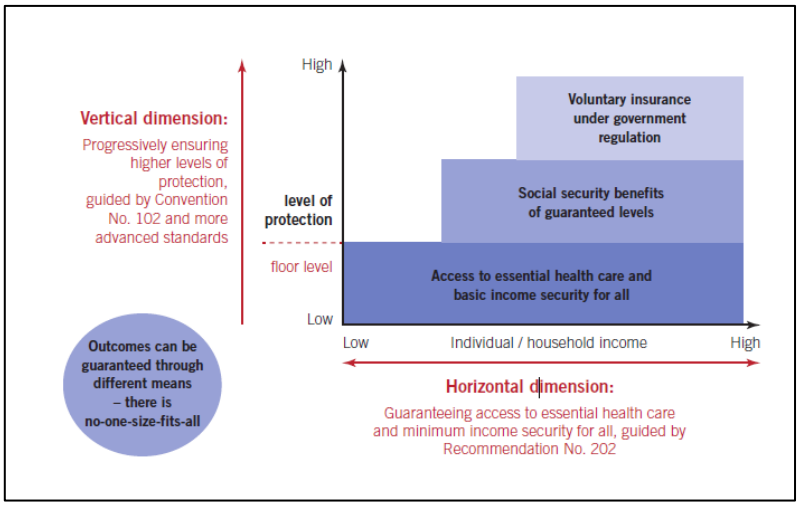
As mentioned above, some major aid organizations are becoming leading donors, for example, the ILO, World Bank, Asian Development Bank (ADB) for multinational aid, Deutschen Gesellschaft für Internationale Zusammenarbeit (GIZ) and the Department For International Development (DFID) of the UK for bilateral aid. Since each donor has its own field of expertise, they are providing social protection support within their specific field. (See Annex 11)

The World Bank supports social protection and labor programs in developing countries as a central part of its mission to reduce poverty through sustainable and inclusive growth. The Bank promotes a system approach aimed at improving individual or social resilience, equity and opportunity and its areas of assistance are wide ranging. The World Bank actively utilizes Conditional Cash Transfers in connection with the promotion of health and educational services, which have been successfully implemented. Further efforts will be made in this area. According to their social protection and labor strategy, in FY2009 through FY2011, largely in response to the global economic crisis, social protection and labor lending increased fivefold, representing the largest sectoral increase in World Bank lending over this period.[56] In order to meet constantly changing needs in midst of the global financial crisis, the World Bank released its “Social Protection & Labor Strategy 2012-2022” in April 2012 and “Africa Social Protection Strategy 2012-2022” in June 2012.[57]

[56] WB (2012a). According to the 2012 World Bank annual report (2012f), the World Bank lending in social protection is USD 1.6 billion in 2007, USD 800 million in 2008, USD 5.3 billion in 2009, USD 5 billion in 2010, 5.7 billion in 2011, and 3.5 billion in 2012. .

[57] The World Bank implements numerous impact evaluations of CCT-centered safety nets. See Box 3-1 and more details on their report WB (2011b).

Figure 1-2. ILO's Two Dimensional Approach



The ILO adopts a human right approach of social protection and supports developing countries aimed at the protection of workers' rights and the promotion of conventions and standards on social protection. The Organization also has a tripartite governing structure (representing governments, employers and workers). Although the ILO has focused on the protection of workers in the formal sector, it has become actively involved in projects for coverage expansion among workers in the informal sector. It launched the social protection floor initiative with the UN in 2009.[58] The objective of the initiative is to start minimum social protection and gradually reach higher levels of social protection according to the economic growth in low-income countries. The final goal is to cover the entire population (the principle of progressive universalism.[59] The focus is especially to protect and empower vulnerable groups throughout their lives. Minimum social protection programs in low-income countries means (a) access to essential health care for all, (b) income security for children, (c) social assistance for the unemployed and poor and (d) income security for the elderly and people with disabilities.

1-3-1-5. Trends in Each Program

A) Social Health Protection

Leading institutions dealing with universal health coverage (UHC[60]) are international organizations, such as WHO, the World Bank, and ILO. In addition, the Rockefeller Foundation and International Development Research Center (IDRC, Canada) have become involved.

Global Partnership : Providing for Health Initiative (P4H)

In 2004 the GIZ, the ILO, and WHO established the Consortium on Social Health Protection in Developing Countries to unify programs in social health protection. Under the Consortium, collaborative programs were implemented in Kenya and Indonesia, and an international conference on social health protection was held in Berlin in 2005. In line with the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) and as a continuation of the Consortium, the Providing for Health Initiative (P4H) was launched as a global network at the G8 summit in Heiligendamm, Germany in 2007. P4H comprises 8 organizations: the World Health Organization (WHO), the World Bank, the International Labor Organization (ILO,) the African Development Bank (AfDB), the French Ministry of

[58] More on the ILO Tokyo Office website http://www.odi.org.uk/PPPG/cape/publicatio ns/tc_social_protection_donors.pdf

[59] The concept of universalism is not adopted in the ILO 102 Convention.

[60] More details will be discussed on Chapter 2-1-1, Box.2-1.

Foreign and European Affairs, the German Federal Ministry for Economic Cooperation and Development (BMZ), the Swiss Development Cooperation (SDC) and the Spanish Development Cooperation Agency (AECID). WHO has the role of secretariat. The purpose of the P4H is to support developing countries in establishing social health protection systems aimed at preventing financial hardship due to medical costs for health services. One of its recent activities is the development of a guidebook for planning social health insurance in 2009. In Cambodia, the Memorandum of Understanding on social health protection was developed between Cambodia and the AFD, WHO, GIZ, ILO in 2009, which includes policy formulation assistance, technical assistance, capacity development of policy design and implementation, and the development of models aimed at coverage expansion. The P4H is active in 17 countries in Africa and Asia.

B) Income security

Non-contributory and tax-based cash transfers (public assistance) for income security among the poor, as implemented in developed countries, was not common in developing countries. However recently, cash transfers started being implemented by donors such as the World Bank, ILO, UNICEF, DFID and HelpAge International as an effective instrument of poverty reduction and coverage extension. Conditional Cash Transfers (CCT), which have become quite common mainly in middle-income countries, have had positive results in improving children's nutrition levels and school enrollment rates. However, the big issues, such as the financial sustainability and legal rights to receive the benefits, remain.[61]

Having established a pension section for social protection, the World Bank has been implementing more than 140 pension projects in more than 60 countries since 2002. The ILO has been promoting the Social Protection Floor aimed at coverage expansion including the establishment of access to essential health care for all, income security for children, income security for the un-/underemployed and poor, income security for the elderly and people with disabilities. The ILO supports technical assistance including technical advice and training in financial management, statistics, and fund management, emphasizing the importance of adequate administration and governance of pension schemes.

C) Social welfare

This section focuses on donor activities in social welfare for children, the elderly, and persons with disabilities, similar to the ILO's Social Protection Floor.

Children: UNICEF launched the strategy on social protection for children in March 2012, titled Integrated Social Protection Systems – Enhancing Equity for Children. UNICEF supports social protection and adopts a human rights approach towards the establishment of universal coverage systems and an inclusive society. UNICEF supports activities in collaboration with other organizations. For example in Kenya, it supports cash transfers to families with orphans and children with disabilities in collaboration with the World Bank. In Zambia, a pilot project was set up in collaboration with DFID and Irish Aid targeting poor

[61] More Information about cash transfer programs for children can be found in Barrientos and DeJong (2004) Child Poverty and Cash Transfers.

families with unmet basic needs. In addition, collaborating with Irish Aid and the Institute of Development Studies, UNICEF analyzed how to end the inter-generational transfer of poverty in social protection programs implemented in Kenya, Zambia and Mongolia.[62]

The elderly: Under the 2010 UN resolution[63] a working group was established to produce the Convention for the Rights of the Elderly. The Convention is expected to include the elimination of discrimination and violence against the elderly, rights to health, and rights to social protection. In 2012, UNFPA and HelpAge International released a report titled "Ageing in the Twenty-First Century: A Celebration and A Challenge". The report features voices from the elderly pointing out the need of equitable access to health and financial protection, the elimination of discrimination, violence and abuse against the elderly, as well as the need to respect the elderly as active citizens in society, while emphasizing the need for investment in the young who are the elderly in the future.

Disability: The UN Convention for the Rights of Persons with Disabilities was adopted in 2006. The 28th article lays down the right to an adequate standard of living and social protection for people with disabilities. In 2011, WHO and the World Bank launched the first world report on disability, which details the disadvantages in accessing social protection among persons with disabilities in comparison to those without disabilities.
(Refer to the JICA Thematic Guideline on Disability and Development for detailed information on donors and disability and development.
（Refer to the Annex 11 for detailed information of donor assistance on social protection.）

1-3-2. Trends in Japanese Assistance

1-3-2-1. Government Assistance

After Prime Minister Ryutaro Hashimoto proposed the "Initiative for a Caring World", the Japanese government's assistance for social protection was enhanced, leading to periodic international meetings including "ASEAN and Japan High Level Officials Meeting on Caring Societies", "ASEAN+3 Ministerial Meeting on Social Welfare and Development" and "ASEAN+3 Health Ministers Meeting".

The Japanese government implements assistance by providing human resources to JICA projects, accepting technical trainees, and undertaking and supporting projects by Japanese organizations in international cooperation. It also provides funds to international organizations such as WHO and the ILO for their programs related to social protection. With ASEAN countries in particular, the government exchanges views at the minister level and implements projects in coordination with the ASEAN secretariat. With the ILO, the government implements projects for APEC member countries.

[62] Jackson, C (2011)
[63] The UN resolution on the establishment of working group A/RES/65/182 (2011)

A) Initiative for a Caring World

At the Lyon Summit in June 1996, then Prime Minister Ryutaro Hashimoto proposed the "Initiative for a Caring World" This initiative has been greatly supported by many other countries and international organizations. The initiative aims to support the development of social protection systems and human resources, while pursuing economic development, by presenting the experiences (both successful and unsuccessful) of developed nations to developing countries on a wide range of social protection issues, including public hygiene, health insurance and pension systems. Developed countries are also asked to share their knowledge and experience on the direction of reform of social protection systems and efforts in tackling common issues such as the ageing of society, slowed economic growth and financial difficulties in the government sector.

Activities under the initiative are conducted with ministerial cooperation as follows: (a) projects for developing countries, (b) projects for developed countries, and (c) global activities. The initiative contributed Japan's expansion of assistance in social protection and lead to such activities as information exchange opportunities and the convening of periodic meetings such as "ASEAN and Japan High Level Officials Meeting on Caring Societies" (annual), the "ASEAN+3 Ministerial Meeting on Social Welfare and Development" and "ASEAN+3 Health Ministers Meeting", which are hosted by the Ministry of Health, Labor and Welfare (MHLW). Participants in each meeting are officials (director-general level) in charge of social welfare and health care policies from 10 ASEAN member states and neighboring countries. The purpose of these meetings is to exchange opinions on coordination between welfare and health and to seek ideal ways of cooperation and development of human resources in this area. Prior to holding these meetings, the MHLW convened the "East Asian Meeting of High-Level Officials on Caring Societies" five times between 1998 and 2003 for the purpose of further deepening the discussions, in response to the East Asian Ministerial Meeting on Caring Societies held in December 1996 in Okinawa.[64]

B) Training programs

Training programs targeting social welfare officials in developing countries were launched in 1983 and were commissioned to the Japan International Corporation of Welfare Services (JICWELS) by MHLW. After the budget for this training was transferred from MHLW to the Ministry of Foreign Affairs, the title of the training changed to "Social Welfare Administration" and "Social Insurance Administration", which had been implemented by JICA in cooperation with MHLW and JICWELS until 2012. In 2013, the training will focus on capacity building in social insurance and universal health coverage.

C) Technical assistance to labor through ILO : ILO/Japan Multi-bilateral Project (the fiscal year 2010～2013)

There is a concern that unemployment might lead to societal instability in ASEAN countries by widening income gaps and increasing social inequalities. As a response to this concern, a program to establish social safety nets in Asia, especially the implementation of active labor policies and unemployment schemes, has been conducted through the ILO

[64] See Annex 1.

Multi-bilateral scheme in collaboration with the ASEAN Secretariat and Japan. It offers support to ASEAN member governments in setting up instruments and institutions allowing immediate measures to guarantee income replacement to the unemployed and opportunities to re-enter the labor market. ASEAN member countries striving to establish unemployment insurance (UI) schemes are the targets of this project. Specifically, the project provides technical assistance to Viet Nam to improve its UI scheme. Expected outcomes are: (a) the establishment of schemes through regional seminars and consultations and by sharing experiences of UI schemes, (b) the implementation of fellowship programs to strengthen the capacity of labor services and institutional capacity that will devise UI schemes for job matching and certification of unemployment services.[65]

1-3-2-2. JICA

JICA has conducted technical cooperation since the 1990s mainly in the area of employment and labor, focusing on the development of vocational skills and occupational safety and hygiene. Cooperation in the area of social insurance and welfare was provided mainly in the form of the dispatch of short-term experts and Japanese Oversees Cooperation Volunteers (JOCV), while long-term commitment was rather limited.[66] However, since 2000, assistance has been expanding geographically and in the area of social insurance and welfare. Long-term experts in social protection have been dispatched to Southeast Asian countries to understand the local conditions better and technical and survey projects were initiated in the region. In Central and South America, social welfare programs for the elderly and children were implemented. In 2012, a basic information survey was conducted to understand social protection systems in 7 countries in the ASEAN region (Cambodia, Indonesia, Laos, Malaysia, Philippines, Thailand, and Vietnam). For detailed project information, refer to Annex 1.

[65] More on the Ministry of Labor, Health and Welfare (2010)

[66] For more on JICA's assistance to disability and development, see the Thematic Guideline on Disability.

Chapter 2. Effective Approaches

The government has the primary responsibility for providing social protection. The objective of JICA's cooperation in social protection is to provide support, primarily to the governments of developing countries, in developing and implementing effective social protection programs. From the perspective of the government officials who draft and implement policies, three perspectives must be considered when establishing a social protection program: (a) the suitability of the program design, (b) effective and efficient administration of the program and (c) infrastructure, personnel and systems supporting the program. We will examine the current issues and effective approaches to these issues in terms of the three perspectives. JICA has carried out basic surveys in the social protection field, primarily in ASEAN countries, and these three perspectives were deduced from the various issues identified in the survey results.[67]

This chapter will explain the three perspectives in 2-1, and describe effective approaches in the three areas of social health protection, income security and social welfare services according to the level of a country's economic development in 2-2.[68] Annex 1 and 11 provide project examples in this area that JICA and other donors have addressed.

2-1. Three Perspectives to Consider

2-1-1. Suitability of Program Design

The suitability of social protection programs is assessed in terms of whether the program's design is consistent with citizens' needs, whether the program is matched with the country's economic and fiscal conditions and whether the program is financially sustainable. A social protection program's design must be considered in terms of its components, specifically (a) the population eligible for the social protection program, the range of services or payments offered (i.e., the program's "coverage") and (b) how the program will be funded.

[67] Surveys conducted in Thailand, Indonesia and Vietnam in 2010-2011 were used as a reference. JICA (2010), (2011a), (2011b)

[68] Here, we have defined a nation's economic development based on its income bracket, but according to Oizumi, given the relationship between a country's social protection program and the national socio-economic system, we could also use the classification of "groups of countries that are socialist or Communist or have adopted similar systems (and countries that are shifting from such systems to a market economy)" (China, Vietnam, Laos, etc.). Oizumi (2006)

A. Coverage of social protection program

According to the ILO and WHO, a social protection program's coverage consists of the following three aspects: (a) scope (which services are covered), (b) extent (who is covered), and (c) level (proportion of the costs covered). These aspects are described in the table below.

Table 2-1. Three Aspects of Coverage

Scope (Expansion in types of benefits and services covered)	The ILO's Social Security (Minimum Standards) Convention (No. 102) identifies the following types of benefits: medical care, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits, and survivors' benefits. Similarly, the ILO's Social Protection Floors Recommendation (No. 202) states that the social protection floors should comprise at least the following: (1) national access to medical care, (2) basic income security for children, (3) public assistance for the unemployed and poor, and (4) basic income security for the elderly and persons with disabilities. The types of services covered by medical benefits also matter—for example, the question of which specific medical services will be covered by benefits, and whether preventative services and advanced medical services will be covered.
Extent (Scope and number of those covered)	When considering those covered by social protection, the main groups mentioned are: when considered in terms of occupation, public employees and private-sector corporate employees (workers in the formal sector), the self-employed and agricultural workers (workers in the informal sector), and the unemployed; in terms of the economic role in households, the main groups would be supporters and dependents. Particularly vulnerable groups are children, women, the elderly, persons with disabilities, those infected with HIV/AIDS and migrant workers. The issue here is the extent to which national citizens overall and workers overall will be covered by social protection.
Level (Improvements in proportion of costs covered)	This addresses the issue of the extent to which the medical costs incurred will be covered by the health insurance program—in other words, what proportion will the beneficiary pay him/herself. In terms of income security, the issues are the level at which unemployment benefits and pension benefits are set relative to salary prior to retirement and the salary of the generation still working, and to what extent cash benefits and benefits in kind will cover the basic costs needed to maintain a bare minimum standard of living. The ILO's Social Security (Minimum Standards) Convention (No. 102) stipulates the minimum standards for benefit coverage, and requires that signatory countries observe this standard, while non-signatory countries should use it as a reference.

Box 2-1: What is Universal Coverage?

Universal coverage refers to a social protection program in which all of a country's citizens are eligible, are enrolled and are beneficiaries. This term is often used in Japan in the context of expanding the beneficiaries of its social health insurance, but in developing countries, it not only refers to expanding the number of those enrolled in the social health insurance programs, but also the expansion of some sort of public program, such as a public assistance program. "Universal coverage" is used as a policy goal. For example, Thailand achieved universal health coverage through a tax-based model to ensure access to medical services to those without social health insurance. This publicly funded medical system (the so-called 30 baht program), which formally provides universal coverage, is generally known as the "UC program."

According to WHO's definition, universal coverage for health (UHC) is "when all people have access to health services (promotion, prevention, treatments and rehabilitation), without fear of falling into poverty"[69]

The ILO states that a minimum level of income should be guaranteed to all the elderly, and similarly, a minimum level of income should be guaranteed in the event of the death of the head of household or in the event of a disability.[70]

Box 2-2: Necessary Information when Designing a Program to Ensure the Program's Suitability[71]

Information needed to design social health protection systems

Designing a program requires that data be obtained. On the healthcare demand side, this would include data on patients' healthcare seeking behavior, disease structure and medical services provided to them, as well as their use of pharmaceutical products; while on the healthcare provider side, data would include the number, distribution of various levels of medical facilities, the cost of each medical service, the price of pharmaceutical products, and the financial situation of the medical facilities. Data related to insurance administration includes the age and income distribution of the target population and the age and number distribution of non-working dependents. The medical needs of citizens and the medical institutions' capacity to provide services should also be ascertained, as well as the cost of medical services. A lack of medical services is often a problem in the social health protection systems of developing countries, and there are many cases in which medical resources are concentrated in a particular region. This means that objective data is important to ensure

[69] WHO (2010)

[70] ILO (2010c)

[71] In Japan, this data is primarily compiled through regular surveys conducted by the government, including patient surveys (type of diseases and injuries along with the medical service provided to them), the Survey of Medical Care Activities in Public Health Insurance (medical service provision, type of diseases and injuries, and use of drugs, among other data), the Survey of Medical Institutions (distribution of medical institutions), Survey on Economic Conditions in Health Care (financial situation of medical institutions), Survey on Pharmaceutical Prices (price of pharmaceuticals), trends in medical costs (costs related to healthcare), National Livelihood Survey (household income and expenditures), and demographic surveys (births and deaths), among others.

that medical services are provided equally.

Information needed to design income security programs

In designing the program, demographic and mortality tables must be prepared[72], the age and income distribution of the target population and household expenditures must be ascertained, and information such as projections of future prices and wages and asset investment forecasts must be obtained.

Information needed to design social welfare services

An adequate understanding of the problems that people living in the relevant regions face in their everyday lives is very important. Accordingly, a survey addressing both quantitative and qualitative aspects with a focus on means of maintaining livelihoods and risks faced in everyday life is needed.

Box 2-3: Policies with the same function as social protection

Social protection is not just a single means of achieving the objective of the well-being of citizens. Other specific programs serve a similar function. Just because a country may be behind in establishing a social protection program as defined by developed countries does not necessarily mean that public welfare lags behind. Different methods may be employed to achieve public welfare as defined under a different concept. It is important to check whether an alternative system functions. For example, in Japan this would include local governments' social welfare activities, corporate welfare such as housing benefits, wage systems and retirement allowances, aftercare plans under labor agreements, private-sector insurance and savings plans.[73] The community-based mutual assistance mechanisms in villages in agricultural countries are another important kind of welfare program.

B. Program financing

Social protection programs support citizens' lives, and once a program is established it must continue to be administered, which means that financial sustainability is extremely important in building trust in the program.

Ensuring the sustainability of a social protection program means that the financing for it must ultimately come from within the country, not aid from external organizations. In low-income countries, aid from external organizations can be effective in facilitating the program's implementation when a social protection program is introduced. However, the long-term fiscal stability of the program cannot be guaranteed unless a domestic funding source is secured to run the program. Relying on financial support from donors results in problems in terms of independence.[74]

[72] Mortality tables show, for each age, the probability that a person of that age will die within a year (probability of death) and the average remaining life expectancy.

[73] For details on these policies, refer to p. 127-131 of *Dai jyu-hakkai shakai hosho no shuhen ryoiki* by Shinichi Oka (2006).

[74] OECD also states in "Perspectives on Global Development 2012, Social Cohesion in a shifting world" (2011) that providing aid for a social protection program sends the wrong signal that domestic financing is being ignored, so by supporting public fiscal management, such as tax collection, aid organizations can help to improve a program's

There is a tendency to assume that only high-income countries can build social protection programs, but in 2010, the ILO estimated the current and future cost of establishing the requisite social protection floor in seven countries in sub-Sahara Africa and five in Asia, and found that the initial cost of implementing such a program would be 2.2-5.7% of GDP. In this estimation, the requisite social protection floor refers to universal old-age pensions, disability pensions, child benefits, basic healthcare for all citizens and unemployment insurance (100 days). What this suggests is that even low-income countries could bear the financial costs of such a program.[75]

The financing methods can be roughly divided into the contributory method where the subscribers pay a contribution, and non-contributory method where the subscribers do not pay a contribution but rather payments are made through a general revenue. In some cases, user charges may be levied when benefits are provided in the form of services, as with healthcare and social welfare services. In all of these cases, public spending (taxes) are an important funding source for social protection, and since citizens are required to pay taxes and insurance premiums, the tax system and social insurance must be addressed in an integrated manner when designing a social protection program.

Box 2-4: Social Protection and Financial Sustainability

The main points in regards to social health protection and income security, which have a particularly large fiscal scale, are outlined below. When the fiscal scale of social welfare services increases, like long-term care insurance, the points at issue are similar to those for healthcare.

Social Health Protection

- **Where will financing come from?:** A wide range of funding sources are often combined in order to enhance the financial sustainability of programs. For example, Japan's health insurance program is essentially financed by insurance premiums paid by the insured and employers, while the community-based health insurance programs aimed at the informal sector and healthcare for the elderly are financed by both insurance premiums and public funding. In Thailand, healthcare is financed by contributions made by the insured and employers of public employees, while public funding covers healthcare for all other citizens. Indonesia and Vietnam's health insurance plans are contributory systems, and the government subsidizes insurance premiums for the poor. In some countries, such as Malaysia, medical care in public hospitals is funded by the government. Some countries in which social health protection is publicly funded have set up specific funding sources, as in Thailand (part of the revenue from tobacco and alcohol taxes, also known as the "sin tax," is allocated to social health protection).
- **How can healthcare be provided more efficiently?** Raising the efficiency of the provision of healthcare is extremely important in ensuring financial sustainability. For example, according to a WHO report[76], 20-40% of the resources used in healthcare go to waste. WHO attributes this to excessive use of expensive pharmaceutical products and antibiotics, inadequate management of pharmaceutical products, low motivation on the part of medical

sustainability.

[75] These research results unambiguously suggest not that developing countries should set up social protection using its own funds, but that social protection promotes economic growth and can be an effective means of reducing disparities and poverty, and thus there is value in establishing such programs. ILO (2008)

[76] WHO (2010)

practitioners, inefficiency of hospital administration, delayed treatment resulting from inaccurate diagnoses, corruption among medical practitioners, and inadequate assessments. Accordingly, standardization of medical processes and pharmaceutical use, appropriately motivating medical practitioners, and standardizing operations and establishing accounting systems at medical institutions are all essential in improving the efficiency of operations.

- **How can the increase in medical costs be controlled?** In general, medical costs increase as a result of technological advancements, a higher standard of living and changes in the demographic structure. Accordingly, introducing a mechanism to control medical costs so that the growth in medical costs can be restrained to reasonable levels is important for the program's financial sustainability. Countries that publicly fund social health protection provide medical care within the scope of their budget, so it is relatively easy to control medical costs, but more ingenuity is needed to control medical costs when a contributory system is adopted. Some of the mechanisms used are the prospective payment system, global budget system, capitation payments, and successive diminution in medical payments based on the length of hospitalization. Schemes that could contribute to the control of medical costs are disease prevention by encouraging medical checkups, having family doctors serve as gatekeepers, having medical institutions specialize in different functions (acute phase, convalescence, chronic phase, etc.), and strengthening screening of invoices from medical institutions.
- **How are low-income and high-income populations handled in a contributory system?** In general, a publicly funded social health protection system is generally set up for low-income people who are unable to pay insurance premiums. In one approach, as in Japan, low-income people are covered by livelihood assistance, outside of the framework of the health insurance program, while countries such as Indonesia, the Philippines and Vietnam adopt an approach where those who are unable to pay insurance premiums are subsidized by public funds in order to be enrolled in the health insurance program. Both cases face the issue of how to secure public funding. There are examples in which people with high incomes are allowed to opt out of social health insurance on condition that they subscribe to private health insurance. It should be noted that in this case, there tends to be significant disparities in the medical services covered by private health insurance and public health insurance. Also, fiscal problems may occur when the insurance premiums paid by people with high-incomes cannot be secured.

Income security

- **How is the demographic structure estimated to change in the future?** When projecting future increases in the elderly population and gains in life expectancy, total benefit costs can also be expected to increase. Moreover, if the working-age population is expected to shrink, the financial capacity will also decrease. Accordingly, when such conditions are anticipated, the future demographic structure must be accurately forecasted in advance, and the level of benefits and contributions must be set to balance between the expenditure and the revenue. One option to avoid the adverse impact of demographic changes is an advance-funding method.
- **What kind of funding method is adopted in a contributory pension system?** Contributory pensions are funded either through an advanced funding system or a pay-as-you-go system. In an advance-funding system, the money needed to pay out future

pension benefits is set aside in advance through insurance premium contributions. In contrast, in a pay-as-you-go system, the money needed for pension payments comes from the insurance premiums paid by the current working population at that point. While the advance-funding system is not affected by changes in the demographic structure, the pension money received in the future will depend on investment returns on the reserves, so adequate benefits may not be available when it is time to make pension payments. Moreover, it is essential to ensure that the financial infrastructure and governance for appropriate management is in place so that the reserve funds can be invested. In a pay-as-you-go system, insurance premiums can be set at levels commensurate with wages and prices at the point when pension benefits are paid out, but the burden on the generation still working tends to be excessively heavy when the population ages.

- **What is the appropriate level of benefits and contributions?** When considering benefits and contributions for income security, the necessary benefit levels in light of the program's purpose must be adequately examined while full consideration is required of the impact on the economy and public finances. Benefits should essentially be set at a level that will provide a stable life in light of the income needs of each subscriber. Regarding contributions in a contributory system, when insurance premiums are high, the business owners' share would be high, which could weigh down corporate activity. Alternatively, this could lead to an increase in irregular employment, which does not require social insurance payments. An increase in the employees' share causes households to curb spending, which can lead to an economic slowdown. If public funding is invested either in a non-contributory system or a contributory system, an increase in the government's share of costs could put pressure on government spending and have a negative impact on public finances.
- **What is the scope of those covered and what is the benefit level in a non-contributory system?** When public assistance for the poor is established, the scope of eligibility and benefit levels should be set at the level that is appropriate to maintain their minimum standard of living and to keep the system financially sustainable. The fiscal burden differs considerably depending on the level of poverty, eligibility for benefits and the specific level of the benefits. Moreover, measures encouraging an escape from poverty by combining this with job assistance and measures to halt the inter-generational poverty trap by setting conditions, such as CCTs should also be considered. When establishing programs without any income means testing specific groups such as the elderly and people with disabilities (social pension)[77], benefit levels should be set at levels that anticipate a future increase in the elderly population, and the expansion of a contributory system should be considered so that the social pension benefits, in the future, can be replaced by the benefits from the contributory pension system.

[77] Thailand, Vietnam and South Africa have non-contributory benefits without income limitations for some beneficiaries, such as the elderly and persons with disabilities. This enables the elderly and persons with disabilities as well as their family to maintain a certain standard of living, and to maintain their dignity. However financial sustainability is an issue as the elderly population is expected to increase. The Chronic Poverty Research Centre's Social Assistance program's database has data on countries that provide social pensions and what this consists of. Barrientos et al (2010) Social Assistance in Developing Countries Database

2-1-2. Efficient and Effective Program Management

The second perspective is the extent to which social protection programs can be efficiently and effectively implemented and managed. In order to do this a number of questions need to be addressed. Is the system providing benefits to the beneficiaries originally targeted, or are they not targeted as beneficiaries? In other words, is the targeting system appropriate? Is information on the program's target group ascertained accurately and promptly? In a contributory system, are contributions effectively collected and; are benefits reaching the beneficiaries in a timely manner? In the provision of service benefits, are payments to the service provider made smoothly? In the asset management system, how are the assets invested? Are the employees involved in system operations implementing the system efficiently and effectively in accordance with the objective? What sort of governance is in place? Is the system in compliance or is it being misused? Is it monitored and evaluated; and is there adequate coordination and collaboration between stakeholders?

Box 2-5: Targeting in Conditional Cash Transfers (CCT) : Mexico's example of *CCTs :*
This is a new form of public assistance—in other words, a social protection program based on cash transfers that has come into favor with mainly in middle-income countries seeking to expand the scale and extent of coverage. This form of public and conditional cash transfers (CCT) is currently used in Latin America, Asia, Central Europe and Africa with the World Bank taking a central role in its dissemination.[78] In CCT programs, the recipients can receive cash payments only if they meet certain criteria, such as sending their children to school and having them receive vaccinations and medical checkups. The cash they receive not only helps to reduce poverty directly, but also creates human capital for the medium and long-term by ensuring that children continue to go to school and remain healthy. The ultimate aim is to break the cycle of intergenerational poverty. Reduction in poverty, increase in school attendance rates and better health among children have been reported.

Scaling up the '*Oportunidades'* project : When the project started in 1996, there were 31,000 beneficiaries, with another 300,000 added in 1997. 26 million households were added in 2000 and a further 750,000 added in 2001. Currently, the project has been expanded to target more than 58 million households, or 20% of the population. What mechanism was used to scale up the project? During the first five years of the project, poor people in rural villages were targeted, and subsequently the scope of beneficiaries was gradually expanded to poor people living in urban areas.

Targeting method : In *Oportunidades*, considerable efforts were made for selecting beneficiaries using rigorous means-testing in order to ensure an effective allocation of resources. First, the central government followed three steps to choose beneficiaries in the rural villages that accounted for the majority of the impoverished. In the first stage of the

[78] According to the World Bank, there are 245 programs in 41 countries around the world (according to information from a CCT seminar held at JICA Research Institute in September 2012). The rapid expansion in social protection coverage, as with Opportunidades, started in 1997 in Mexico, Brazil's Bolsa Familia, and Indonesia's Safety Net Scheme, have attracted considerable attention as well.

targeting, geographical targeting was used to select communities in rural areas with 50 to 2,500 residents and with high rates of poverty. In the second stage, proxy means testing was used to choose households within the communities identified as having a high level of poverty that met the eligibility criteria. Households that were selected had a monthly income of US$18 or less[79], and spoke indigenous Amerindian languages more than Spanish. In the third stage, a community meeting was held at which residents had a chance to examine the list of those eligible for the project within the community. If there were no objections, the beneficiary list was finalized.

Success factors: The scaling up succeeded because the central government's data collection, to confirm which states had the lowest human development indicators, along with accurate targeting (see below), rigorous monitoring, and the inclusion of policy evaluation by external organizations from the time the policy was introduced, made it possible to ascertain the effect of the policies. In addition, problems with policy design and execution could be identified quickly and remedial measures taken immediately. Another factor for the project's success was the government' strong and long-term political commitment to reducing poverty and redressing disparities, even after a new president took office; stronger collaboration between the central and local governments; rigorous monitoring and evaluations; and the development of a fiscal management system (securing payment methods and mechanisms, etc.)

Reference : Lancet (2012) The quest for universal health coverage: achieving social protection for all in Mexico

Box 2-6: Governance in Social Protection

The definition of governance varies significantly among major donors due to differences in its interpretation and expression. In "Governance Assistance of JICA: Toward indigenous development of democratic institutions, administrative functions and legal institutions in the developing world" (November 2004, JICA), governance is defined as "the development and operation of all the institutions, including government organizations and systems, the synergetic relationship among government, civil society and the private sector, and the processes of decision making, in order to mobilize, allocate and manage the resources of the country efficiently and in a manner that reflects the will of the people, with the aim of realizing the stability and development of the country." So what is governance when it comes to social protection? The International Social Security Association (ISSA), an international organization whose members come from social security agencies and organizations in countries around the world, defines governance as "the actions of an organization invested with authority which uses this authority to achieve the objectives of the social security organization". A social protection system can be a contributory or non-contributory social health protection scheme, a pension scheme, or the provision of social welfare services, and is essentially a mechanism for the provision of benefits in kind, such as medical services and social welfare services, or the payment of cash, such as pensions, with funding coming from insurance premiums or tax revenue. Given that this system is so closely involved in redistributing resources in this way, the public's trust in it is essential. This means that it is very important that when the system is developed and administered, the collection and management of funds and delivery of services and cash payments is carried out fairly and efficiently, based on transparent and equitable rules and with the cooperation of related

[79] This corresponds to one-fourth of Mexico's median income.

organizations—in other words, "good governance."[80]

The World Bank identifies three areas that should be addressed when reinforcing governance in social protection. The first is clear and simple rules. Specifically, the criteria for selecting program beneficiaries, the targeting method and the criteria for setting benefit levels should be clear and easy for everyone to understand. Rules refer not only to laws, but also to manuals that are easy for program employees and the public to understand and listening to the views of members of the public when devising these criteria. This can mitigate the risk of program changes as a result of political and economic conditions as well as the risk of political intervention. The second is roles and responsibilities. Specifically, this includes clarifying the roles and responsibilities of the related organizations at each level, from the policy level to the service delivery level; clarifying the division of roles and responsibilities of the related organizations, from financing to service delivery and monitoring; ensuring consistency between incentives among the related organizations and employees and the program's objective; and document the relationship between organizations. The third is controls and accountability mechanisms. These mechanisms ensure that "the right beneficiary gets the right benefit at the right time." Specifically, mechanisms on the supply side include audits, quality control checks, spot checks, policies to ensure access to information, and complaints-handling systems, while mechanisms on the demand side include complaints and appeals, third party monitoring, beneficiary satisfaction surveys and monitoring by the public. The World Bank gives the following cases as examples in which initiatives to reinforce governance led to improved social protection.

Moldavia's case: Providing the public with knowledge and information and communicating with them is indispensable in gaining the public's trust. Moldavia set up a communication division to educate the public. Media coverage on pension reform in line with the prepared communication strategy increased, and pamphlets were prepared and distributed nationwide. After the project was implemented, as a result of the communication division's establishment, the public's knowledge about pensions increased and led to an increase in participants and an extension in the payment period for insurance premiums.

Romania's example: Stronger collaboration between the central government and local governments and the enhanced capacity of local administrators were important factors for the program's success. Romania set up a social assistance program in 1995. In the first year, the central government raised funding and left operations up to local governments. From the second year, financial responsibilities were also shifted to local governments, but without any funding from the central government, local governments ran into difficulties in running the program sustainably. As a result, benefit recipients fell from 6% of the population in 1996 to 2% in 2001. To redress this situation, the central government shared responsibility for costs in 2002, and ultimately (2011) became fully responsible for providing the funding.

Reference: ISSA (2009) ISSA Good Governance Guidelines for Social Security Institutions

WB (2012) Rules, Roles and Controls: Governance in Social Protection with an Application to Social Assistance

[80] The pension records-keeping problems revealed in Japan in 2007 (about 50 million records for pensions had not been integrated into the unified individual pension identification numbers) highlighted the shortcomings in the governance of Japan's pension system. The report issued by the Ministry of Internal Affairs' Third-Party Committee to Check Pension Records (October 2007) pointed to several decisive shortcomings in the organization's governance: the Social Insurance Agency, which manages pension records, groups its employees according to the type of employment contract under which they were hired, so there was no sense of unity among employees. The sharing of information, awareness of problems and knowledge was impeded, and remedial steps were not taken. The overall organization was inefficient, inward-looking, rigid and authoritarian with lax organizational discipline, and instructions from the Social Insurance Agency did not arrive at the social insurance-related organizations in the prefectures.

Box 2-7: Social protection sub-systems (programs related to social protection)

Social protection systems are made up of various sub-systems that are mutually compatible, whether they are for health protection, income security or social welfare service delivery.

Health protection

Health protection consists of the following sub-systems.

Sub-systems related to medical service delivery: education of medical specialists such as doctors and nurses, standards and official licenses for medical institutions, placement of medical institutions and division of functions, licensing and distribution of medical equipment and pharmaceuticals, health promotion and disease prevention mechanisms, and information systems to improve and maintain the quality of health care.

Sub-systems related to financing medical costs: (In the case of non-contributory health protection systems) Rationale, calculation standards and processes of government spending, division of responsibilities between central government and local governments, etc. (In the case of contributory health insurance) Insurers' organization and administrative mechanisms, mechanisms for ascertaining and managing contributor information, a mechanism for calculating contributions, a mechanism for collecting contributions, handling of low-income people, the rationale and calculation standards for public subsidies, etc.

Sub-systems related to payment and management of medical costs: Mechanisms designed to control the growth of medical costs, such as mechanisms for hospital accounting, payment systems for medical services, mechanisms for screening and paying invoices for medical expenses from medical institutions, and a system for determining payment for medical services.

Income security

Income security systems consist of the following sub-systems.

Sub-systems related to cash benefits and benefits-in-kind in a non-contributory system: Mechanisms for identifying beneficiaries, mechanisms to ascertain and manage beneficiary information, rationale, calculation standards and processes of government spending, division of responsibilities between central government and local governments, mechanisms for actual payment of benefits, etc.

Sub-systems related to cash payments in a contributory system (old-age pensions, survivor's pension, disability pension, unemployment benefits, accident payments): Insurers' organization and administrative mechanisms, mechanisms for ascertaining and managing contributor information, methods for calculating contributions, mechanisms for collecting contributions, mechanisms for administering reserve funds, mechanisms for setting benefit amounts, treatment of the low-income population, rationale, calculation standards and processes of government subsidies or government cost-share, mechanisms for certifying beneficiaries for disability pensions (disability recognition), certifying beneficiaries for unemployment benefits, mechanisms to coordinate job search support (job referrals, skill development) for recipients of unemployment benefits, certification of beneficiaries for occupational accident payments, etc.

Social welfare service delivery

Social welfare service systems consist of the following sub-systems.

Sub-systems for overall social welfare services: Education for social workers and other specialists, volunteer training, consultation mechanisms for social welfare services, such as welfare offices, standards to ensure quality of services, process and criteria for approving service providers, mechanisms to prevent the abuse of children, persons with disabilities and the elderly, advocacy mechanisms for children, persons with disabilities and the elderly, etc.

Sub-systems related to social welfare services for children and mothers and infants: Education of specialists such as child-care workers and clinical psychotherapists, standards for and licensing mechanisms of juvenile and mother-child facilities (shelters, child protection facilities, etc.), siting and division of functions for juvenile and mother-child facilities, etc.

Sub-systems related to social welfare services for persons with disabilities: Mechanisms facilitating participation of persons with disabilities in the decision-making process, livelihood support for persons with disabilities (job assistance, support in participating in society), education for specialists such as OT, PT and clinical psychotherapists, mechanisms for disability certification, standards for and licensing mechanisms of various facilities for persons with disabilities, siting and division of functions for various facilities for persons with disabilities, communication support such as sign-language interpreting and Braille translation, mechanisms for links between healthcare and education, etc.

Sub-systems related to social welfare services for the elderly: Livelihood support for the elderly (job assistance, support in participating in society), education of professional caregivers and other specialists, mechanisms for certifying the elderly who require long-term care, standards for and licensing mechanisms of nursing homes and other long-term care facilities, siting and division of functions for long-term care facilities, etc.

Reference: *Shakai hoshoron*, edited by Yoshinori Hiroi and Yasuhiko Yamazaki (2007)

2-1-3. Infrastructure, Personnel and Systems

The third perspective is whether there are facilities, personnel and systems that support social protection programs.

In health insurance, it is meaningless when a program is established without the actual provision of medical services. Facilities such as public health centers, medical clinics, and hospitals, personnel such as doctors and nurses, occupational therapists (OT) and physical therapists (PT), and systems for the procurement and management of pharmaceuticals and medical supplies are essential, and support the effective implementation of a health insurance system.

In income security such as pensions, programs with contributory systems, for example, need experts such as pension actuaries, experts in managing reserve funds, personnel and

systems for managing individual subscribers' information and remittances. Programs with non-contributory systems need systems for certifying beneficiaries, information management systems and systems for remittances.

In social welfare services, services cannot be provided without residential and day care facilities that provide care and nursing for children and the elderly, nursery teachers, caregivers and nurses to provide services, and social workers to identify welfare issues in communities and individual welfare needs as well as to coordinate necessary services and volunteers.

Box 2-8: Social Protection and the Private Sector

The private sector plays a major role in social protection. The key roles are listed below.

① **Role as service provider**

Social Health protection: Medical service providers (private hospitals and medical clinics, pharmacies, etc.), providers of medicine-related services (laboratory tests, medical waste disposal, maintenance of medical equipment, hospital cleaning services, laundering services for bedding and other articles, disinfection and sterilization, patient meals, medical administrative work, etc.), companies involved in the manufacture, sale and leasing of pharmaceuticals, medical supplies and medical equipment, information system-related personnel involved in health insurance (design, development, maintenance and inspection of information systems, etc.), financial service providers (private-sector health insurance; relationship with public insurance varies by country—in some cases, coverage is similar to that of public insurance and covers the amount that the insured person paid out of pocket for public insurance, in other cases, private insurance covers patient's out-of-pocket expenditures, and in one case covers services not covered by public insurance.)

Income security such as pensions: Financial service providers (private life insurance and private annuity insurance), investment service providers for pension reserves and corporate pensions, information system-related personnel involved in annuity insurance (design, development, maintenance and inspection of information systems, etc.)

Social welfare services: Various service providers in social welfare services (long-term care providers under the public insurance system, or those commissioned by the government to provide services within the framework of public programs, welfare service providers for persons with disabilities, child welfare facility operators), service providers for social welfare service facilities (facility cleaning, laundering services for bedding and other articles, food service, etc.), companies manufacturing, selling and leasing nursing equipment, companies providing services in the open market (babysitters, etc.), individuals and organizations providing social welfare services as volunteers (for example, the commissioned welfare and child welfare volunteers in Japan, health volunteers in Thailand, NGOs, companies involved in social action, etc.)

② **Role as program administrator**

Social Health protection: Administrators of social health insurance (Japan's health insurance societies for employee health insurance programs, Rwanda's regional

insurance administrators for community-based health insurance, etc.), private-sector health insurance companies with roles as insurers under the national health insurance system (Germany, the Netherlands).

Income security such as pensions: Corporate pension administrators (corporate pension funds in Japan), associations that administer collection of pension premiums. (In the Philippines' pension system, mutual associations of self-employed persons are commissioned to collect insurance premiums from self-employed persons.)

③ Private sector as contributor to system

Social Health protection: Employers' contribution for employee health insurance programs

Income security such as pensions: Employers' contribution to public insurance to national pension systems

Social welfare services: Employers' contribution to public insurance for welfare services if there is one. (Examples are long-term care insurance in Japan, South Korea and Germany)

The relationship of the private sector with public programs is outlined below.

① Role within the framework of the public program

Private medical institutions designated by the government as institutions providing health care services covered by social health insurance; health insurance associations functioning as administrators of social health insurance; private health insurance in Germany and the Netherlands, which is subject to regulations as a national program, such as benefit coverage and insurance premium calculations; long-term care providers who have been designated by the government; social welfare providers who have been designated by the government as social welfare service providers for persons with disabilities; nursery care providers entrusted by the government to provide nursery services; welfare and child welfare volunteers and health volunteers commissioned by the government, etc.

② Outside the public program, but acting with a close relationship with the public program:

Pharmaceutical manufacturers and distributors; companies providing health-related services to medical institutions; companies administering pension funds; businesses providing information systems related to social insurance, etc.

③ Active in the market outside of the public program

Private health insurance companies and private life insurance companies in Japan, other service providers such as babysitters

④ Active outside the market and with no relationship to the public program

Volunteer activities by NGOs and residents, corporate social responsibility activities, etc.

The roles of the private sector in social protection programs vary by country. Even if we look at the social health protection sector alone, there are countries such as the United States where it is primarily the private sector that finances and provides medical services, and countries such as Germany where the public sector is essentially responsible for financing and providing medical services but anyone not enrolled in the public health insurance program is required to enroll in private health insurance. There are also countries such as the Netherlands where the national health insurance program is administered entirely by private health insurance companies, countries such as Japan where medical services are financed by the public sector under the social health insurance program but private medical

institutions play a major role in providing medical services, and countries such as the Northern European countries where the public sector plays the main role in providing and financing medical services. The OECD calculated social expenditures by the public sector and private sector and found that private sector social expenditures account for an average of 10% of overall social expenditures, compared to about 36% in the US, about 15% in Japan and about 10% in Germany, showing significant disparities among the countries.[81] Generally in many developing countries the public sector is inadequate but plays a major role in medical services, but in the case of income security and social welfare services, assistance from families and the community plays a substantial role. In some countries, such as the Philippines, the private sector is instrumental in providing medical services, but a national health insurance program provides the funding. Ultimately, the way where the government sector, private sector, and assistance from families and the community is balanced in social protection depends on the public's value system, but the following aspects should be considered.[82]

- Impartiality: For example, adverse selection and "cream skimming" are risks in private health insurance programs, so regulations governing the insurance premium calculations and freedom of contract are essential. In particular, in cases in which the private sector is given a role within the national health insurance system, public regulations on insurance premium calculations (in private health insurance schemes, insurance premiums based on risk are the norm, while in national health insurance schemes, insurance premiums based on income are the norm) and a restriction of freedom of contract are needed. Moreover, a bigger role for the private sector could mean that the level of medical services and social welfare services that can be received accordingly differs depending on income. The question of the extent to which such disparities will be tolerated ultimately comes down to the public's sense of fairness. In cases in which private health insurance companies are the main provider of medical financing, preceding national health insurance, as in the US, it will be extremely difficult to subsequently introduce and expand national health insurance and put private health insurance under public regulation.
- Efficiency: Generally private companies are given a role as service providers in order to enhance efficiency (as in the case of care service providers under Japan's long-term care insurance). There are also cases, as in the Netherlands, where the administration of national health insurance is entrusted to private health insurance companies in an attempt to enhance efficiency through "managed competition."

Reference: Kenji Shimazaki (2011), *Nihon no iryo—seido to seisaku* (Medicine in Japan: programs and policies)

[81] OECD Social Expenditure Database (SOCX) divides social expenditures in OECD countries into social expenditures made by the public sector and social expenditures made by the private sector.

[82] The OECD's (2004) "Private Health Insurance in OECD Countries" lays out the roles of private health insurance in OECD countries and analyzes costs and effect for individuals and medical systems overall.

2-2. Approach by Country's Income Level

Historically, social protection expands progressively as the country's income level rises, and the approach needed at each level differs. In this section, we will take a look at the requisite approaches for the least developed countries (per capita GNI under US$1,005), low and middle-income countries (per capita GNI around US$1,006-3,975) and upper middle-income countries (per capita GNI of US$3,976 or more). Changes in the population structure, such as an ageing population and declining birth rate, and changes in disease structures and the occurrence of disease (the shift from infectious diseases to lifestyle diseases, and protection from diseases common among the elderly) are important elements in designing social protection programs. These changes are related to a country's income level,[83] so it is logical to address the necessary response to social protection according to a country's income level. In general, as the economy expands, the average life span is extended leading to the population ageing, and changes in disease structure are the result of improvements in sanitation as infectious diseases are replaced by chronic conditions.

In this section, we will describe the necessary approach for each income level in terms of the three perspectives described in the previous section for the three social protection programs, i.e., (1) social health protection, (2) income security such as pensions and (3) social welfare services. Social health protection and income security such as pensions are further divided by financing method into non-contributory and contributory systems.

As we discussed in Box 1-1, one problem of an ageing population in developing countries is that it occurs before the economy has grown sufficiently, which is different from what developed countries have faced thus far. Accordingly, future trends in the demographic structure should be carefully considered when considering effective approaches for individual countries. Moreover, some countries in Central Asia and Eastern Europe need to address the issue of how they should rebuild the social protection programs developed under Communism in consideration of their new political and economic realities. Approaches should be tailored to the realities in these countries.

2-2-1. Least developed Countries (GNI per capita below US$1,005)[84]

2-2-1-1. Social Health Protection

(Suitability of program design)

- Coverage of basic medical services

  At this stage of development, sanitary standards are low, and in many cases infectious diseases such as malaria and tuberculosis are still a major threat. Moreover, pre-natal checkups and delivery in a medical institution have not yet been adequately provided, and there are often problems with mother-child health indicators. Accordingly requisite approach is to provide all citizens, including the poor, with vaccinations, mother-child

[83] Yoshinori Hiroi/JICA (2004), p6

[84] JICA's "Table of General Terms and Conditions for Japanese ODA Loans" was referred to here. GNI figures are for 2010.

health care, and medical care for infectious diseases such as tuberculosis, malaria and HIV/AIDS either free of charge or at an affordable cost. Moreover, given the administrative capacity needed to obtain resident information and collect insurance premiums, it is not realistic to establish a contributory social health protection system for all, although it would be possible for government employees and private company employees. A non-contributory system would be a realistic option when developing some kind of social health protection for the poor.

- Ensuring financial sustainability of non-contributory programs
  When establishing a non-contributory scheme, ensuring financial sustainability is extremely important. Donor funds are often used and close collaboration with donors is crucial.

(Efficient and Effective program administration)

- Developing a targeting system
  When adopting a non-contributory scheme that limits the scope of coverage (for example, limiting eligibility to the poor), mechanisms to identify beneficiaries (targeting system) must be developed. Targeting systems should be clear and simple to implement with limited administrative capacity. The roles and responsibilities of those involved should be clarified and impartiality in program implementation should be ensured through monitoring and complaint management. The government agencies involved must coordinate with each other when developing a targeting system to ensure consistency with other poverty programs.

(Infrastructure, personnel and systems supporting programs)

- Establishing basic medical service delivery
  The most important issue is the training of medical personnel such as doctors and nurses and the establishment of public health centers to provide basic medical and preventative services as well as hospitals to provide basic medical treatment services.

Box 2-9: Social health protection in Africa

African countries, especially those in Sub-Saharan Africa, suffer from poor health conditions, with infectious diseases such as HIV/AIDS, tuberculosis and malaria rampant. About half of all deaths of children under the age of five and maternal deaths worldwide occur in this region. This can be attributed to extreme poverty, severe malnutrition, poor sanitary environment, lack of public health infrastructure such as public health centers, an overwhelming shortage of medical personnel and a lack of medical institutions. Moreover, social protection coverage is more limited in Africa than in Asia and the ratio differs by country. According to the ILO, on average only 10% of the working population is covered by social protection programs. Moreover, almost 80% of the population does not even receive the bare minimum of treatment. Given these conditions, the leaders of African countries have adopted important strategies such as the Africa Health Strategy (2007-2015) and the African Nutrition Strategy (2005-2015). The Africa Health Strategy aims to realize universal access to basic health services, and African countries have pledged to allocate 15% of their national budgets to the health sector.

International organizations, the governments of developed countries, and the private sector are all reinforcing health development assistance to African countries. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) have been established, with massive amounts of money in recent years being used to combat HIV/AIDS, tuberculosis and malaria in particular. At the Fourth Tokyo International Conference on African Development (TICAD IV), the Japanese government committed to provide 43 billion yen through technical and grant aid cooperation for health development in Africa over five years from 2008. Although health services are expanding and health standards are improving due to these government initiatives and financial contributions from the international community, conditions remain difficult.

Africa's current issue of controlling the spread of infectious diseases and ensuring access to medical services is similar to Japan's experiences after the Second World War, when tuberculosis was a major health problem for some years. While establishing health insurance programs, at that time Japan tackled tuberculosis as a national problem by investing large amounts of tax revenue in government funding for patients' co-payments for tuberculosis treatment and medical assistance as part of livelihood assistance. We should not forget that Japan was establishing its public health system at the same time as a nationwide network of public health centers was being constructed, health checkups and vaccinations were provided, and public health centers obtained patient data. The construction of a water supply system and improvements to the sanitary environment were also major contributing factors. Not all the public health measures taken at that time would be recommended at present, but Japan's experiences do have implications for African countries in that in parallel with developing its health insurance program, the Japanese government actively invested public money to combat infectious diseases threatening public health and social safety and worked toward improving access to medical care.

Reference: Ikuo Miyazoe (2011), *Afurika ni okeru hoken kaihatsu: Kenko suijun no kasokuteki kaizen to nihon no kaihatuenjyo e no teigen* (Health development in Africa: Rapid improvements in health conditions and recommendations for Japan's development aid)

2-2-1-2. Pensions and Other Forms of Income Security

(Suitability of program design)

- Minimum level of public assistance for the socially vulnerable

  At this stage of development, providing public assistance to the poorest so that they can maintain a minimum livelihood is essential. This can be done by giving cash payments directly to the poorest, by the government providing temporary employment, or by providing benefits in kind such as food and housing. Moreover community and family ties are generally strong, and those who fall into poverty for some reason usually receive assistance from their families and neighbors. The government can also help the poorest by organizing residents as volunteers and providing subsidies to activities carried out by charity organizations.

  With the exception of government employees and employees of private companies over a certain size, it is not realistic to base income security on a contributory system in terms of citizens' income levels, administrative capacity, and the fund management environment. A non-contributory income security program with limited beneficiaries, such as the poor, is essential and realistic.

- Ensuring financial sustainability
  Ensuring financial sustainability is extremely important in establishing a non-contributory income security program. Donor funds are often used and close collaboration with donors is crucial.

(Effective and efficient program administration)

- Developing a targeting system
  When adopting a non-contributory income security program that limits the scope of coverage (for example, limiting eligibility to poor people), mechanisms to identify beneficiaries (targeting system) must be developed. As with non-contributory health protection programs, targeting systems should be clear and simple to implement. The roles and responsibilities of those involved should be clarified and impartiality in program implementation should be ensured through monitoring and complaint management. The government agencies involved must coordinate with each other when developing a targeting system to ensure consistency with other poverty programs.

2-2-1-3. Social Welfare Services

(Suitability of program design)

- Delivery of the bare minimum of public social welfare services is needed for orphans, persons with disabilities who need specialized care, the elderly with no relatives, victims of disasters, and others. In general, families, relatives and neighbors are the primary caregivers. Services may be needed in public institutions, orphans may be raised by foster parents, and a place to live, food and daily necessities may be provided for victims of disasters. In addition to these direct deliveries of services by the government, volunteer groups, NGOs and charity organizations provide services, which in some cases also receive some form of public support.

(Effective and efficient program administration)

- Affiliations between stakeholders in the delivery of social welfare services
  In many cases, it is more common for social welfare services to be delivered by local government bodies, neighbors, NGOs and volunteers with the central government playing a role in promoting and organizing these efforts, than it is for the central government to directly provide these services. Coordination at various levels is essential: between the central government and local governments, between the central and local governments and NGOs, volunteers and community associations, and coordination with donors when donor funds are provided.

(Infrastructure, personnel and systems supporting the program)

- Establishment of infrastructure for minimum level of social welfare services
  The scope of those requiring public assistance is limited and the government's financial constraints are significant. Therefore the focus is on establishing institutions for the care of orphans and residences for the elderly with no family and on hiring the personnel to work in these institutions.

2-2-2. Low- and Middle-Income Countries (per capita GNI of US$1,006-3,975)

2-2-2-1. Social Health Protection

(Suitability of program design)

- Coverage expansion to include non-communicable diseases and more advanced medical services

  Generally at this stage of development, as sanitation standards and nutrition conditions improve, the disease structure shifts from infectious diseases to chronic conditions. Accordingly, social health protection coverage must expand from the prevention of infectious diseases and basic medical services to non-communicable diseases and chronic conditions. Moreover, a mechanism to cover more expensive treatment, such as the cost of cancer treatment and dialysis, should be established to make the social health protection program more substantial.

- Coverage expansion to the informal sector

  Generally a contributory health insurance program is provided to public employees and employees of private companies of certain size, although the informal sector, such as the self-employed and farmers, often account for a large percentage of the population. Therefore, expanding health insurance coverage to the informal sector becomes an issue here. The government must choose either a contributory or a non-contributory system. In a contributory system, while the relationship between benefits and contributions is clear and funding for health costs can be secured without being affected much by government budget constraints, there are difficult problems, such as how health insurance premiums can be collected and how medical services should be provided to non-subscribers and those who are delinquent in making payments. Conversely, in a non-contributory system, there is no need to collect insurance premiums and the issue of non-subscribers and delinquent subscribers does not appear. The program, however, will be affected by government budget constraints resulting in the limited medical services and access to those services. Even if a contributory system is adopted, government funding would be unavoidable because the government would have to cover insurance premiums and/or provide a non-contributory scheme for those with a low-income unable to pay premiums.

- Ensuring financial sustainability

  Whether a contributory or non-contributory system, financial sustainability must be ensured. To this end, it is important to incorporate mechanisms to enhance the efficiency of health care and mechanisms to control the growth of medical costs. Setting up an appropriate payment system for medical services is a key. Moreover, in a contributory system, the extent to which public funds will be used for those with low-incomes and whether the high-income population will be allowed to opt out of public insurance will have a major impact on ensuring the program's financial sustainability.

(Effective and efficient program administration)

- When expanding a contributory health insurance program to the informal sector, it is extremely difficult but important to establish a mechanism for reliably collecting insurance premiums and obtaining and managing information on the insured. Moreover, when public funds are used to provide social health protection for those with low-incomes, a targeting system to identify eligible beneficiaries must be developed.

- Developing information systems
  Generally the number of employees in the private corporate sector increases, resulting in an increase in the covered population in a contributory health insurance plan. In addition, the number of beneficiaries increases either in a contributory or non-contributory system when social health protection coverage is expanded to the informal sector. Accordingly, an information system with a high processing capacity must be developed to acquire and manage information on beneficiaries. Moreover, when a fee-for-service plan and prospective payment system for respective diseases is adopted, an information system is needed to ascertain patients' medical information and to pay medical institutions.

(Infrastructure, personnel and systems)

- Correcting regional disparities in medical service delivery
  Medical institutions at a certain level have usually been established, primarily in the capital cities, but in many cases there are not enough medical institutions and doctors and nurses in outlying areas. It is important to correct the regional imbalance in the medical service infrastructure and foster medical practitioners such as doctors and nurses in the required numbers. Improving the quality of health care is also an important issue.

2-2-2-2. Pensions and Other Forms of Income security

(Suitability of program design)

- Ensuring coverage of employees in contributory income security program
  Generally the economy is gradually becoming formalized, and the number of private-sector company employees is growing, so the income of these employees after leaving their jobs must be assured in a contributory income security program such as a pension plan.
- Ensuring financial sustainability of income security for employees
  When establishing a contributory pension plan for employees, it is extremely important to ensure its financial sustainability. If a reserve funding scheme is adopted, there are relatively few problems, but in a pay-as-you-go system, it is very important to ensure a balance between the benefit level and the contribution level while taking into account such aspects as a future decline in birthrates, the ageing population and economic growth (refer to Box 2-4. "Social Protection and Financial Sustainability").
- Ensuring coverage of the socially vulnerable in non-contributory income security program
  At this stage, there are countries that make cash payments in a non-contributory system to the socially vulnerable, such as the poor, persons with disabilities and the elderly. Conditional Cash Transfers (CCT) are a particularly common method used with a poor population.
- Ensuring the financial sustainability of non-contributory income security programs
  When cash payments are made as part of a non-contributory plan, the financial sustainability of this plan must be ensured. It is important to set the scope of coverage and the level of payments in accordance with the fiscal situation.

(Effective and efficient administration of programs)

- Ensuring governance of contributory income security programs for employees and

monitoring their implementation.

Ensuring governance and monitoring implementation is extremely important in contributory pension plans for employees. Generally in pension plans for employees, the employee is required to make contributions for a certain number of years before pension payments are made, and contributions are built up from the time the program is launched until the time payments will begin to be made. Governance and monitoring are important issues to ensure the management of the incrementally increasing reserve funds and the proper investments (refer to Box 2-6: “Governance in Social Protection”).

- Development of information systems for contributory income security programs for employees

  In contributory pension plans for employees, information on the insured person must be accurately obtained and managed and insurance premiums must be effectively collected. In addition, an information management system must be built in to manage enrollment and contribution records of the insured over the long-term and to accurately make pension payments.

- Development of a targeting system for non-contributory income security programs

  When making cash payments as part of a non-contributory income security program to the socially vulnerable, such as the poor, mechanisms to accurately and effectively identify beneficiaries (targeting system) must be developed. Governments generally adopt a wide range of countermeasures other than cash payments as anti-poverty measures, and must coordinate with other government agencies to ensure consistency with other anti-poverty measures (refer to Box 2-5: “Beneficiary Targeting in CCT”).

2-2-2-3. Social Welfare Services

(Effective and efficient program administration)

- Development of mechanisms for social welfare service delivery

  In addition to emergency social welfare services, there are often demands for a permanent social system for people with special needs, such as children and adults with disabilities and the elderly. First, local administrators must set up an assistance consultation counter and assign assistance consultants. Moreover, standards for social welfare facilities for children, persons with disabilities and the elderly must be developed to ensure the quality of the social welfare services.

(Facilities, personnel and systems)

- Training social welfare service personnel

  In order to meet citizens’ welfare needs, it is first necessary to train social workers who can ascertain needs, coordinate services and provide support with consultations. In addition, a training curriculum for the professionals who provide childcare services and long-term care services for persons with disabilities and the elderly must be prepared. Even at this stage, it is more realistic for social welfare services to be provided by NGOs and volunteers rather than governments. This means that mechanisms for training the volunteers who provide daily assistance to people in need in the community and mechanisms for promoting the activities of NGOs and volunteers will be required.

2-2-3. Upper Middle-Income Countries (GNI per capita US$3,976-6,925) and Higher

2-2-3-1. Social Health Protection

(Suitability of program design)

- Ensuring financial sustainability (controlling medical costs)
  In general, medical needs expand as income levels rise. Therefore, managing medical costs becomes an important issue to ensure the financial sustainability of a social health protection system. The following initiatives must be taken to increase efficiency in medical service delivery and hospital management: improving the payment system for medical services, and improving hospital accounting systems (refer to Box 2-4: “Social Insurance and Financial Sustainability”).
- Addressing issues of an ageing society
  At this stage of development, the average lifespan extends and the population ages as a result of higher standards of medical care and higher living standards. Dementia and lifestyle diseases require long-term medical treatment and rehabilitation. These medical needs, which are problems particularly acute for the elderly, require an appropriate social health protection system.

(Facilities, personnel and systems supporting the program)

- Improving quality of medical care
  As a rule, these countries have some kind of public health protection system that encompasses the informal sector, but there are pronounced disparities between the medical services in public medical institutions covered by the public health protection system, and medical services in private medical institutions not covered publicly. In this case, people in the middle-income ranks and above generally receive care at private medical institutions, which strips public health protection of its original meaning. Thus, such actions as improving the quality of public medical institutions and integrating private medical institutions into the public health protection system are required. The payment system for medical services also needs to be improved so as to encourage medical institutions to improve the quality of medical care.

2-2-3-2. Pensions and Other Forms of Income Security

(Suitability of program design)

- Effective income security for old age
  At this stage, the population ages, industries grow more sophisticated, and nuclear families become the norm and the birth rate declines. Therefore there is a general need for social protection to maintain livelihoods in old age. Accordingly, an effective income security program such as old-age pensions becomes necessary.
- Expansion of contributory income security programs to the informal sector
  In general at this stage, a contributory income security program for the formal sector and a non-contributory income security program for the poor in the informal sector have almost been fully established. However, in many cases a contributory income security program for the informal sector’s population, other than the poor, has yet to be established. Expanding a contributory income security program to the informal sector begins to be an issue at this stage.
- Improving the income replacement rate for contributory income security programs

As economic standards improve, the insured demand higher levels of payouts in both contributory and non-contributory systems. In a contributory income security program, the insured urge improvements in the income replacement rate (the ratio of pension payments to the income level of the current working generation), and insurance premiums are built up particularly when the population structure is young (i.e., the current working generation paying insurance premiums is overwhelmingly high compared to the retired generation receiving pensions). In many cases, there are intense political pressures to improve pension levels. However, once pension levels are raised, it is almost politically impossible to lower pensions. For these reasons, it is necessary to anticipate the population's future ageing. [85]

- Ensuring financial sustainability
  Ensuring financial sustainability is an issue for both non-contributory and contributory income security programs, especially when the birth rate is declining and the population is ageing. In countries with non-contributory pension systems for the elderly, a retirement income security scheme through a non-contributory system needs to be gradually shifted to a contributory pension system by covering the current working generation with a contributory pension system. Even in a contributory income security system that uses a pay-as-you-go method, the balance between the levels of benefits and contributions becomes an issue at this stage because of a decrease in the number of people paying into the system and an increase in pension recipients. Hence, some sort of measure is necessary, such as raising the age at which pension payouts begin and increasing contribution rates (refer to Box 2-4: "Social Protection and Financial Sustainability").

(Effective and efficient program administration)

- Improvement of sub-systems
  At this stage of development, income security programs have grown large in scale, both in terms of the number of beneficiaries and the program's financial size. Consistent sub-systems must be developed in contributory programs for accurate information management of the insured and contribution collection and smooth payouts.
- Enhancing governance
  In contributory income security programs, insurance premiums from the current working generation steadily flow shortly after the program is launched, but there are almost no pension payments to be made, so massive contributions can be built up. Enhancing governance is essential in order to ensure that the managed assets are preserved and invested in a sound manner, in order to preserve confidence in the program (refer to Box 2-6: "Governance in Social Protection").

2-2-3-3. Social Welfare Services

(Suitability of program design)

- Augmenting service types (expanding beneficiaries)

[85] Professor Hiroi has stated that when Japan incorporated the automatic price indexation slide and wage slide in the public pension program in 1973, pension levels were subsequently raised, a kind of fiscal illusion resulted from the economic growth achieved while Japan was still a "young" country, and coupled with the rapid decline in the birth rate and ageing of the population, the country is paying the price of this ageing society. Hiroi/JICA (2004)

At this stage, the family unit weakens and community ties are loosened as a result of an increase in nuclear families, urbanization and industrialization. Social welfare services addressing the need for childcare, long-term care and other functions that used to be primarily taken on by families and the community are needed. In some countries, population ageing coupled with the weakening of family ties calls for the establishment of public long-term care services for the elderly.

- Ensuring financial sustainability
  Up until this stage, social welfare services have primarily targeted the poor and people with no family. At this stage, however, there is a great demand for services for people in need of long-term care and childcare, regardless of their economic status (universalization of social welfare services). As a result, the program becomes large in size, and financial sustainability must be addressed, particularly in light of such conditions such as a decline in the birth rate and the ageing of the population.

(Effective and efficient program administration)

- Stronger collaboration between government agencies, central and local governments, and governments and the private sector
  Needs for a wider range of social welfare services heighten, in terms of both beneficiaries and type of services. Efforts to collaborate with private-sector businesses to provide social welfare services will be essential. Moreover, collaboration between government agencies and responsibility sharing between the central and local governments become important in order to provide services that respond to needs more efficiently.

(Facilities, personnel and systems)

- Establishing infrastructure for social welfare services
  As noted above, demands for various social welfare services increase at this stage, and not only facilities that provide the bare minimum of social welfare services, but also facilities providing childcare and long-term care services must be systematically built. Social welfare professionals such as social workers, childcare and long-term care staff must be trained.

2-3. Prospective Aid Resources

Social protection systems have a public nature and many functions are controlled and managed by public organizations. It is therefore assumed that cooperation is primarily provided by government-related agencies. However, much of the support for social protection systems is not the transfer of the system itself; instead, it aims to develop the capacity of stakeholders of the countries. Thus it is not necessary to limit the aid resources to those who have administrative experience. Rather, those who understand the particular conditions of developing countries and have knowledge and experience in systems of various countries, including Japan, may in some cases be the most suitable resources.

It is often effective to refer not to present-day Japan but to its past experiences when tackling the

challenges faced by Southeast Asian countries. Because these countries often show strong interest in the past experiences including the situation before the way when the Community-based Health Insurance system was introduced and the way the universal health insurance coverage was achieved after the war, assistance resources can be academic experts specializing in the history of social protection and those who were involved in the above achievements.

Table 2-2. Aid Resources from the Viewpoint of Three Perspectives

Perspectives	Knowledge and Skill Required	Prospective Aid Resource
1. Suitability of program design	• Experience in social studies and needs studies • Knowledge of the history of the development of social protection and systems of different countries • Knowledge of administrative laws, and laws concerning social protection • Knowledge and experience in formulation of administrative plans	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • National Institute of Population and Social Security Research • National Institute of Public Health • Local government officials • Researchers in administration and laws concerning social protection • Consultants
	• Knowledge of the historical development of Japan's Community-based Health Insurance program	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • Researchers in the history of social protection and health care policies
	• Knowledge of actuarial science	• Actuarial profession • Researchers
	• Knowledge of medical cost control	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • National Institute of Public Health • Researchers in health economics • Researchers in hospital management • Managers of medical institutions • Consultants
	• Knowledge of fiscal management	• Researchers in public finance
	• Knowledge of community welfare	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • Officials and ex-officials of local governments • Members of organizations working in community welfare such as social welfare councils in municipalities, NGOs
2. Efficient and Effective Program Management	Administrative work experience	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • Official and ex-officials of local governments
	Experience in managing social insurance	• Officials and ex-officials of the Ministry of Health, Labor and Welfare working in employment insurance • Officials and ex-officials of local governments working in Community-based Health Insurances • Managers of social insurance insurers such as Japan Health Insurance Association and Japan Pension Service
	Work experience in operational system design	• System engineers • System consultants
	Knowledge of information management of the insured	• Officials and ex-officials of the Ministry of Health, Labor and Welfare working in employment insurance • Officials and ex-officials of local governments working in Community-based Health Insurance

	Knowledge and work experience in pension funds	• Professionals in organizations dealing with pension investment or fund management • Academics
	Work experience in social welfare service implementation	• Social welfare councils in municipalities • Providers of social welfare services • Specialists in social welfare and human resource development
	Knowledge and work experience in community welfare	• Officials and ex-officials of the Ministry of Health, Labor and Welfare • Officials and ex-officials of local governments • Members of organizations working in community welfare such as social welfare councils in municipalities, NGOs
3. Infrastructure, Personnel and Systems	Knowledge and work experience in social welfare human resource development	• Japan National Council of Social Welfare, social welfare councils in municipalities • Providers of social welfare services • Stakeholders in human resource development
	Knowledge on a computer information system for social insurance programs	• Working-level officers of local governments working for Community-based Health Insurance • Working-level officers of insurers such as Japan Health Insurance Association and Japan Pension Service • Working-level officers of the examination and payment organizations such as Japan Health Insurance Association, Social Insurance Medical Fee Payment Fund, and All-Japan Federation National Health Organizations • System consultants • System engineers

For any person involved in assistance in this field, knowledge and understanding of the society, the healthcare and social protection systems of developing countries, especially of the country he/she will be working in, is required. Social welfare workers may also be listed as aid resources. They include case workers and other officials in the welfare department of municipal governments, and personnel of private institutions and NPOs. The contribution of officials of welfare-related organizations is anticipated from the viewpoint of developing officials engaged in welfare and the implementation of welfare programs. Consultants are expected to continue playing a key role in implementing cooperation. However, as the emphasis is towards the establishment of a self-sustained system for which management is primarily the responsibility of the counterpart country's officials, it is important that the consultants play a supportive and secondary role based on a solid understanding of the counterpart country's various social systems,

Chapter 3. Directions of JICA's Cooperation

3-1. Why Does JICA Support Social Protection?

① Realization of fundamental human rights and human security

Access to social protection is an internationally recognized human right[86] and enshrined in international human right instruments. Protecting the rights of citizens in the county is the state's responsibility and realizing these rights is a shared responsibility in the international community.

JICA promotes the concept of human security, which places individual human beings at its core, seeking to defend them from fear and want: fears from conflict, terrorism, disaster, environmental destruction, and infectious disease, and wants in the face of poverty and in social services and infrastructure. Social protection is related to human security in that protecting people from various threats and empowering them increases their abilities to address these threats themselves. Assisting in social protection is highly relevant with JICA's areas of work.

② Realization of inclusive and sustainable development, and contribution to global peace and stability

Supporting social protection contributes to global peace and stability. Social protection reduces poverty at the societal level and contributes to providing people with a sense of stability by preventing them from falling into poverty. Building a stable nation through establishing comprehensive social protection is the first step toward peace and stability not only within a country, but also within regions, and the international community.[87]

Social protection contributes greatly to the realization of JICA's vision "Inclusive and Dynamic Development". "Inclusive development" represents an approach to development that encourages all people to recognize the development issues they face, to participate in addressing these issues, and to enjoy the benefits of such endeavors. "Dynamic development" refers to the creation of self-reinforcing virtuous cycles of mid- to long-term economic growth and poverty reduction in a constantly changing environment where a variety of issues arise simultaneously and get entangled with each other. JICA's assistance

[86] Please refer to Annex 7 "Social protection and human rights"

[87] According to OECD report (2009b, p25) in Nepal social protection is on the agenda to help consolidate the peace process as the first stage of state-building. Nepal reformed the social protection system under the strong commitment after the post conflict in 2006. ODI (2012) reports that 95 percent of social expenditure is funded by Government of Nepal and social expenditure increased by 15 percent in FY2011/12 compared to the budget in previous year. Cash transfers were mainly provided in the reform. While OECD and ADB took this Nepal activity as a success case, it is reported that there is no clear evidence that cash transfers for the poorest people have an impact on public social protection program, or that they contribute to state-building as an issue of financial sustainability remains（ODI 2012）. Major donors are the World Bank, DFID, ILO, and ADB. They assist in design, analysis and collection of data.

aims to promote development without creating disparities.

③ Responding to urgent policy agendas

JICA's mission is to assist in the establishment of social protection that responds to urgent and emerging issues in developing countries. As many developing countries have achieved economic growth, their policy priorities are shifting toward improvement in the standard of living and sharing the benefits of economic growth. The establishment of social protection programs such as health care or pension programs has been emerging as one of their urgent policy agendas. In Southeast Asian countries, the rapid ageing of their populations is adding to the urgency and obligating them to respond to the challenge by reconstructing their social protection systems.

④ Realization of mutual learning in development assistance

Social protection assistance can foster mutual learning: Japan learning from developing countries' experiences and developing countries learning from Japan's experiences. Japan has one of the most rapidly ageing societies in the world and has responded to the issues in different policy areas such as health care, pensions, long-term care and the social environment. Supporting this area is one of Japan's responsibilities. Southeast Asian countries are expected to face these issues of ageing in the near future. They show great interest in Japan's experience with ageing and consider Japan at the "forefront" of the issue. Responding to the ageing society and reforming its social protection system are Japan's ongoing agenda. Studying and comparing Japan's social protection systems with those of other countries' and learning from their initiatives and experiences will contribute to solving similar challenges in Japan's communities.[88]

3-2. JICA's Priority Areas in Social Protection

One of the characteristics of Japan's experience in social protection is that Japan established its social protection system through mainly contributory schemes based on the western social protection model but at a relatively early stage of economic growth and when there was still a very large agricultural population. As previously mentioned, the development of a rapidly ageing society and the policies undertaken to respond to this situation are also one of the characteristics. When planning JICA's activities, these characteristics should be considered as comparative advantages. (See Annex 9 for the comparative advantages of Japan's experience in social protection.[89]) In this section, JICA's priority areas will be listed below and in reference to the stages of development discussed in Chapter 2.

[88] For example, if information technology can be utilized at a low cost in some communities of developing countries, where ageing and depopulation has progressed, to reach the elderly in order to confirm their safety and to track their condition, it could also be adopted in Japan.

[89] See also Shimazaki (2013) for Japan's experiences and lessons of the achievement of universal health coverage

3-2-1. Least Developed Countries (GNI per capita of US$1,005 or Less)

3-2-1-1. Social Health Protection

- Establish foundations to provide basic health services (within the framework of health sector cooperation)

  In the area of social health protection, the least developed countries need to establish the necessary foundations for providing basic health services such as medical institutions, human resources in health care, distribution and management systems of pharmaceutical products. JICA will assist in addressing this need in the framework of health sector cooperation.
- Non-contributory schemes

  As the World Bank, ADB and other donors have previous experience in initiating non-contributory programs in different countries, JICA will consider a co-financing or collaboration program of action with those donors when supporting non-contributory programs through ODA loans and grant aid schemes (See Annex 1 for collaboration cases and ODA loans.)
- Contributory schemes

  When countries at this stage of development consider establishing contributory schemes for the future, JICA will respond to government officials' needs to identify the necessary information and key points in designing a system through knowledge-sharing and consultation.

3-2-1-2. Income Security (Pensions)

- Non-contributory income security programs

  In the least developed countries, establishing non-contributory income security programs is more realistic. When establishing them, securing financial resources are essential. In providing technical assistance, a framework of public finance management assistance would be appropriate to increase the sustainability of financial resources within a country. As in social health protection mentioned above, the World Bank, ADB and other donors have previous experience in initiating non-contributory programs in different countries and JICA will consider a co-financing or collaboration program of aid with those donors when supporting non-contributory programs through ODA loans and grant aid schemes.
- Contributory income security programs

  When countries at this stage consider establishing contributory schemes for the future, JICA will respond to government officials' needs to identify the necessary information and key points in designing a system through knowledge-sharing and consultation.

3-2-1-3. Social Welfare Services

- Assistance for those affected by natural disasters and the socially vulnerable

  At this stage, provision of basic services is required using the resources available within the countries. The following frameworks would be appropriate: (a) for those affected by great disasters, JICA's emergency disaster relief (emergency humanitarian aid), (b) for

the socially vulnerable, dispatches of volunteers (Japan Overseas Cooperation Volunteers and senior volunteers) and cooperation under JICA partnership programs to respond to needs in the field.

- Development of social welfare services and human resources
  When governments begin to consider the development of social welfare services and social welfare professionals, JICA will respond to government officials' needs to identify the necessary information in designing a system, the types of services needed and the roles of professionals through knowledge-sharing and consultation.

3-2-2. Low- and Middle-Income Countries (GNI per capita of US$1,006～3,975)

3-2-2-1. Social Health Protection

- Coverage expansion for the informal sector
  For countries at this stage of development with contributory schemes that expand coverage to the informal sector, JICA will assist the countries with contributory schemes in designing and improving the program and sub-systems. For example, information management of the insured, contribution calculation, identification of beneficiaries who need contribution exemption, contribution collection, and measures for those with low-incomes and the non-workers are issues of major concern for expanding the coverage to the informal sector. Assistance will be given in reference to Japan's experience.
- Medical fee mechanism
  Establishing a medical fee mechanism that ensures the quality of medical services and controls medical costs is important from the point of view of financial sustainability. In providing assistance, the knowledge of Japanese academics will be an important resource. The DPC (Diagnosis Procedure Combination) introduced in Japan's medical fee schedule in 2003 was developed on the basis of the DRGs (the Diagnosis Related Groups) in the USA and other countries but adjusted to Japan's circumstances. A similar approach will be relevant for developing countries.
- Establishment of an information system
  Information management of the insured persons' identity needs to be effectively and accurately implemented, as does the examination and payments of medical fees. This requires a reliable information management system. JICA will assist in this area by tapping human resources, such as social insurance administrators and from the private sector.

3-2-2-2. Income Security (Pensions)

- Employee-based income security
  For an employee-based income security program, JICA's assistance will be focused on ensuring the program's financial sustainability and establishing or improving the related sub-systems. The cooperation issues will be an actuarial study of setting contribution and benefit levels, and management methods of reserve funds. Assistance will be provided by utilizing the knowledge and experience of academics, social insurance administrators, pension actuary professionals, pension fund management organizations, and other professionals in the private sector.

3-2-2-3. Social Welfare Services

- Development of a system providing social welfare services

  JICA will assist in a human resource development program for social workers who conduct consultation support and arrange the necessary services required based on a vulnerable person's identified social welfare needs. Another area for cooperation will be the development of standards of social welfare institutions. The dispatch of JOCV and senior volunteers who have knowledge in social work will be effective in this regard. JICA's Partnership Program can be applied to social welfare needs in the field where state involvement would be too early.

3-2-3. Upper Middle-Income Countries (GNI per capita of US$3,976～6,925) and Higher

3-2-3-1. Social Health Protection

- Medical cost control

  JICA will assist in the improvement of the medical fee system and the processing of medical fees, the establishment/improvement of the medical information system, and in the mechanism of financing medical costs for the elderly. In providing assistance, the knowledge of Japanese academics will be one of the important resources. Japan's experience in establishing DPC is relevant for upper middle-income countries from the point of view of medical cost control and quality development of medical services.
- Quality development and management of medical services

  Establishment or improvement of the medical information system and improvement of the medical fee system will be assisted for the purpose of improving the quality of medical services. In providing assistance, the knowledge of Japanese academics will be utilized.

3-2-3-2. Income Security (Pensions)

- Expansion of the coverage to the informal sector in a contributory income security

  There are many challenges shared by countries when expanding coverage to the informal sector in contributory income security programs: financial models (funded pensions or pay-as-you-go pensions), information management of the insured, contribution collection, and contribution and benefit setting in pay-as-you-go pensions. Assistance resources in this area will include social insurance administrators and pension actuary professionals.

3-2-3-3. Social Welfare Services

- Long-term care for the elderly

  JICA will support the following according to the social, economic and cultural situations of each country: development of long-term care services and long-term care professionals; capacity development of professionals, families and volunteers as caregivers; and, policy development for public support of long-term care. In assisting development of long-term care services and long-term professionals, the knowledge and experience of local government officials or long-term care service providers in Japan will be effectively utilized, and the dispatch of JOCV and senior volunteers will be promoted. As to policy development of long-term care, policy makers and

administrators will be supported so that they can develop sustainable public policies within the fiscal constraints. Japanese academics will be one of the resources for this assistance.

- Ensuring financial sustainability of social welfare services
  In regards to social welfare services, especially long-term care services, JICA will promote evidence-based assistance for the cost analysis of the services and for the analysis of financial resources to ensure financial sustainability within the fiscal constraints. Active involvement of Japanese academics will be promoted.
- Various activities for ageing[90]
  Referring to Japan's experience, knowledge-sharing will be promoted to identify the actions necessary to be undertaken. To respond to the issues of ageing, healthcare, pensions and long-term care services will not be enough. A number of initiatives are necessary: such as the establishment of age-friendly environments in housing and urban areas; ensuring the livelihood of the elderly and employment promotion for the elderly; developing products that take into consideration the physical conditions of the elderly (universal design); and disaster and violence prevention for the elderly.
- Strengthening the partnerships between central governments and ministries, central and local government partnerships, and public and private sector partnerships
  As previously mentioned, a multisectoral approach is needed when assisting the socially vulnerable, such as social welfare services and the housing and employment, industries. Sharing responsibilities and strengthening the ties between the central and local governments and the public and private sectors are also essential.

  JICA will assist in strengthening coordination among the health care, social welfare and housing sectors, the clarification of responsibilities of central and local governments, and the building of capacity of local government officials in collaboration with the public sector (profit and non-profit organizations). To support this endeavor, local government officials, academics, service providers in the private sector as well as central government officials will participate, while referring to Japan's experiences in the "forefront" of dealing with an ageing population.

3-3. Assistance Approach

A) Policy makers and Implementers' capacity development

One of JICA's strengths in technical assistance is an assistance approach based on dialogues with the various levels of stakeholders from the central to local staff, which in turn can contribute to strengthening their capacities. In the field of social protection, the same approach is adopted emphasizing capacity development.

[90] As a framework promoting concrete activities, WHO (2007) identifies 8 activity areas in "Global age-friendly cities : a guide", namely: a) outdoor spaces and buildings（as checklists, pleasant and clean environment, importance of green spaces, somewhere to rest, age-friendly pavements, safe pedestrian crossings, accessibility, a secure environment, walkways and cycle paths）, b) transportation, c) housing, d) social participation, e) respect for the elderly and social inclusion(activities to reduce discrimination and violence）, f) employment and civic participation, g) communication and information, and h) community support and medical services.

The target of capacity development can be groups at different levels such as high-level policy makers who are responsible for the overall management of social protection programs, central government officials (in charge of policy making or program design), technical staff (such as pension actuaries or cost simulators), municipal employees as implementers, social workers, family members, NGOs, care workers, and community volunteers as service providers. Although individuals are the direct targets of capacity development, it is important to ensure that individual capacity development leads to strengthening the capabilities of institutions and communities to improve policy or program development and implementation resulting in strengthening the capabilities of societies as a whole.

The purpose of JICA's capacity development assistance in social protection is to strengthen capabilities in order to address the issues described in the Chapter Two. In a social protection system, long-term stability is the most important element. In this regard, any assistance should ensure the financial sustainability of the programs.

The outcome of assistance programs aiming for capacity development are more difficult to measure objectively and quantitatively than assistance programs for hard infrastructure development. Realistic and measurable indicators for monitoring the programs should be identified at an early stage of the project. For this, discussions among the stakeholders are essential at the designing stage or the initial stage of the project.

B) Effective assistance through the appropriate selection and combination of various aid schemes

Another of JICA's strengths in development assistance is its utilization of various aid schemes, such as technical assistance, official development assistance loans, grant aid, volunteer dispatching, and partnership programs promoting cooperation within civil societies. As mentioned above in section 3-2 "JICA's Priority Areas in Social Protection", the appropriate selection and combination of these various aid schemes according to the project components can lead to effective assistance.[91] (For example, official assistance loans for non-contributory health care and income security programs, technical assistance for contributory health care and income security programs, technical assistance or volunteer dispatching for human resource development in social welfare services, and partnership programs at the local level for local social welfare needs which are premature for state involvement.) Combinations of assistance are also effective. (For example a combination of official loan aid, aimed at assisting financial gaps, and technical assistance, aimed at the development of social protection policies and programs; a combination of technical assistance in designing information systems for health care and income security programs; and official aid loans upon introduction of the system.)[92]

[91] Examples of JICA programs with different schemes are shown in Annex 1-2.

[92] Refer to Annex 1-2, ODA loan results No.1-2. JICA implemented projects co-financed with the ADB. The ADB also implemented a technical assistance project on establishing a targeting system.

C) Knowledge exchanges and policy advice through training programs, symposiums and seminars

Promoting knowledge exchanges with developing countries is effective in designing a project and in increasing Japan's contribution to the establishment of social protection systems. Japan's knowledge and experience[93] in social protection systems can be introduced through symposiums and seminars that would offer opportunities for further discussion. Furthermore, simultaneous discussion is needed to narrow down the topics leading to concrete project development. This may be time consuming but it is an important process.

In addition to introducing Japan's experience, promoting south-south cooperation is also an important form of assistance. This can be promoted by introducing the good practices of other countries that are facing similar development issues or through collaboration with countries that have more developed social protection systems such as Thailand. For example, Vietnam and Laos are receiving technical cooperation in social health protection from the Thai government, to which JICA can provide support.

To create an information-sharing platform on social welfare, health and labor, it is essential to effectively utilize the annual ASEAN Japan High Level Officials Meeting on Caring Societies, and JICA training in social insurance/social welfare administration conducted annually. Improvements in training content and promotional campaigns to increase the number of participants are needed, as such training programs are not known in target countries. Particularly, collaboration with ASEAN member countries on social health protection will focus more on continuous dialogue on specific themes such as the control of health expenditures or the improvement of medical fee payments, rather than the mere introduction and transfer of Japan's social protection system. For example, for countries, such as Malaysia, which are facing challenges in health care system reforms, getting information from other countries and inviting foreign professionals to participate is required more than ever. However, assistance from international organizations is decreasing every year because Malaysia is classified as a high-income country. Japan's efforts to share information with ASEAN member countries are pertinent to meeting these needs.

3-4. Points to Remember When Providing Assistance

A) Unique conditions of each country

When providing support to establish systems, it is necessary, first, to know and understand the different situations of a country and the country's long-term vision towards basic nation-building. Furthermore, the stakeholders must share the country's vision for social protection. Social protection systems in developing countries vary from those in developed

[93] For example, program establishment and implementation in social health protection and income security, information management systems, administration, human resource development, issues on ageing, etc.

countries due to diversity in their history, culture, religious beliefs, concepts of happiness and in their economic, social, and political systems. Although this thematic Guideline organizes effective approaches according to the income level of a country, the same income level does not necessarily mean the same approach can be taken to establish social protection systems. The diversities mentioned above must also be taken into consideration.

There are also a number of important fundamental factors that must be taken into account when designing social protection programs. Geographic conditions such as islands and mountains are important when deciding an insurance premium collection method or service delivery system. In the same way, economy and labor market situations, such as, economic prospects, income distribution among the people, the extent of formal economic development, and the situation of non-regular employment, need consideration when designing a health care or income security program. The former communist countries, for instance, could build on the former social protection systems of the old regimes. Demographics such as population ageing and falling birthrates affect the financial sustainability of a program and the design of social welfare services. Family and social conditions such as the trend toward nuclear families affect the types of services to be provided in income security and social welfare. However, the most fundamental elements that affect the way a social protection system is developed are the people's views toward social equality and solidarity.

B) Particular challenges and opportunities in developing countries that developed countries did not experience in the 20th century.

When designing assistance programs in developing countries and after identifying the needs of the countries, we need to work together with policy makers and implementers and invent possible and innovative solutions that address particular challenges and opportunities that present themselves, because the social protection systems and experiences of developed countries are not transferable to developing countries without the specific conditions that make the systems work in developed countries.

Although developing countries do share some common development challenges with developed countries, advanced information technology, such as the Internet or mobile phones, is rapidly becoming available, which was not available when developed countries faced similar issues. Demographically, Southeast Asia will face rapid ageing of the population in the near future. However, the income levels of these countries are far below than that of Japan when it went through the similar ageing process. Developing countries will be required to respond to the tasks ahead when it comes to ageing and expanding the coverage of health care and income security program to the informal sector, while simultaneously under administrative, financial and economic constrains. In terms of the administration at social protection system in more advanced countries, community based insurance programs usually identify beneficiaries by their addresses or income status through the municipality tax system. Such a system usually does not exist in developing countries.

C) Political risks

The sovereignty of nation-states must be respected when establishing social protection systems. A quick and easy intervention could be risky because it may be taken as interference in the domestic affairs of the state. Thus, any assistance activity needs to be provided carefully. It is also necessary to fully consider the risks involved in policy changes associated with a regime shift. In many cases, social protection systems are directly linked to guarantees of status and the economic interests of public servants and military personnel, and therefore, are not necessarily discussed from the standpoint of welfare alone. In some socialist countries or socialist countries in transition to market-based economies, employees' social protection is directly related to labor issues (political party), and cooperation on social protection may be considered as interference in political decisions.

D) Respect for informal resources

Human resource development in the field of social welfare in often cases is more likely to focus on the development of professionals such as caregivers. Public social welfare services were developed to complement the decline and lack of mechanisms to spontaneously solve problems through self-help and mutual support groups in a local community. If informal human resources such as neighbors, relatives and acquaintances in communities function fully, the need for institutionalizing such human resources should be examined carefully. It does not make sense if the development of professional human resources damages the human relations in traditional local communities.

In this regard, studies of communities are important in order to identify the unique characteristics and links in the social welfare system: to what extent do the local people depend on these local systems; to what extent are resources in social protection services available from the community to the state level; is there a system coordinating these resources; how does the political and administration system function; what are the family structures, etc. It is imperative to link the findings of such research to policy-making cooperation.

E) Traditional and religious elements

There are some cases where religious organizations and similar bodies play an important role in social welfare and have a social protection function in developing countries as well as developed countries.[94] In many developing countries, temples, churches and mosques run facilities to protect orphans and elderly widows.[95] These existing traditional and indigenous organizations maintain a strong public faith and virtually function as social welfare organizations, and it is, therefore, worth considering assistance for these social welfare organizations as a type of logistic support. At the same time, as public social welfare services expand, it is necessary to give consideration as to how to maintain harmony with these traditional services.

[94] Japan is rather unusual in this respect for not having many facilities run by religious institutions. Also the influence of religious institutions on volunteer activities such as grass-roots activities is weak in Japan, but they play a very important role in Western and Southeast Asian countries.

[95] See p. 215 "Discussion Paper on Poverty Reduction and Human Security" JICA (2005) for the role of Buddhism in the development of social protection systems.

In health-related areas, faith healers and folk healing practices are widely used and, function as alternative providers in remote areas where access to basic health care and welfare services are very limited. These old local practices and traditional assistance services must be respected unless they harm the health of the residents or prevent the introduction of more effective methods.

F) Establishing environments for long-term and continuous political dialogues

Establishing social protection systems requires long-term planning, strategy, and political commitment. Assistance to countries based on their needs, requires continuous dialogue and an implementation structure to establish a middle- to long-term field-based network. Therefore, a long-term commitment to assist a country is needed.[96] Major donors such as the ILO, World Bank and GIZ are playing important roles in the establishment of social protection in Asia. These donors carry on continuous policy dialogue with countries to identify needs in addition to technical project implementation.

In Asian countries where development of social protection is under way, the development of social protection may repeat the trials and errors at the design stage. Therefore, based on their needs, it is necessary to establish a mechanism to change the assistance approach according to their situational changes. A recent JICA study reveals[97] that "a running partner approach" is desired for implementers to garner ideas in designing their own programs, rather than showing the direction of their social protection system. "Running together" is an approach whereby Japan shares its experiences and responds to any detailed questions so that policy makers understand the necessity and effectiveness of social protection. A social protection system needs continuous reform after its establishment as needs constantly change in accordance with chancing situations. JICA will give advice on policy, however, it is equally important to build trusting relationships with countries as a dialogue partner.

3-5. Challenges Ahead

A) Ensuring human resources and documenting Japan's experience in social protection

Training specialists in the social protection sector is an urgent task. Japan has many experts in the social protection systems of Japan and western countries. Few of them, however, are capable of working in a foreign language, have enough knowledge of social protection systems in developing countries, or are able to undertake assignments abroad for a fixed period of time. Experts must have skills in capacity development. Although it depends on the objectives of a project, skills to elicit close communication with and capacity from the counterpart personnel are required, when promoting cooperation in the practical management of systems. Stakeholders in special fields, especially experts directly engaged

[96] OECD (2009c)
[97] JICA (2011a) (2011b)

in system management at the work site, cannot leave the domestic site for long periods of time, and thus have difficulty working overseas. These experts do not have much overseas experience, or their language proficiency is not adequate. Therefore, further study is necessary to devise strategies to reduce the burden on the experts, for example, a combination of short-term dispatch with training in Japan.

Ensuring human resources in developing countries is also important. There are a number of foreign students from developing countries who are studying Japan's social protection policies and measures dealing with ageing issues. The development and expansion of acceptance of such students is important in terms of long-term capacity development in developing countries. It is important for JICA to develop contacts with educational and research institutions such as universities, and organize various seminars and training programs in order to train these students.

As resources are needed to effectively assist other countries in social protection, it has been pointed out that documentation in English regarding Japan's experience (successes and failures) in social protection is essential[98]. This documentation will be used as basic information leading to further policy dialogue and project design. Although it is unrealistic to transfer Japan's social protection system into developing countries, in some cases, Japan's negative experiences[99] can be learned from.

B) Multisectoral coordination

It is very important to strengthen multisectoral coordination and collaboration in the fields of education and health within JICA. As mentioned above in the section on international trends, assisting developing countries to build coordinated and comprehensive social protection systems is a major trend in development. Multisectoral coordination is essential in establishing social protection systems, for example in finance, service delivery, administration, and in redistribution systems. In the area of social health protection, the provision of medical services and a social health protection system that provides services are inseparable. In order to avoid a situation where there is a system but no service, it is necessary to give consideration to a system design that is consistent with cooperation schemes in the health and medical service areas. As parallel activities to the establishment of a health protection system, procedures to reduce unequal access to service should be implemented. Issues concerning many low-income households or in social welfare as a whole are closely related to poverty and are inseparable with such development issues as rural development, regional development, agricultural technology development,

[98] Iwana (2011) See Shimazaki (2013) for Japan's path to universal health coverage prior to the 1961's achievement that was documented for the occasion of the TICAD V.

[99] For example, in Japan, in regard to utilizing informal resources, concepts, vision and principles of social welfare programs were not clarified so that the concept of Japanese social welfare state, wherein individual efforts and mutual aid among communities and families are taken for granted, was promoted when the economy took down turn and national revenues went into the red. This concept does not look at the weakening family structure resulting in human rights violation toward the elderly and the exhaustion of family members when functioning as caregivers.

improvement of health and hygiene, infrastructure development[100] and employment and labor. Social protection must focus on reducing and preventing poverty so that coordination with JICA's poverty sector is also important. Further cooperation between traditional areas and the social protection sector is necessary. This will create a new sector that utilizes the traditional cooperation framework.[101]

C) Systematic knowledge and evidence collection, building on past experience

One of the features of Japan's ODA is to value the importance of the decision-making process which is based on mutual agreement among stakeholders. JICA also values trusting relationships, the participation of local counterparts, a trial and error and hands-on learning experience, and a long-term institutional relationship.[102] Hands-on experience is JICA's strength. It is proven that these approaches are useful when pursuing development. However, it has been pointed out that Japan's development research is neither evidence-based, nor academic, but just a production of superficial materials that only summarize existing research or reports carried out by international organizations.[103] JICA can contribute to overcoming such problems in Japan's knowledge production by conducting academic research with its hands-on experiences. It is also important to generate a global level of knowledge that is versatile and applicable to a wide range of development assistance activities, and to disseminate the knowledge widely.

In the field of social protection, as well in many of the social sciences, it is very difficult to conduct rigorous experiments to collect data and to generate evidence without raising ethical issues. Focusing too much on data collection for the purpose of accumulating evidence could generate resentment from states and should be avoided. Evidence-based policy making, however, is required in developing countries as well as in developed countries. Since JICA has a variety of hands-on experience in the field, one of JICA's important contributions will be to respond to the developing countries' needs, and to generate the evidence required for their policy-making initiatives, Furthermore, in regions such as Southeast Asia where social protection is a common challenge, sharing the generated evidence with the countries within the region is a regional interest.

In addition to conducting academic research, documenting and analyzing the process of interventions is important as well. What does not work? What are the success factors? What are the factors of the different outcomes that have been generated with the same interventions in other projects? What are the reasons for the interventions not having been implemented as planned? One country's experience is not necessarily transferable to another country, but this analytical work will be useful.

[100] For example, ensuring access to health care centers or pension offices and ensuring building accessibility

[101] For example, the establishment of micro funds in agricultural development, or the establishment of guilds or trade unions and mutual aid systems in the trade sector

[102] JICA（2003a）

[103] Sawada, Yasuyuki (2008) The Research Institute of Economy, Trade and Industry (RIETI) An article titled "Development assistance: improve the research skill" dated 31 October 2008 from Nikkei Shinbun

In practice, when providing specific technical assistance to develop capacity among stakeholders, a data collection system should be integrated into project design, which can study the effectiveness of the program and determine the points to be improved. Continuous data collection and analysis is essential to create long-term impacts on countries establishing and improving social protection systems. Not only its knowledge and experiences in social protection in Japan, but also its systematic knowledge and evidence collection from past experiences with its assistance operations is important for JICA when providing evidence-based policy advice specific to country contexts. These may also be utilized when considering financial assistance.

Box. 3-1. Overview of Impact Evaluations in Social Protection

The World Bank analyzed 149 impact evaluations (which have a development focus, including the evaluations not funded by the World Bank) in social safety nets to find the evidence on the impacts of social safety nets (SSNs) interventions. The evaluations covered 32 developing and transition countries in five regions. More than half of the evaluations are conditional cash transfer. Examples of measured intermediate and final outcome indicators[104] are as follows.

- Education outcomes: enrolment/dropout rate of school, etc.
- Health outcomes: mortality, vaccination, number of people who are covered by health insurance, etc.
- Nutrition Outcomes：Height/weights of children, etc.
- Income/consumption/poverty outcomes：poverty incidence rate, poverty gap, Gini coefficient, income inequality, etc.
- Labor supply/economic activities outcomes：unemployment, child labor, income, etc.
- Indirect effects：Remittances, age of first marriage, change in household size, etc.

The World Bank identifies the gaps in knowledge and impact evaluations in the report such as: 1) what kind of impacts are there in other social safety net instruments?, 2) how specific factors in program components or implementation process contribute to the impacts of SSNs in the context of a country?, 3) what are long-term effects after the completion of the program?, and 4) what are the effects of program duration and length of participation?.

The followings are examples of indicators in different impact evaluations per area.

Social Health Protection：SKY micro-insurance program in rural Cambodia[105]

＊Does health insurance increase access and utilization to health care?

＊Does health insurance improve the health outcome of the beneficiaries？（frequency and duration of illness）

＊Does health insurance decrease the economic outcome of the beneficiaries?（medical expense, household loan）

Income Security：Brazilian non-contributory pension program[106]

＊Does pensions change the size of households

＊Does pensions decrease labor participation among elderlies and members of households?

＊Does pension change nutrition and enrolment/dropout rate among children?

Social Welfare：Accessibility for persons with disabilities[107]

＊Direct educational indicators(enrolment rates, retention and transition rates, completion rates, interruption and dropout rates, literacy rates);

＊A cost analysis of the given intervention (cost of education per child, etc.)

＊Qualitative outputs (views and opinions of the children, parents, teachers and community members regarding a given intervention)

Source：WB (2011) Evidence and Lessons Learned from Impact Evaluations on Social Safety Nets

[104] Regarding impacts of social protection please see also Chapter 1-2-2.
[105] AFD/USAID (2010)
[106] Kassouf (2012)
[107] Bakhshi P, Kett M, Trani J-F (2012)

Annexes

Annex 1. Japan's Major Cooperation Projects on Social Health Protection, Income Security, Social Welfare

1-1. Major Cooperation Projects by Governments

A. Trainings

Table 4-1. Trainings conducted by Governments

Title of Training Program	Objective	Description	Participants (1983-2003)
Training Program for the Asian Social Welfare Administrators*	To offer professional training for social welfare administrators of ASEAN members and neighboring countries, contributing to the development of human resources in these countries, to the improvement of the level of welfare, and to the mutual understanding and friendship between Japan and these countries	The program consists of general training, professional training, presentation of country reports, social welfare administration practices, and local government training, etc. A class starts with a presentation followed by a discussion and Q&A. Visits to welfare-related administrative organizations and others are provided on an as needed basis.	259
Training Program for the Asian Social Insurance Administration*	To offer professional training for managerial-level of officials in charge of social protection policies in ASEAN members and neighboring countries, contributing to the development of the social protection administration through the introduction of social protection systems of Japan	There are two courses: the Health Insurance Course and the Pension Course, consisting of general lectures (introduction of principles and conditions of social protection of Japan) and course-specific lectures (introduction of conditions of each specific area). Visits to insurance-related facilities and pension-related facilities are offered on an as needed basis.	133

* Both were relegated from JICA in 2004.

B. East Asian Meeting of High-Level Officials on Caring Societies

Table 4-2. East Asian Meeting of High-Level Officials on Caring Societies

Round	Period	Theme
First	January 12 – 13, 1998	Health care Finance System
Second	February 1-2, 2000	Income Security for Needy Persons – Focusing on Japan's Experience in the Establishment of a Pension System
Third	November 20-22, 2000	Current Situations and Issues of Health Insurance System
Fourth	November 19-22, 2001	Independence of the Handicapped Persons and Their Participation in Socioeconomic Activities
Fifth	January 15-17, 2003	Child Welfare

(Source) Ministry of Health, Labor and Welfare

C. ASEAN and Japan High Level Officials Meeting on Caring Societies

Table 4-3. ASEAN and Japan High Level Officials Meeting on Caring Societies

Round	Period	Theme
First	November 4-7, 2003	"Human Resources Development" in Social Welfare and Health
Second	August 30-September 2, 2004	Aging Society and Human Resources Development in Welfare/Health
Third	August 29-September 1, 2005	Partnership in Social Welfare/Health and Human Resources Development— Focusing on Maternal Child Health Welfare and Health Welfare for Handicapped Persons

(Source) Ministry of Health, Labor and Welfare

1-2. JICA's Major Cooperation Projects

Good practices in technical assistance are the project titled "Public Health Insurance Information System Development" in Thailand (No.2 in the table below) and the project titled "Development of a Community Based Integrated Health Care and Social Welfare Services Model for Older Persons in communities of Thailand （CTOP）(No.6 in the table below). The first project found sustainable after the project completed, a new health insurance administration system were being utilized in all the medical administrative institutions in 76 prefectures. This project is highly evaluated by the Thai Government and the phase II started in 2013 incooperating the lessons learned from the previous project.

A.Technical Cooperation Projects

No	Sector	Region/ Country	Project Title	Description	Period
1	Health protection	Asia/Korea	Health care Center for the Elderly in Korea	Technology transfer is made to the Health care Center for the Elderly, which the Korean Sacred Foundation is planning to establish. It targets cerebral embolism, which is a notable cause of many deaths and bedridden patients in Korea. The purpose is to improve the quality of health and the quality of life of elderly persons in Korea, within the following comprehensive framework of activities: 1. Disease prevention (internal medicine), 2. Diagnosis (internal medicine, radiology), 3. Treatment (internal medicine, surgery), 4. Rehabilitation, 5. Home nursing, 6. Research (epidemiology, nutrition)	1990.1-1995.10
2	Health protection	Asia/Thailand	Public Health Insurance Information System Development in Thailand	Thai Government established the 30-baht healthcare program in 2002, which covers about 40 million, second third of the population. This made it possible to cover those who were not covered by a health insurance in the past. This project was implemented to support system development and improvement of management capacity of the National Health Insurance Agency to implement nationwide coverage of the health insurance system in Thailand. Specific activities are as follows: 1. Accumulation of knowledge and information necessary for system development for paperwork involved in health insurance; 2. Improvement of capacity development of operational processing of the National Health Insurance Agency through the establishment of a pilot system; and 3. Proposal on the improving health insurance office system, based on the achievements of the pilot system. **Lessons learned** This project was highly appraised by the final and ex post evaluation. In the ex post evaluation, it was found that a new health administration system established through the project had being adopted in medical insurance offices in all the 76 state. Success factors are: establishing health insurance information system was a high priority in Thailand and political backing was given to the project, 2) effective and efficient technical assistance was achieved by a parallel implementation of developing manuals and establishing a pilot information system, which led to have opportunities reutilizing learned skills and theories at the same time、3) capacity of administration skills was improved by planning suitable trainings according to the needs of the target groups such as logical thinking, planning, meeting management, documentation which are usually not included as training topics, 4) strong commitment of Thai Government. Challenges are, first, to set up capacity development indicators in coordination with stakeholders at the early stage of the project implementation. There were no clear realistic indicators set up to measure the outcomes although this project aimed for institutional and human capacity development. Assistance in capacity development is in general hard to measure objectively the outcomes compared to that of the assistance in infrastructure. Second, it is important to document the project implementation from the earlier stage by either JICA experts or counterparts. For example, the vision of the projects or implementation status is critical information to ensure the relevance of a project. These documents will help new staff to take over the implementation.	2003.7 ～ 2006.7

3	Social welfare	Latin America /Mexico	Rehabilitation for Female Street-children	In Mexico City where the number of girls who live on the streets has increased, this project aimed to have such girls (in recent years, more than half of such girls are dependent on some kind of drugs) be socially rehabilitated through physical and mental recovery and capacity development and implemented activities such as 1) departure from drug dependence, 2) reduction of violent behavior, 3) acquisition of social ability not to revert back to life on the streets, 4) going back to school, and 5) acquisition of social participation ability through vocational training. Upon implementation of this project, "Casa Alianza", a local NGO, was utilized for vocational training, Japan Overseas Cooperation Volunteers and experts were dispatched.	2004.11 ～ 2007.11
4	Social welfare	Latin America /Chile	Social Welfare Policies for the Elderly	In Chile, the country with the third highest aging rate in Latin American, the important issues were care for the increasing elderly population, health promotion business and implementation of welfare services. This project aimed to develop the ability of welfare administration for the elderly in Chile and introduced a general and comprehensive welfare plan for the elderly carried out by the local governments of Japan where welfare for the elderly has advanced. Through this project, Chile carried out 1) provision of comprehensive consultation service for the elderly, 2) formulation of the plan on health promotion business and 3) establishment of the cooperation system between the central and local governments, etc., which meet the current circumstances of each local government.	2004.10 ～ 2007.9
5	Income security JICA's first technical assistance on pension	Asia/China	Development Study on the Improvement of Pension Systems in Rural China	With regard to the rural society endowment insurance system which have been implemented in various regions in China, evaluation and monitoring will be implemented in eight (8) targeted areas to find improvements in the systems and to improve the implementation of such systems. In addition, based on the results of this evaluation and monitoring, the rural society endowment insurance system which could be spread throughout the country and stably operated was clarified and further, the policy recommendations for the purpose of widespread use throughout the country as a sustainable public pension system were arranged. Further, through implementation of the survey, capacity development was carried out in relation to the establishment of a pension system for staff of the Ministry of Labor and Social Security and also targeted local government.	2006.01 ～ 2009.01
6	Health protection/Social welfare	Asia/Thailand	Development of a Community Based Integrated Health Care and Social	It is expected that Thailand will experience a rapid aging society in the near future and in order to improve the quality of life of the elderly, it is necessary to prepare a model to implement current inefficient services more effectively by organizing and consolidating them. Based on this situation, the project established a framework of cooperation among organizations which are involved in healthcare and welfare services for the elderly in the targeted areas (one tambon[108] in four provinces, respectively, i.e., Khon Kaen, Chiang Rai, Surat Thani and Nonthaburi), and analyzes situation of healthcare and welfare services for the elderly in the targeted areas to formulate an integrated model plan. In addition, through implementation of this project, it aimed to strengthen the capacity of personnel who engage in healthcare and welfare services for the elderly.	2007.11 ～ 2011.11

[108] 基礎的行政単位

			Welfare Services Model for Older Persons in communities of Thailand（CTOP） **Lessons learned**	One of characteristics of the project is that this project aimed to coordinate different ministries (social protection and health), and cooperate with communities by residents' participation, and the elderly who are still active participated as service providers. Thai Government shows their interest in expanding the model to other areas. The project received a high evaluation by the final evaluation. The success factors of the projects are: a) effective project implementation（ for example a monitoring system established to visualize the changes occurred which helped to increase motivations among stakeholders.）, b) active involvement of community stakeholders which increased their ownership to the project, c) providing mutual learning opportunities across project sites which stimulated local activities, d) increased institutional networking (among staff in charge of medical and social protection) , e) public private partnership, f) development of effective instrument to expand a model in rural communities such as documents including knowledge and lessons learned. Lessons learned are three folds: a) assistances for the vulnerable, the elderly and people with disabilities are highly relevant in Thailand transitioned rapidly to upper middle income countries from the view point of Japan's assistance mission "Inclusive Growth", b) Japan is a forefront of the population ageing in that health care programs for the elderly is decentralized. The assistance on ageing is an important development assistance agenda in Thailand. And also, assistance on ageing can provide opportunities of mutual learning. Utilization of community resources are also important in developed countries. c) other countries in transition have similar development issues on ageing as Thailand (ageing society, lack of coordination among ministries and central/rural government, lack of implementation capacity in rural institutions). Thai's experiences will serve as a good practice for other countries. It is important to study scientifically and provide evidence based outcomes and disseminate the outcomes to other countries.	
7	Social welfare	Asia/Thailand	Project on Long-term care service development for the frail elderly and other vulnerable people	The purpose of the project is to provide policy advices on financially sustainable long-term care program for the elderly. This project will target the elderly who need long term care, which were outside of the target of CTOP, and utilize the community-based integrated services which is the outcome of the CTOP. Expected outcomes are threefold: 1) Evidence based policy advices given, 2) a model service developed and implemented on pilot project sites which are effective and sustainable 3) a human development program developed for care workers and care coordinators. Major activities are cost analysis, evidence analysis, policy advice, long term care services at home on the basis of care coordination in 6 pilot project sites (urban and rural), trainings for care workers and care coordinators, etc.	2013.1 ～ 2017.8

B.Yen Loan

The followings are the cases in which improvement of social protection systems of support receiving countries have been promoted through structural adjustment lending, etc.

No	Region/ Country	Project Title	Scheme	Objective	Amount	Fiscal Year
1	Asia/Mongolia	Social Sector Assistance Program (II)	Co-financed with ADB	The project is on social welfare, health, education and urban development sectors. This is the phase two of the 2009 social sector assistance program (I), in which all lending conditions were achieved. This project aims to enhance the protection of the poor by shifting the focus to the poor in one part of welfare programs which used to target the entire households regardless of their incomes.	¥15.5 billion	2012
2	Asia/Mongolia	Social Sector Assistance Program	Co-financed with World Bank and ADB **Lessons learned**	It is a loan provided to support policy actions of Mongolia under social protection reform formulated as a result of the financial crisis in 2008, in the fields of social welfare, healthcare, education and urban development. This program aimed to trim influence by the financial crisis in particular to the poverty group through development of safety net, etc., and then build capacity to respond to financial crisis in the future. This project received a high evaluation in the ex post evaluation done by ADB.[109] One of success factors is that the project was implemented in conjunction with a technical assistance. The report strongly suggests long term assistance by ADB as establishing a targeting system requires a technical assistance aimed at long term capacity improvement. The 20 months of the project duration is reported insufficient.	¥2.894 billion	2009
3	Asia/ Kyrgyz Republic	Social Sector Adjustment Program	Co-financed with the World Bank	This program aims to improve the balance of payment of the Kyrgyz Republic whose economy was experiencing great hardship as a result of the Russian economic crisis. It also provides support for the reform of social protection systems, such as the pension system, which placed a burden on the state finances. The pension plan was under a transition from the system in which payment is made regardless of its participation, to a system in which payment is made according to the premiums paid and to the retirement age. However, adjustment of benefits was not able to keep up with the pace of inflation due to the fragile economy which imposed negative impacts on pensioners.	¥2.318 billion	1999
4	Asia/Thailand	Economic and Financial Adjustment Loan	Co-financed with the Second Economic and Financial Adjustment Loan of the World Bank	It is a structural adjustment loan provided as a part of assistance to help the Thai economy recover, based on the New Miyazawa Initiative. It aims to strengthen the structure of the Thai economy through financial reform, enterprise reform, and the promotion of privatization, while seeking a short-term economic recovery by extraordinary spending increases as social protection and employment measures.	Equivalent to US $60 million	1999
5	Europe/ Russia	Coal Sector Adjustment Loan	Co-financed with the second Coal Sector Adjustment Loan of the WB	It is a structural adjustment loan for the support of the Russian coal sector reform. The reform plan, or the loan condition, included the phrase, “improvement of the social protection system for mineworkers who will be affected by the reform.”	Equivalent to US$ 80 million	1998

C.Training Program（Group, Youth invitation program, country focused）

Type	Start Year	Country	Course Title	Center in charge	Status	No of Participants															
						97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	Total
Group	1997	N/A	Ageing Society and Welfare Services Seminar	Kyusyu	Done	8	7	6	7	6												34
Group	1999	N/A	Nursing Care for the Elderly	Chugoku	Done			9	10	11												30
Group	2004	N/A	Study Program for Senior Social Welfare Administrators (Note 1)	Tokyo	Continued								9	8	9	10	5	6	11			58
Group	2004	N/A	Study Program for Senior Social Insurance Administrators (Note 2)	Tokyo	Continued								9	7	8	13	7	6	4			54
Group	2007	N/A	Day Care Services in Welfare Programs for the Elderly (Day care and Prevention of	Hokuriku	Continued											4	4	2				10
Group	2007	N/A	Development of Comprehensive Victim Support System	Tsukuba	Continued											10	8	5				23
Group	2010	N/A	Social Welfare Services Administration	Tokyo	Continued														12	9	9	30
Group	2011	N/A	Social Insurance Administration	Tokyo	Continued															6	13	19
Youth	2007	Indonesia	Social Welfare（Orphanages）	Kyusyu	Done											18						18
Youth	2007	Thailand	Young Leaders for Thailand (Child and Youth Welfare)	Shikoku	Done											15						15
Youth	2007	Turkey	Social Welfare (Foster Care)	Shikoku	Done											19						19
Youth	2008	India	Young Leaders for India (Social Welfare)	Hokuriku	Done												15					15
Youth	2008	Thailand	Social Welfare (Child Welfare and Youth Development)	Kyusyu	Done												16					16
CF	2000	Cambodia	Social Welfare Administration	Tokyo	Done				5	5	5	5	5									25
CF	2002	Thailand	Country focused Training Medical Insurance Administrators for Thailand	Tokyo	Done						10											10
CF	2003	Philippines	Social Insurance and its Promotion	Tokyo	Done							4										4
CF	2005		Civil Society Support	Tokyo	Done									5								5
CF	2006	China	Social Welfare Services Model for Older Persons	Tokyo	Done										17							17
CF	2007	Thailand	Measures for Ageing Society	Tokyo	Done											17						17
CF	2012	Egypt	The Training for Strengthening the Multidisciplinary Mechanism to Protect Children in Need	Tokyo	Done																8	8
CF = Country-focused					Total	8	7	15	22	22	15	9	23	20	34	106	55	19	27	15	8	427

(Note 1) As part of official development assistance (ODA) from the Government of Japan, Japan International Cooperation of Welfare Services (JICWELS) provided the training program for senior administrators in social welfare services in developing countries under the supervision of the Ministry of Health, Labor and Welfare from FY1983. The budget was transferred to the Ministry of Foreign Affairs in FY2004 and JICA provided training for three consecutive years. Since FY2007, it has provided the training with cooperation from the Ministry of Health, Labor and Welfare, JICWELS and other concerned organizations. The training has been provided under the following names: Study Program for Senior Social Welfare Administrators in Asian Countries in 2004, Study Program for Senior Social Welfare Administrators in Asian Countries in 2005 and 2006, and Study Program for Senior Social Welfare Administrators since 2007.
(Note 2) As part of official development assistance (ODA) from the Government of Japan, Japan International Cooperation of Welfare Services (JICWELS) provided the training program for senior administrators in social insurance policy in ASEAN member countries and other developing countries under the supervision of the Ministry of Health, Labor and Welfare from FY1991. The budget was transferred to the Ministry of Foreign Affairs in FY2004 and, since then, JICA has provided training with cooperation from the Ministry of Health, Labor and Welfare and JICWELS. The training has been provided under the following names: Study Program for Senior Social Insurance Administrators in Asian Countries in 2004, Study Program for Senior Social Insurance Administrators in Asian Countries in 2005 and 2006, and Study Program for Senior Social Insurance Administrators since 2007. (Source) JICA Website (http://www.jica.go.jp)

D. Individual Expert Dispatch (Source) JICA Website (http://www.jica.go.jp)

Year	Country	Details of work	Office in charge	Term (short/long)	Period
2002	Cambodia	Social Welfare Advisor		Long-term	2002.06-2004.06
2004	Philippines	Delinquent Youth Training Facility Management/Monitoring and Evaluation of Educational Training Programs		Short-term	2004.09-2004.11
2005	Lao People's Democratic Republic	Social Protection Advisor		Long-term	2004.08-2009.08
2008	Myanmar	Social Welfare（Rehabilitation Assistance for Victims of Human Trafficking）	JICA Myanmar Office	Short-term	2009.03-2010.03
2010	Vietnam	Advisor on Anti-trafficking measures	JICA Vietnam Office	Long-term	2010.05-2011.05
2011	Thailand	Social Protection Advisor		Long-term	2011.11-2012.8

E. JICA Partnership Program

Year	Country	Project Title	Period	Type of scheme	Implementing organization	Center in charge
2003	Sri Lanka	Establishment and management of information center and orphanages for orphans	2003.12-2006.11	Support	Shiai Kyokai	Hiroo Center
2004	China	Okayama Shanghai Teacher Training Center for Care Giving for Seniors	2005.04-2008.03	Partner	Asahigawasou	Chubu International Center
2005	China	Construction Improvement Plan for the Elderly in Cold Region	2007.08-2010.01	Community proposal	Asahikawa International Committee	Sapporo International Center
2006	China	Elderly Care and Support Seminar	2006.07-2008.09	Community proposal	Gifu Jyurakuen	Chugoku International Center
2007	Cambodia	Life Saving Safety Network for the Social and Economical Disadvantaged People in West Phnom Penh	2008.01-2011.01	Partner	Tokushima International Cooperation Japan (TICO)	Shikoku Branch Office
2008	Philippines	Recovery Project for Drug Addicts in Poverty Group in Manila	2009.05-2012.03	Support	Asia-Pacific Addiction Research Institute (APARI)	Hiroo Center
2008	China	Jiangxi in China Teacher Training Project for Care Giving for Seniors	2009.07-2012.03	Partner	Asahigawasou	Chubu International Center
2011	China	Staff training project in the field of medical welfare in Shanghai	2011.09-2014.03	Partner	Asahigawasou	Chubu International Center
2011	Serbia	Psycho-social project for the children in Ralja, Smederevo, Kaludjerica, Belgrade	2012.02-2015.01	Support	ZDRAVO DA STE	Hiroo Center
2012	Brazil	Development of Psychological Support for Returnee Dekasegi and Their Children in the State of San Paulo	2012.6-2015.03	Community proposal	Sao Paulo State University	Hiroo Center
2012	Philippines	Capacity building project for Child caring institutions' Personnel towards Children's Well-being and independence in Central Luzon	2012.10-2015.09	Partner	—	Hiroo Center
2012	China	The leader training support project of Nursing care in Shaanxi Province	2012.12-2015.11	Support	Shaanxi Labor College	Hiroo Center

(Source) JICA website (http://www.jica.go.jp)

F. Dispatch of Volunteers

(a) Elderly Assistance（1965～Feb. 28）

		Asian Region				Classified Total	Africa Region	Classified Total	Pacific Region	Classified Total	North Ameriica and Latin American Region															Classified Total	Total
Classfication of Volunteers	Job Type	Sri Lanka	Thailand	Maldives	Laos		Gabon		Palau		Argentina	Uruguay	Ecuador	Costa Rica	Colombia	Chile	Dominican Republic	St. Lucia	Nicaragua	Panama	Paraguay	Brazil	Peru	Bolivia	Honduras		
Senior Overseas Volunteers	Social Worker		2			2					1	1														2	4
	Nutrition Improvement		0			1																					1
	Basic Health		1			1																					1
	Occupational Therapist		1			1																					1
	Social Welfare											2		1									1		1	5	5
	Comprehensive Regional Development Project															1										1	1
	Gymnastics													2												2	2
	Culture															1										1	1
	Physical Therapist		1			1																					1
Classified Total			6			6					1	3		3		2							1		1	11	17
Japan Overseas Cooperation Volunteers	Computer Technology														1	3										4	4
	Social Worker	5	2			7	1	1										1								1	9
	Nutritionist												1			1				1						3	3
	Housekeeping																		1						1	2	2
	Nurse								1	1						4										4	5
	Tourist Industry															1										1	1
	Construcion Machine				1	1																					1
	Occupational Therapist	1				1								2		7	1									10	11
	Handcraft															2										2	2
	Swimming													3												3	3
	Gymnastics	1				1										2										2	3
	Health Nurse															2										2	2
	Vegetable															3										3	3
	Care						1	1																			1
	Physical Therapist	3		1		4								1		2										3	7
	Acupuncture and Message															2										2	2
Classified Total		10	2	1	1	14	2	2	1	1			1	6	1	29	1	1	1	1					1	42	59
Japan Overseas Cooperation Volunteers (short term)	Social Worker																	1								1	1
	Physical Therapist	2																									2
Classified Total		2				2												1								1	3
Japaese Society Senior Volunteers	Welfare										1						1				1	7		1		11	11
	Health Nurse																							1		1	1
	Acupuncture and Message																1									1	1
Classified Total											1						2				1	7		2		13	13
Japanese Society Youth Volunteers	Elderly Care										2										4	5				11	11
	Social Walfare Counselor																1									1	1
Classified Total											2						1				4	5				12	12
Total		12	8	1	1	22	2	2	1	1	4	3	1	9	1	31	4	2	1	1	5	12	1	2	2	79	104

(b) Support for Street Children (1965～Feb. 28, 2010)

		Asian Region			Classified Total	Africa Region								Classified Total	European Region	Classified Total	Middle East Region			Classified Total	North Amerika and Latin American Region							Classified Total	Total
Classfication of Staff	Job Type	Nepal	Bangladesh	Philippines		Uganda	Ghana	Kenya	Zambia	Tanzania	Niger	Burkina Faso	Rwanda		Romania		Yemen	Egypt	Morocco		Guatemala	Colombia	Nicaragua	Paraguay	Bolivia	Honduras	Mexico		
Senior Overseas Volunteers	Social Welfare	1			1																								1
Classified Total		1			1																								1
Japan Overseas Cooperation Volunteers	Social Worker							3	1	1	1	2	1	9	3	3					3							3	15
	Music																							1				1	1
	Housekeeping						1	3						4															4
	Nurse																								1			1	1
	Automobile Service			2	2																								2
	Handcraft							1						1				1		1							1	1	3
	Judo																									1		1	1
	Primary School Teacher							1						1															1
	Edible Crop. Rice Cultivation							1						1															1
	Youth Activities					2		3	5			1		11			1	9	1	11	2	1		1			3	7	29
	Village Development Promoter																		1	1			1				1	2	3
	Electronic Device			1	1																								1
	Beautician																							1				1	1
	Woodwork																					1						1	1
	Welding							1						1															1
	Refrigerating Equipment			2	2																								2
Classified Total				5	5	2	1	13	6	1	1	3	1	28	3	3	1	10	2	13	5	2	1	3	1	1	5	18	67
Japan Overseas Cooperation Volunteers (short term)	Social Worker												1	1															1
	Youth Activities		1		1														1	1						1		1	3
Classified Total			1		1								1	1					1	1						1		1	4
Total		1	1	5	7	2	1	13	6	1	1	3	2	29	3	3	1	10	3	14	5	2	1	3	1	2	5	19	72

G. Study Project

Description	Title	Year
Report on Support Research	Basic survey in relation to social safety network – for the purpose of establishment of social safety network in developing countries–	2003
Report on Support Research	"Development of Japan's Social Protection System -An Evaluation Implications for Developing Countries- " (in Japanese and English)	2004
Report by Visiting Researcher	Facing up to the Problem of Population Aging in Developing Countries: New Perspectives for Assistance and Cooperation.	2006
Report by Visiting Researcher	Financial Market Enhancement and Social Protection in the Ageing East Asia-Possible Area of Intellectual Assistances-	2008

(Source) JICA website (http://www.jica.go.jp)

Annex 2. Social Protection Experiences in low and middle income countries

In this section, social protection experiences in low- and middle-income countries are listed below, which are presented as successful cases by international donors. Program listed below include schemes out of the scope of this Guidelines (health protection, income security, social welfare).

A. ILO/UNDP

Country	Program	Type	Coverage	Impact
Argentina	Asignación Universal por Hijo (AUH)	Universal child allowance	85% of Argentine children	• Reduced poverty (-22%) and extreme poverty (-42%); • Positive impact on household income (for poorest households income almost doubled, for poor households income increased by 30%); • Reduction in income distribution gap.
Bolivia	Renta Dignidad	Universal old-age pension (noncontributory)	800,000 beneficiaries (97% of total eligible beneficiaries)	• 5.8% reduction in extreme poverty between 2007 and 2009 (especially in rural areas).
Brazil	Rural Social Insurance Programme	Non-contributory pension and disability programme for the rural poor	80% of agricultural workers - 66% of rural population	• Reduction of 4 million poor people (53.5% of the rural population was still poor but this figure would have jumped to 68.1%); • Reduction of 4.1 million indigent people (26.1% of the rural population was indigent in 2008, but without social transfers it would have been 41.3%).
Colombia	The General System of Social Security in Health	Universal health coverage	90% of the population	• Facilitated the use of health services, especially among the poorest population and the rural population; • Reduced poverty by more than 2% and inequality by more than 3%.
Chile	Red Protege	Social protection system. The three pillars of the system are: a) Chile Solidario (social protection for the poor and	NA	The reform is to design a program based on a life cycle approach, to include family members as beneficiaries, to provide cash transfers, and to promote human rights approach.

		vulnerable) b) Chile Crece Contigo(targetting for children),c) employment protection system Reformed 2006-2010		
Mexico	Oportunidades (Human Development Programme)	CCT	25% of the population	• Education in rural areas: including increase in attainment; • Health: including increased preventive medical check-ups, 11% reduction in maternal mortality and 2% reduction in infant mortality; • Nutrition: including increase in the absolute height of children and families' increased total consumption.
Ecuador		Universal pensions (contributory)		・ Set up a national social protection committee ・ Legalization
Rwanda	Vision 2020 Umurenge Programme	Public works, direct support and financial services	9,692 households benefited from direct support transfers – 78,004 benefited from public works	Ongoing evaluations: • Reduced poverty; • Contributed to improvements in human poverty dimensions (such as education, health, food security and nutrition), community asset development, the environment and social participation.
South Africa	Child Support Grant	Means-tested non-contributory cash transfer	10 million children - take-up rate ranges between 78% and 80% of the children who are eligible	• Reduced the poverty gap by 28.3%; • Reduction of income inequality (all three social grants – old-age pension, disability grants, child support grant – lower the Gini coefficient by 3%.)
Mozambique	Social Protection Floor	Cash transfers for the poor, access to health care for the vulnerable	NA	•Developed a national social protection strategy in 2010 •Social protection law was enacted in 2007
Burkina Faso	Social Protection	Universal social security in health	NA	Steps taken for Social Protection Floor were: 1. Capacity building, 2. Program design, 3. Synergy between programs, 4. Definition and establishment of targeting system, 5.

	Floor			Establishment of data collection system and monitoring/evaluation system, 6.innovative mechanism in finance
India	Mahatma Gandhi National Rural Employment Guarantee program	Wage employment programme	52.5 million households	• Increase in minimum wages for agricultural labourers; • Decreased out-migration from villages; • Women's empowerment; • Positive impact on the geographical-ecological environment. Note: This is one of poverty reduction programs which Indian Government (rural development) initiated in 2005 to ensure jobs. Yearly 100 days of works are guaranteed in law. The target is adults in rural areas who accept the minimum wage of 2.39 USD (as of 2009) and participation of public works. The financial source is both central and local Governments. The wages are paid by 100% Governments
China	The rural New Cooperative Medical Scheme (NCMS	Voluntary enrollment targeting rural residents and the poor	833 million enrollees by the end of 2009; the enrolment rate was 94 per cent of the target population and about 62 per cent of the whole population	The proportion of out-of-pocket expenditure has come down from nearly 80 per cent to about 60 per cent. Farmers' out-of-pocket spending as a share of per capita net income decreased from 74 per cent to 44 per cent with the introduction of the Schemes.
Thailand	Universal Coverage Scheme	Universal health care	80% of the population	• 88,000 households in 2008 were prevented from falling below the poverty line; • Increased access to care; • Increased quality of care.

Source：Successful Social Protection Floor Experiences Vol. 18 p15～p16

B. WB, ADB, and OECD

Country	Program	Impact	Source
Nepal	Universal old age pensions	Under constrains financial, political and economic, Nepal provided universal pensions for the elderly and increased the level of benefits.	ADB (2012) Social pension for older people in Asia
India	Expansion of micro health insurance to the informal	Actor：Self Employed Women's Association, currently Labor Union, established a micro health insurance for working women in the informal sector in 1972. Member：At the beginning 32,000 people, now expanded to 4 states including Gujarat and total 195,472 people. A future plan is to expand the program to other	ILO: Extending social security coverage to informal economy workers way forward (p31)

	sector [110]	states than 4 states and increase members to 350000 people. Beneficiaries：Initially only a member, but the coverage was expanded to his/her family members and children.	
Mauritius	schemes widely applied to all elderly residents	Impact on the living standards of elderly persons and their families, namely on children	OECD (2009) Can Low-Income Countries Afford Basic Social Security?
Namibia	schemes widely applied to all elderly residents	Impact on the living standards of elderly persons and their families, namely on children	Ibid
Mali	Micro Health Insurance	In Mali, a micro health insurance has been implemented since 20 years. It was scaled up to a national project, which is expected to contribute to the achievement of universal health coverage. In 1996, a legal framework to support the micro health insurance. In 2010 to 2011, the government finally launched a scale up strategy. In the national strategy, it is clearly stated that subsidies should be allocated to the micro health insurance. This is an example towards universal health coverage by scaling up a micro health insurance to a national program.	Mbengue, Cheikh, Katie Senauer, and Fred Rosensweig. August 2012. Scalling up Community-based health insurance in Mali. Brief. Bethesda, MD: Abt Associates Inc.
Ghana	LEAP (Livelihood Empowerment against Poverty) Health care and cash transfers for the poorest	A trial started in 2008. Progressively the program was expanded. 35000 households received the benefits in 2010.	University of North Carolina Website www.cpc.unc.edu/projects/transfer/countries.ghana

[110] According to ILO, there are three pathes to expand a program to the informal sector. ILO (2012) Extending social security coverage to informal economy workers way forward (p31) ① expansion of existing programs, ② establishment of epecific program targeting informal sectors, and ③ promotion of micro insurance

C. WHO

WHO provide success story documents towards universal health coverage. WHO states that the cases presented in these documents reveal problems as well as progress, and thus should not be considered as completely successful, but they do offer valuable insight on the steps countries have taken in order to move towards Universal Coverage, and as such represent valuable lessons learned that can inspire other countries. These "Success Story" documents are produced under the providing for Health (P4H) initiative by the World Health Organization with support from the French Ministry of Foreign and European Affairs.（Refered to Chapter 1-3-1 International trends）

- Burundi's adoption of performance -based-finance to fund fee-exempt health services
- Cambodia: breaking down the barriers to access using health equity funds
- Chile: improving access, quality and financial protection
- Ghana: coverage expansion through political commitment and innovative policy choices
- Rwanda: Building from the bottom, steering and planning from the top

Source：WHO Website for P4H http://www.who.int/providingforhealth/p4h_success_stories/en/index.html

D. Help Age International

Countries where universal pensions (include near universal) are in place in Africa are:

- Namibia
- Botswana
- South Africa
- Lethoto
- Swaziland
- Mauritius

Source: A video titled "Pensions in Africa" on the website of Help age international

E. Institute of Developing Economies, Japan External Trade Organization (IDE-JETRO)

Mr. Usami, a researcher in IDE-JETRO, explains about why some nations/regions, regardless of a lower income per citizen ratio compared to newly developing nations like NICS, has remarkable statistics regarding infant death ratio or literacy (also known as low development welfare state) in a report published in 2003, "Introduction: Comparative Study of Social Security Systems in Asia and Latin America – A contribution to the Study of Emerging Welfare States". The report explains the social protection system situation of the nation and how such a system was established. Mr. Usami picks up cases from Cuba and Kerala, India.Social protection in Cuba: In Cuba, they have universalized social services and provided strong coverage, most of them rarely seen in other nations, and increased the living standards of the poor and the socially vulnerable. There are two political/economical reasons that made this universalization successful. The first reason is the government's decision to distribute a handsome coverage equally to all citizens as one of their policies. The second reason is the financial support they have received from the Soviet Union, which made this provision possible.

Social protection policies in Kerara, India: The first reason that made this possible is the grouping of citizens, active requests and movements, active criticism of the government by regional

democratic parties, the existence of public movements, and the fact that welfare policies and public movements had a positive synergy effect. Second reason is the movement by the private sector. Everything from circulation of foods, medical care, and education were not all supported by the government. Private sectors played an important role in delivering these services.

Source
Social protection in Cuba: http://d-arch.ide.go.jp/idedp/KSS/KSS053100_011.pdf
Social protection policies in Kerara, India: http://d-arch.ide.go.jp/idedp/KSS/KSS053100_010.pdf

F. Good practices database of International Social Security Association (ISSA)

Documentations of experiences from all over the world can be searched. For example, in the search of disability scheme, descriptions of programs from Mexico, Jordan, and Brazil are found. More on ISSA Website：http://www.issa.int/Observatory/Good-Practices

Annex 3. Basic Socio-Economic Indicators

In this section, basic socio-economic indicators from 17 countries listed below are compared per regions or countries and levels of economic development.

Table 4-4. 17 Countries for the Comparison

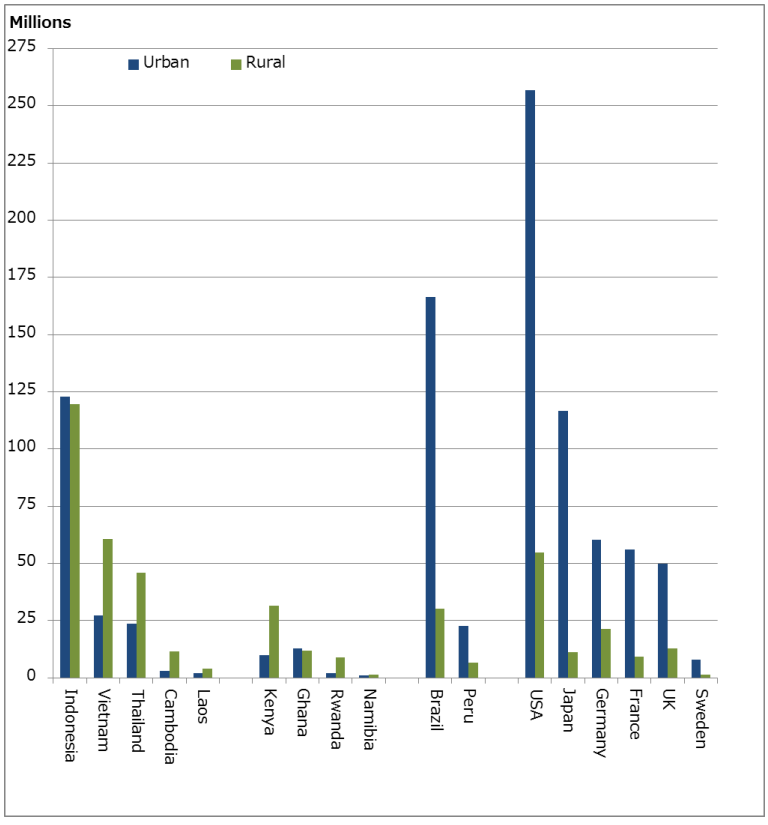
Asia	Indonesia, Cambodia, Vietnam, Laos, Thailand, Japan
Africa	Kenya, Ghana, Namibia, Rwanda
Latin America	Peru, Brazil
USA and Europe	USA, UK, Germany, France, Sweden

Low income	Cambodia, Laos, Kenya
Middle income	Vietnam, Indonesia, Ghana, Rwanda
Upper middle income	Thailand, Peru, Namibia, Brazil
High income	Japan, USA, UK, Germany, France, Sweden

＊Income level is classified based on the WB classification as of March 2013.

A. Demographic

Figure 1. Urban and rural population (% of the total population) （2011）



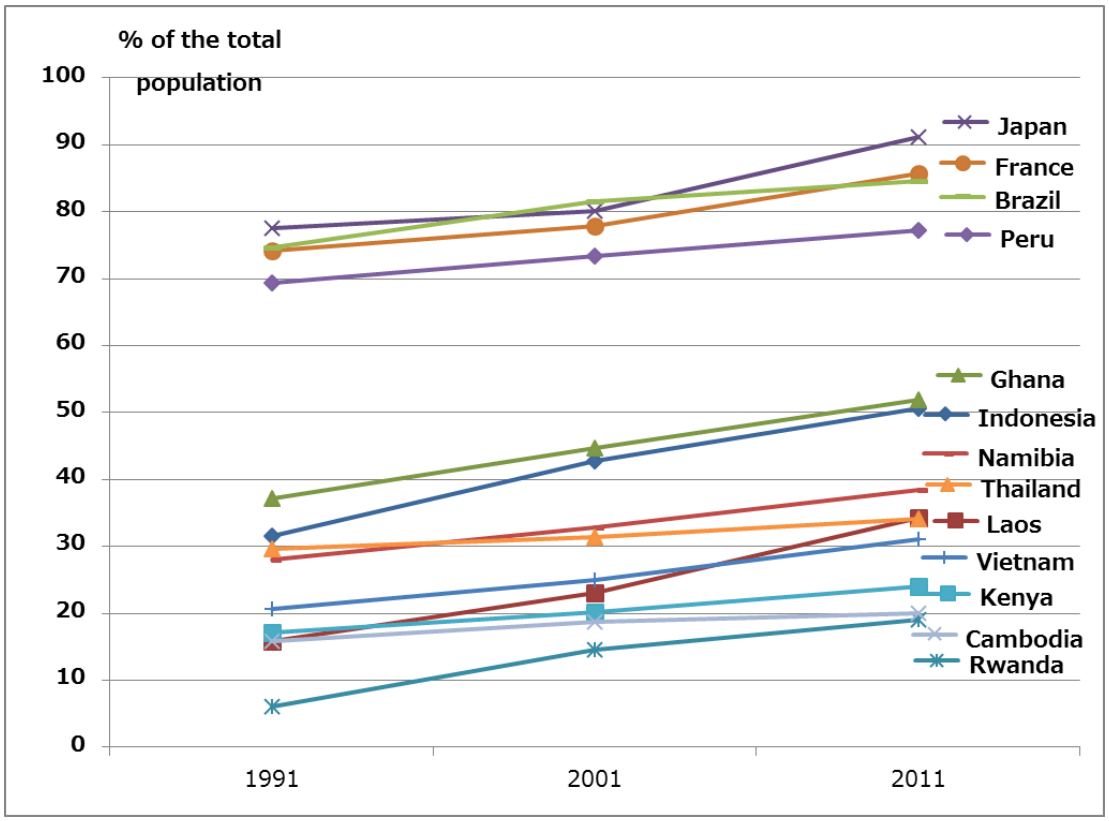
In general, population is concentrated in rural areas in low income countries.

In upper middle income countries and high income countries, urban population is greater than rural population, while, rural population is greater in low- and middle-income countries, except for Indonesia and Ghana.

Source：WB, World Development Indicators 2011

Figure 2. Transition of urban population（2011）

Urban population is increasing in all countries.

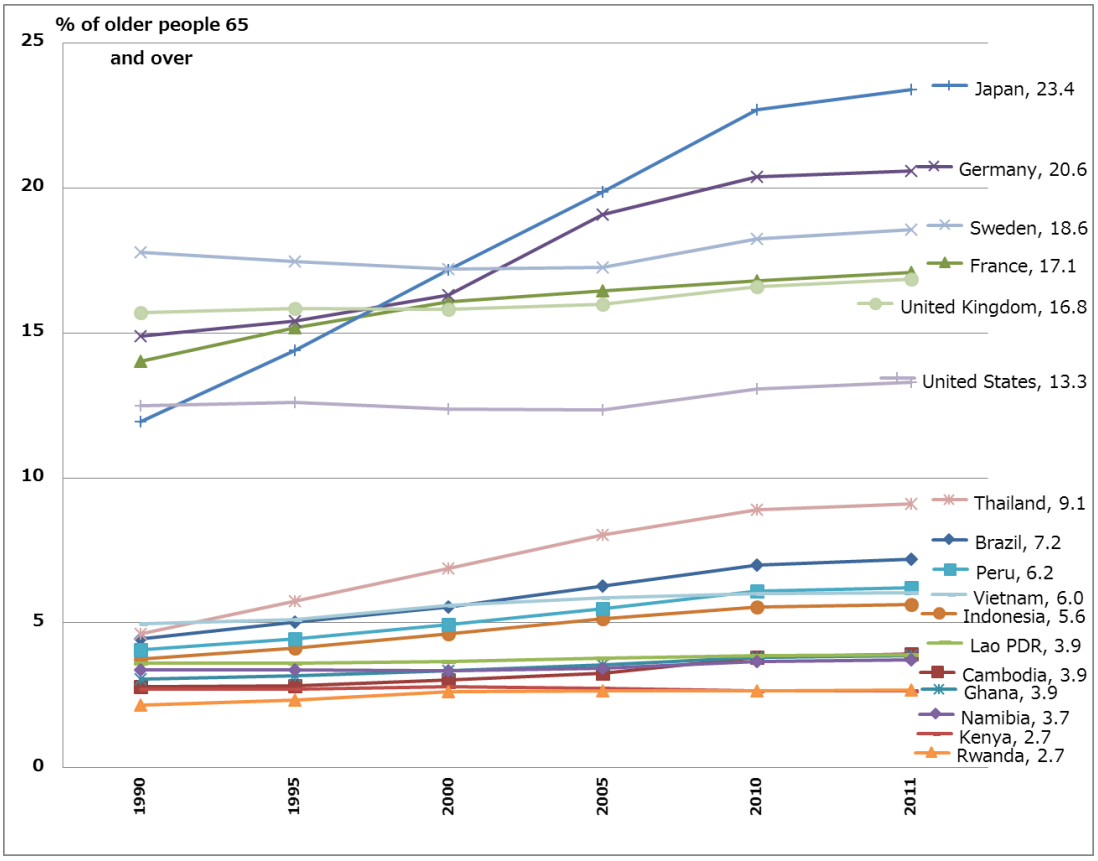


Source：WB, World Development Indicators 2011

B. Ageing

Figure 3. Transition of percentage of older people 65 and over to the total population（1990～2011）

The population ageing is occurring rapidly especially in Thailand among upper middle income countries. The percentage of older people 65 and over among upper middle income and low- and middle-income a country is also increasing.



Source：WB, World Development Indicators 2011

Table 2. Population over 60 per region

	2011	2050
Africa	6%	10%
Latin America	10%	25%
Asia	10%	24%
Oceania	15%	24%
North America	19%	27%
Europe	22%	34%

There are marked differences between the percentages of older people in different regions. By 2050, all of regions except for Africa reach more than 20% of the percentage of older people over 60. The percentage of older people is higher in high income countries, however, the speed of population ageing is faster in low- and middle-income countries.

Source：UNFAP (2012) Ageing in the Twenty-First Century: A Celebration and A Challenge

Table 3. Speed of Population Ageing

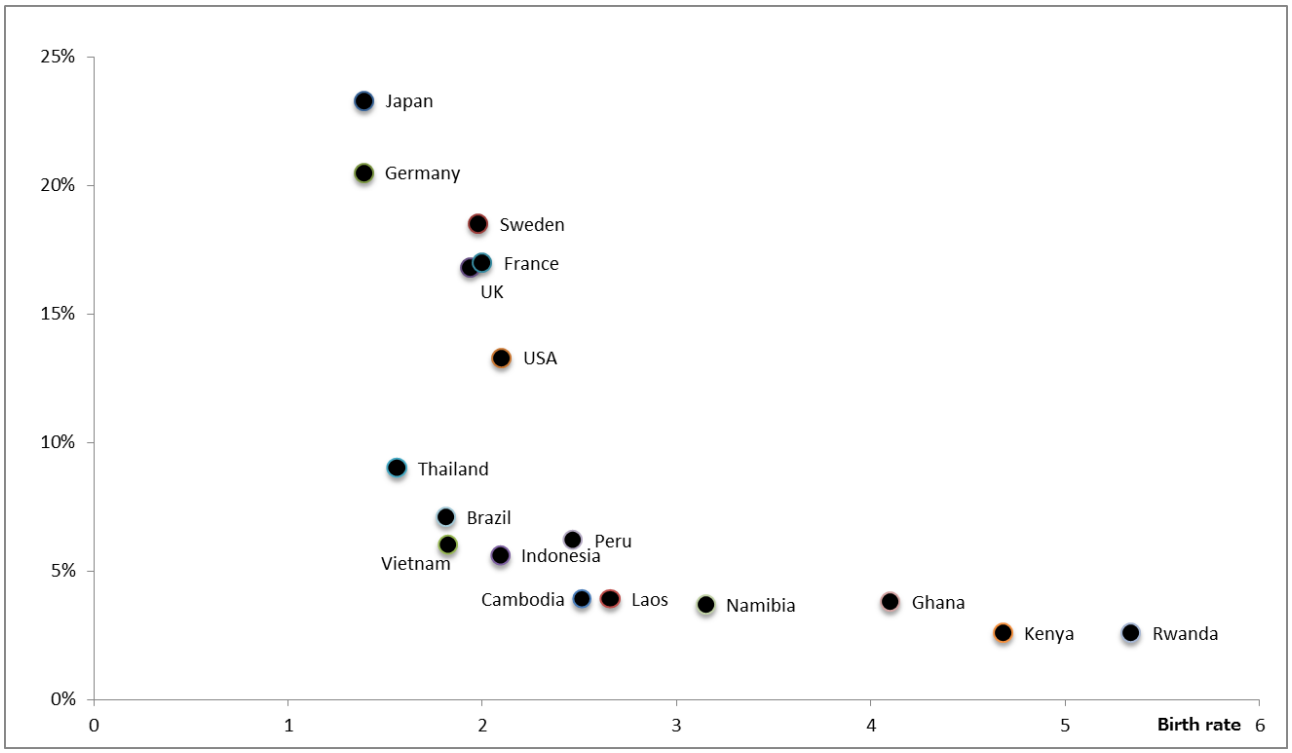
	Speed of population ageing Time required or expected for population aged 65 or older to increase from 7% to 14%
France	115
Sweden	85
UK	47
Germany	40
Japan	25
Indonesia	27
Thailand	23
Laos	19
Vietnam	15

When time required for population aged 65 or older to increase from 7% to 14% compare with other countries, France took 115 years, Sweden 85 years, relatively shorter is 40 years of Germany and 47 years of UK. Japan reached 7% in 1970 and 24 years later reached 14% in 1994, which is very fast. In Asia, the speed is even faster and expected the fastest.

Note: According to the commonly-used UN definition, any society whose proportion of the population aged 65 and over is great than 7%, 14%, or 20% is called “ageing society”, “aged society”, and “super aged society” respectively.

Source：United Nations, World Population Prospects, the 2010 Revision

Figure 4. Total fertility rate and Percentage of older people 65 and over (2011)

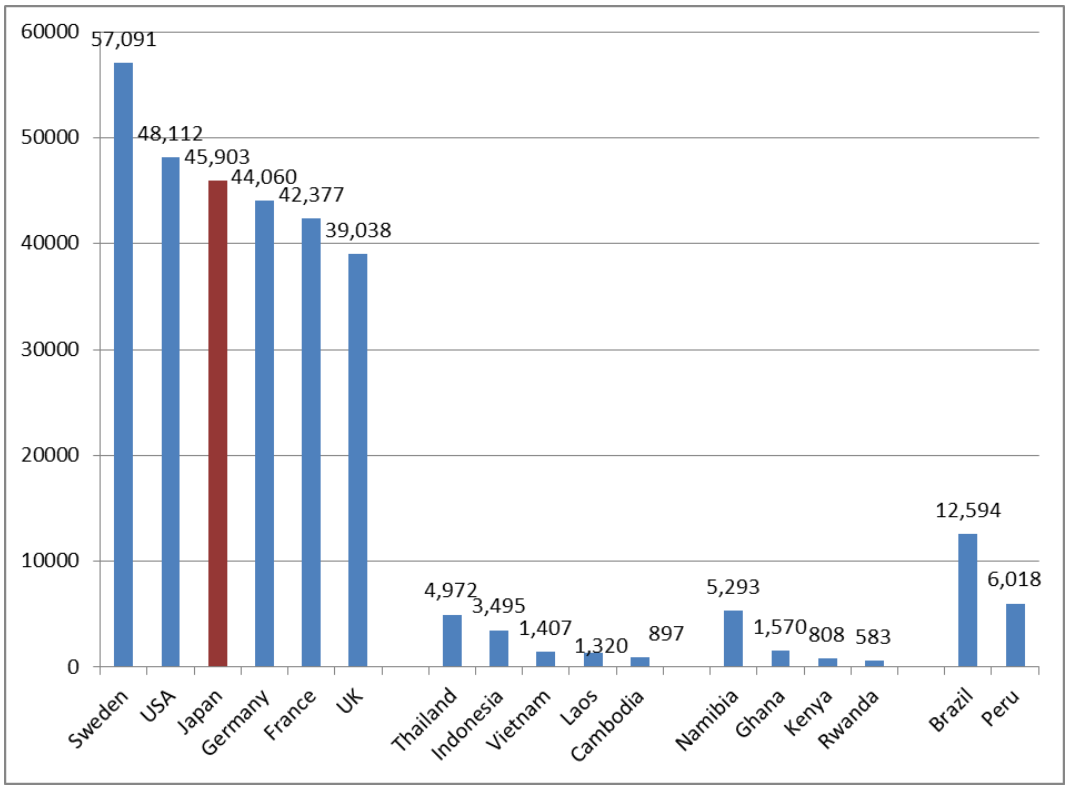


Note: Countries with the base year 2010 other than 2011 are France, Germany, Japan, Sweden, UK, USA and Vietnam.

Source：WB, World Development Indicators 2011

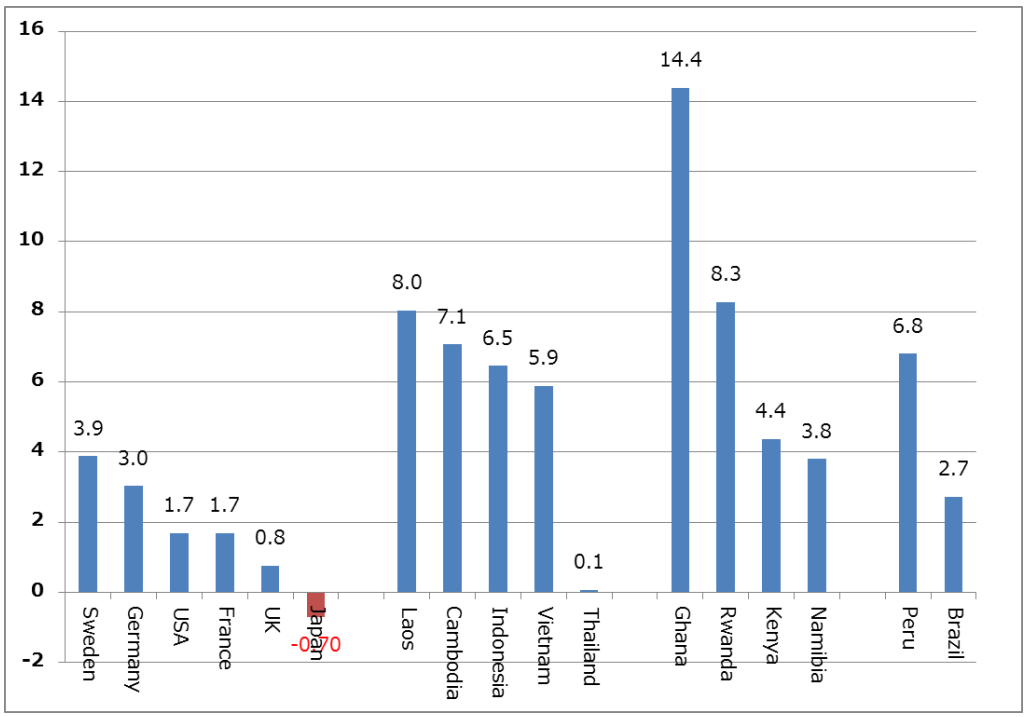
C. Economy

Figure 5. GDP per capita current US$ (2011)



Source：WB, World Development Indicators 2011

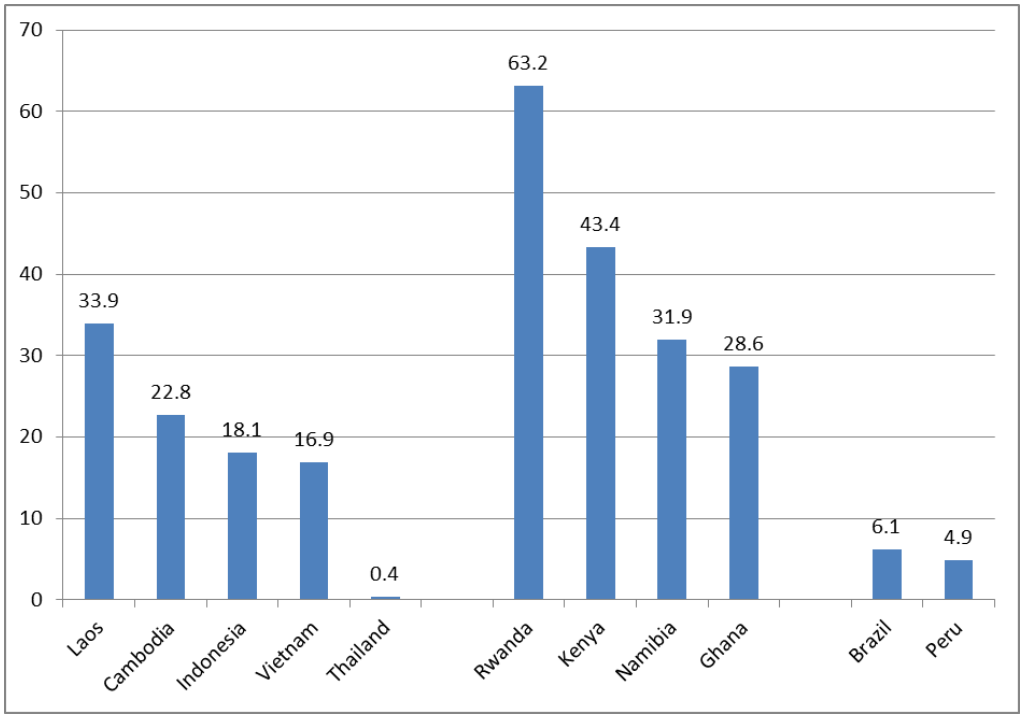
Figure 6. GDP Growth annual %



Source：WB, World Development Indicators 2011

D. Poverty・Income Disparity

Figure 7. Poverty headcount ratio at $1.25 a day (PPP) (% of population)



Notes: 1) The base year is different per country: Rwanda (2011), Indonesia and Peru (2010), Thailand and Brazil (2009), Laos, Cambodia and Vietnam (2008), Ghana (2006), Kenya (2005), and Namibia (2004).
2) No data available for high income countries
Source：WB, World Development Indicators 2011

Table 4. Comparison of Poverty headcount ratio at $1.25 a day (PPP) (% of population)

Country	Poverty headcount ratio at $1.25 a day (ppp) (% of population)	
Cambodia	38.69 (2004)	22.75 (2008)
Laos	43.96 (2002)	33.88 (2008)
Vietnam	40.05 (2002)	16.85 (2008)
Indonesia	29.31 (2002)	22.64 (2008)
Thailand	1.64 (2002)	0.37 (2008)
Kenya	19.57 (1997)	43.37 (2005)
Rwanda	74.56 (2000)	72.1 (2006)
Ghana	39.12 (1998)	28.59 (2006)
Namibia	49.14 (1993)	31.91 (2004)
Peru	12.41 (2002)	4.91 (2010)
Brazil	10.56 (2002)	6.14 (2009)

Poverty headcount ratio has been decreased in all countries, except for Kenya.

Note: No data available for high income countries.

Source：WB, World Development Indicators 2011

Table 5. Gini coefficient (Comparison per year)

Country	Gini coefficient	
Japan	32.3 (mid 1990s)	32.0 (mid 2000s)
USA	36.1 (Id.)	38.1 (Id.)
UK	35.4 (Id.)	33.5 (Id.)
Germany	27.2 (Id.)	29.8 (Id.)
France	27.0 (Id.)	27.0 (Id.)
Sweden	21.1 (Id.)	23.4 (Id.)
Indonesia	29.0 (1999)	34.0 (2005)
Vietnam	35.5 (1998)	35.6 (2008)
Thailand	41.5 (1998)	40.0 (2009)
Cambodia	38.28 (2004)	37.85 (2008)
Laos	34.91(1997)	36.74 (2008)
Namibia	74.33 (1993)	63.9 (2005)
Rwanda	51.51 (2000)	53.09 (2006)
Peru	56.17 (1998)	48.14 (2010)
Brazil	60.35 (1998)	54.69 (2009)

UNDP has shown that in many countries the current Gini Coefficient is higher than it was in the 1980s [111].

A study conducted by the ILO in 83 countries (representing 70 per cent of the world's population) has shown that during 1995–2007, inequality between the highest and lowest wages increased in over two-thirds of the countries.[112]

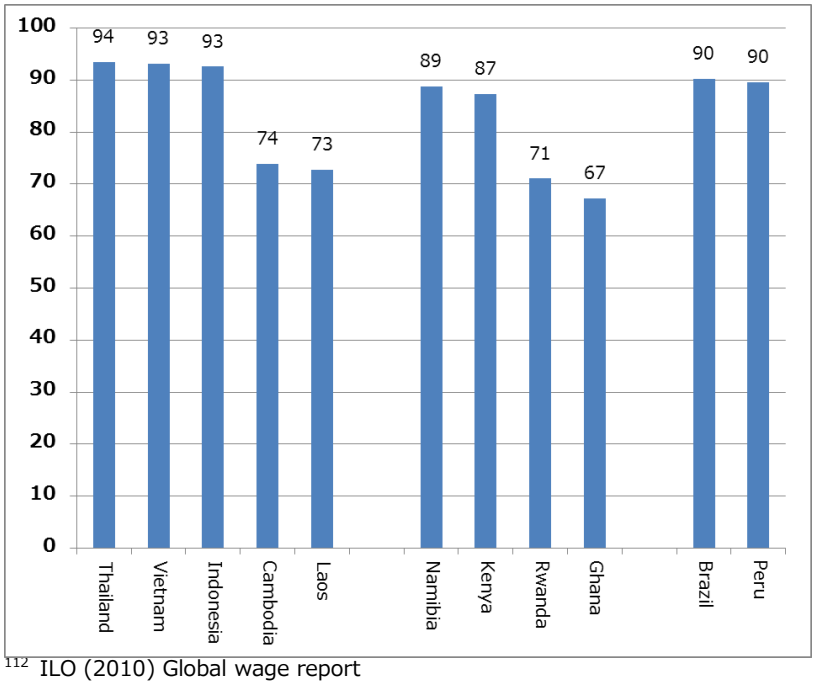
Note: Gini coefficient is an indicator demonstrating income disparity in societies. Figures closer to 100 mean greater income disparity.

Source: High income countries：OECD（2008）Growing Unequal? Income Distribution and Poverty in OECD Countries

Other countries：WB, World Development Indicators 2011

E. Education

Figure 8. Literacy rate（over 15 years old）



Notes: 1) The base year is: Brazil, Cambodia and Indonesia (2009), Ghana, Kenya, Rwanda and Vietnam (2009), and Peru (2008).

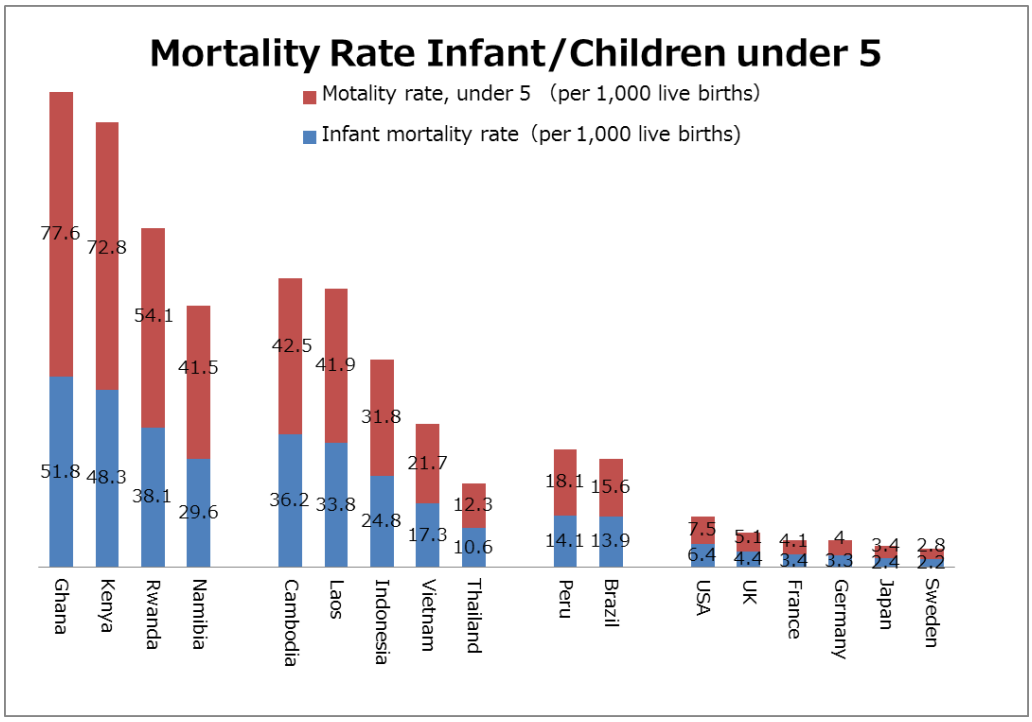
2) No data available for high income countries

Source：WB, World Development Indicators 2011

[112] ILO (2010) Global wage report

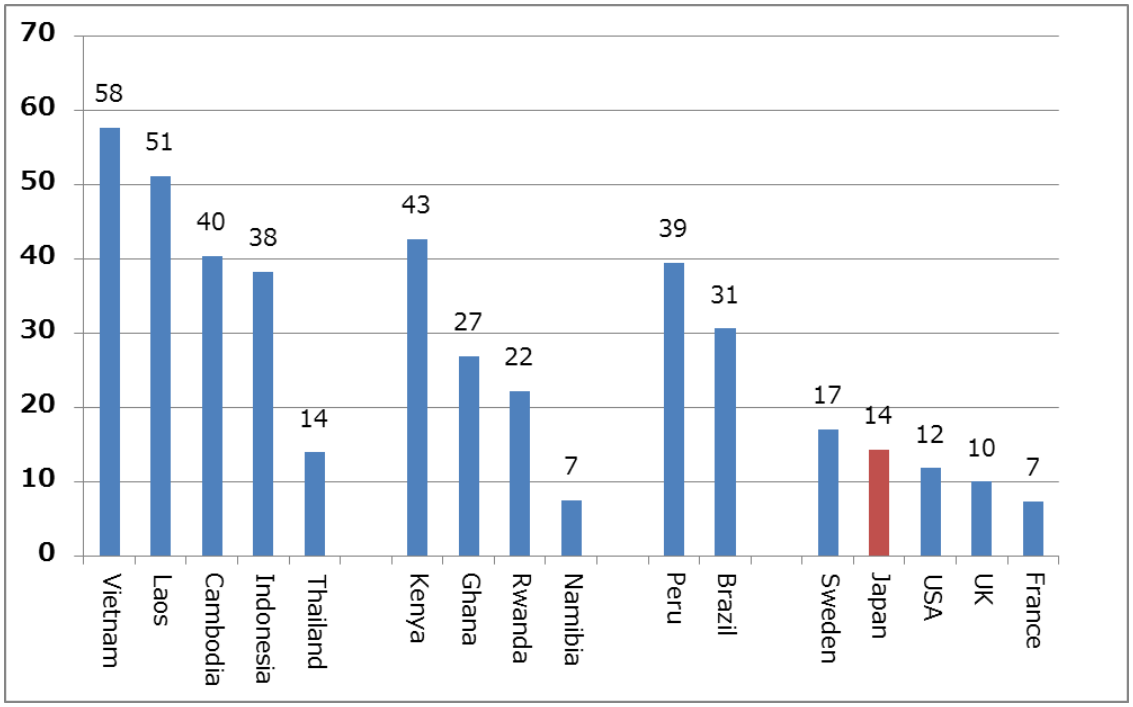
F. Health

Figure 9. Mortality Rate Infant and Under 5 (2011)



Source：WB, World Development Indicators 2011

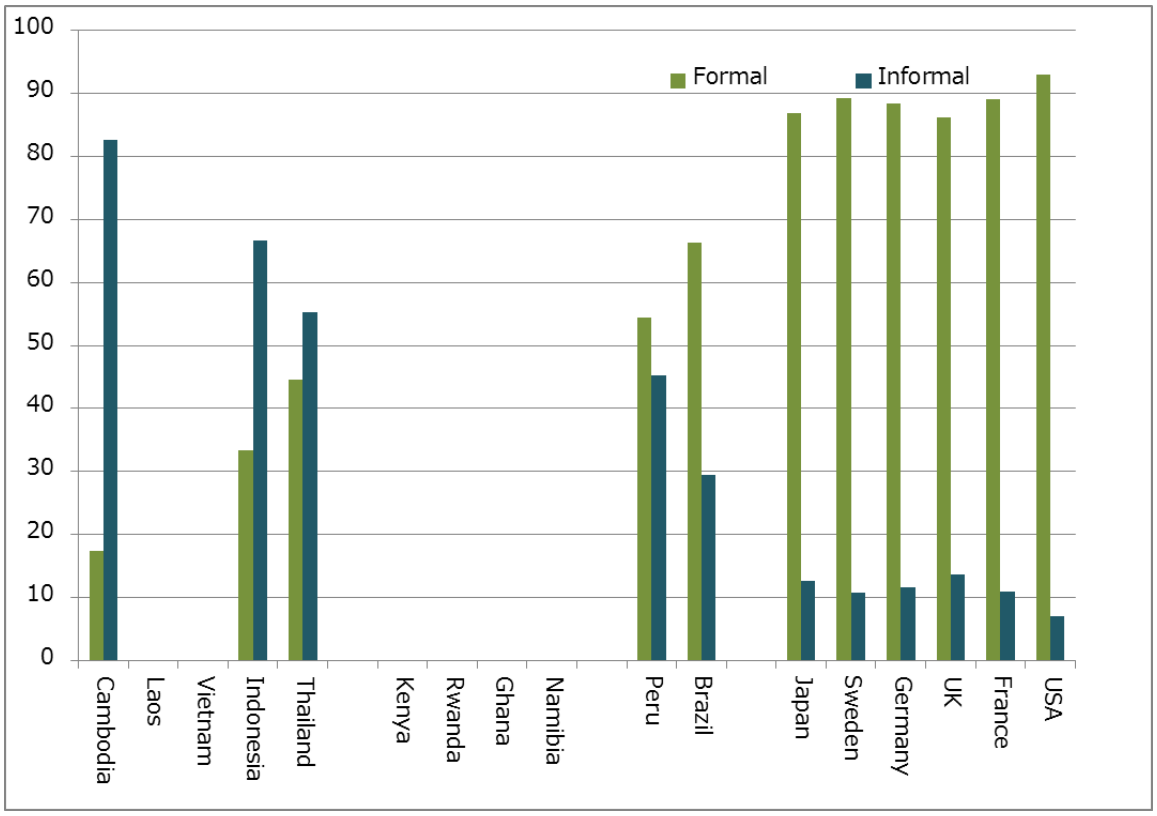
Figure 10. Out-of-pocket health expenditure (% of private expenditure on health)（2010）



Source：WB, World Development Indicators 2011

G. Labor

Figure 11. Formal（Wages and Salaried workers）and Informal （Self-employed） (2011) (% of total employment)

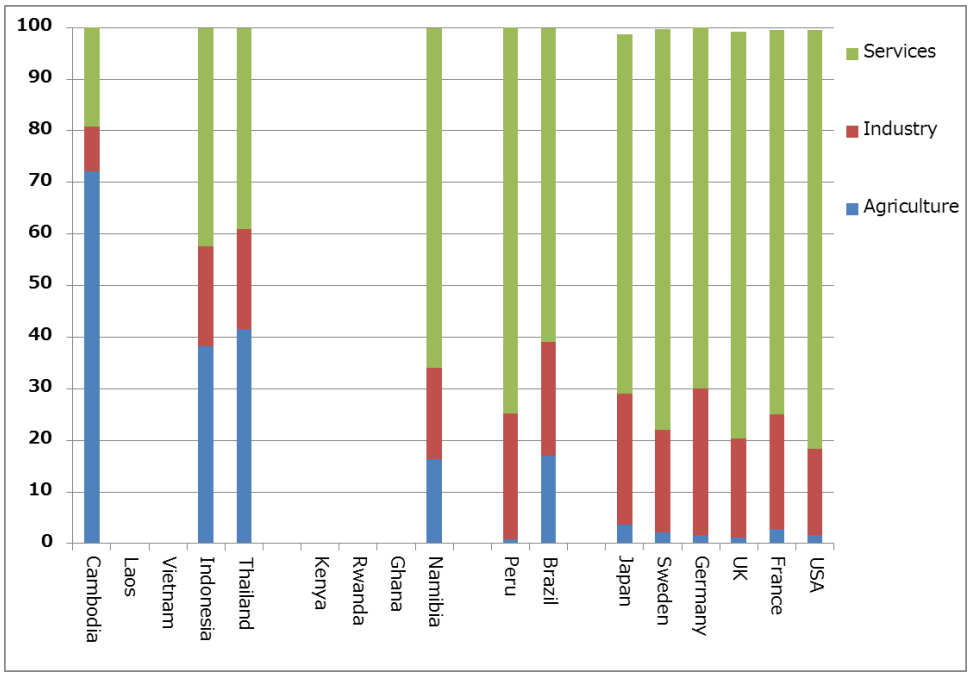


The recent ILO analysis[113] shows that informal employment is negatively correlated with income per capita and positively correlated with poverty across countries. This suggests that as GDP increases and/or as poverty declines across countries, workers are more likely to be aware of their rights to certain legal and social protections and worker benefits and successfully achieve such protections and benefits. Five countries (India, Brazil, Mexico, Vietnam and Pakistan) concentrate three-fourths of the total informal employment estimated for the 46 analyzed countries. In over half of the 44 countries where ILO has data disaggregated by sex, women outnumbered men in informal employment as a percent of non-agricultural employment.

Source：WB, World Development Indicators 2011

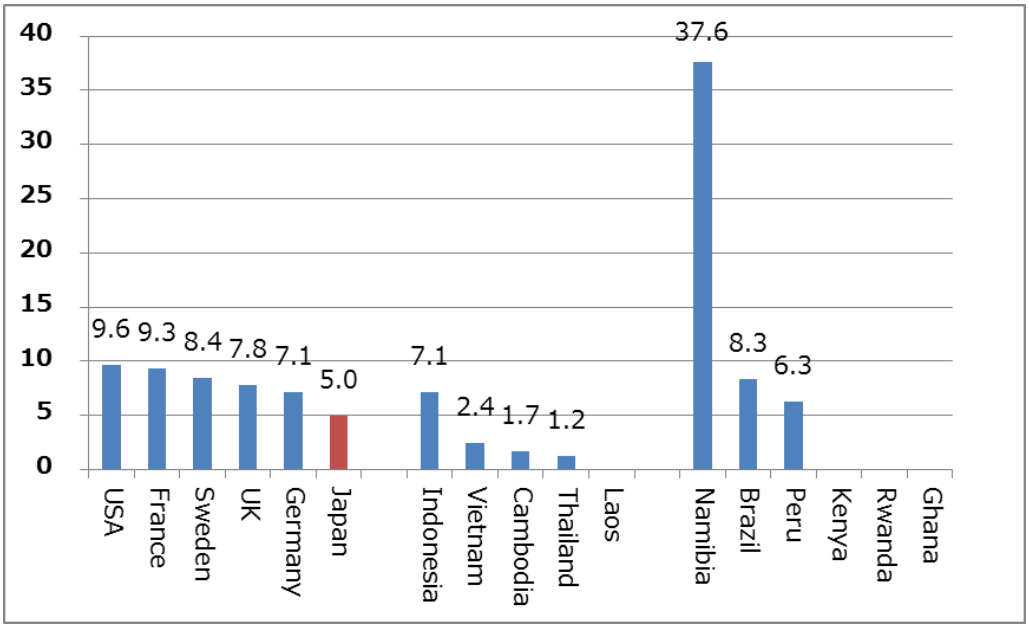
[113] ILO (2011) Statistical update on employment in the informal economy

Figure 12. Industrial structure：employment by category(%)（2009）



In general, employment in agriculture is low in high income countries (except for Peru). Employment in agriculture is bigger in low- and middle-income countries and especially in Asia.
Note: The base year for Peru and Cambodia is 2008.
Source：WB, World Development Indicators 2011

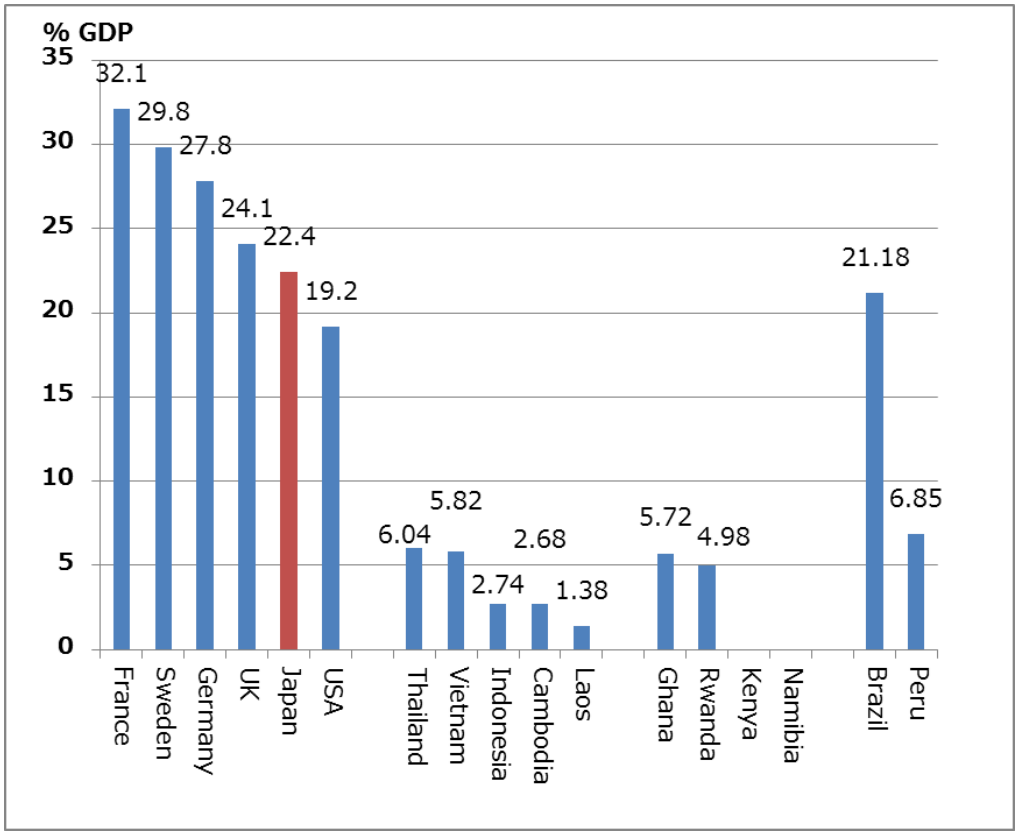
Figure 13. Unemployment rate



Note: The base year is: high income countries (2010), Thailand and Peru (2009), and Cambodia, Namibia, and Vietnam (2008).
Source：WB, World Development Indicators 2011

H. Social Protection Programs

Figure 14. Social Expenditure % of GDP



Notes: 1) In OECD Definition of Social Expenditure, the main social policy areas are as follows: Old age, Survivors, Incapacity-related benefits, Health, Family, Active labor market programs, Unemployment, Housing, and Other social policy areas

2) ADB Definition of Social Expenditure: Government Expenditure on Health consists of expenditure by government to provide medical products, appliances, and equipment; outpatient services; hospital services; public health services; among others. Government Expenditure on Social Security and Welfare consists of expenditure by government to provide benefits in cash or in kind to persons who are sick, fully or partially disabled, of old age, survivors, or unemployed, among others.

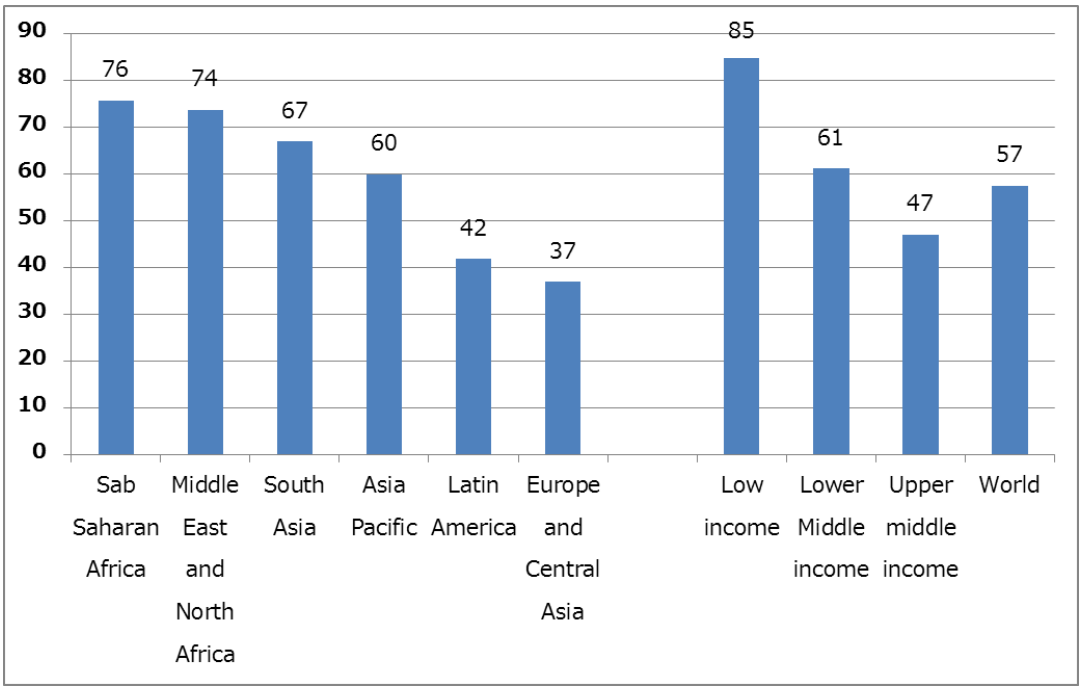
Source

＊High income countries：OECD Social Expenditure % of GDP (2012), OECD Social Expenditure Database

＊Low- and middle-income income countries：Public social security expenditure (including health) as % of GDP, ADB (2010) Key Indicators for Asia and the Pacific (Laos ILO Social Security inquiry 2005, Vietnam IMF 2010, Thailand IMF 2009, Rwanda ILO Social Security Inquiry 2005, Ghana ILO Social Security Inquiry 2004, Peru ECLAC 2010, Brazil ECLAC 2009)

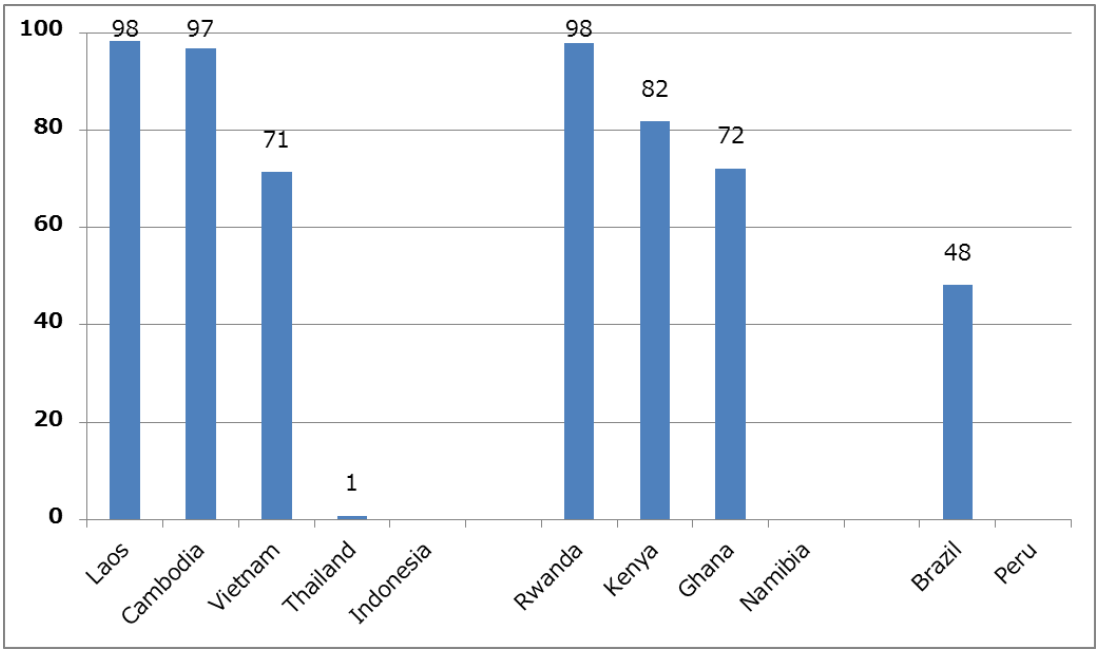
＊ECLAC: Data Base of Social, Economic and Environmental Indicators for Latin America and the Caribbean

Figure 15. % Population who are not covered by social protection (by region and by income levels）（2005～2010）



Source：WB, ASPIRE （Atlas of Social Protection, Indicators of Resilience and Equity）

Figure 16. % population who are not covered by social protection (by country)



Note: The base year is: Brazil and Thailand (2009), Cambodia and Laos (2008), Vietnam (2006), and Kenya, Rwanda, and Ghana (2005).

Source：WB, ASPIRE

Annex 4. International Social Security Standards ILO Social Security (Minimum Standards) Convention (C102, 1952) and Social Protection Floors Recommendation (R202, 2012)

The ILO has adopted social security standards, which are the Social Security (Minimum Standards) Convention, 1952 (No. 102, 1952), the Income Security Recommendation (No. 67, 1944), and the Medical Care Recommendation (No. 69, 1944). In this section, we look at the two of them, in particular Social Security (Minimum Standards) Convention (C102, 1952) and Social Protection Floors Recommendation(No. 202, 2012).

The Convention No. 102 defines 9 branches of social security ; Medical care benefit, sickness benefit, unemployment benefit, old-age benefit, employment injury benefits, maternity benefit, family benefit, Invalidity benefit, survivors' benefit, and sets minimum standards for these nine branches. Member states can ratify the convention if the country meets the standards for more than 3 social security branches. 47 countries so far ratified the Convention (as of March 2013). Japan is only country ratified in Asia, 5 countries in Africa, and 9 countries in South America. There is no country ratified in the Middle East[114].

The new recommendation concerning National Floors of Social Protection No.202 call for members states to providing people with essential health care and benefits, as well as income security for children, income security for elderlies, income security for persons with disabilities constituting national social protection floors. The Recommendation provides guidance to member states to ensure that all members of society enjoy the right to social protection and at least a basic level of social protection throughout their lives, and progressively ensure higher levels of social protection.

[Outline of Convention No. 102]

Convention No.102 sets a framework of common important basic social security principles on which any social security system should be based to encourage the widest development of social security schemes. The convention is composed of 15 different parts (see the table in page 92) and 87 articles. Japan adopts the Part III to XI. After the convention, the Employment Injury Benefits Convention (No. 121, 1964), Medical Care and Sickness Benefits Convention (No. 130, 1969) were adopted. Japan ratified the No. 121, which is higher standard than No.102, the Part VI is therefore not currently applicable to Japan.

[114] The dinition of Middle East differs in Japan and in western countries. This Gudeline uses the one of JICA from http://www.jica.go.jp/seikatsu/mideast.html

No	Title	Description
Part I	General provisions	It defines terms used in the Convention and conditions to ratification.
Part II	Medical care	It defines the scope of the persons protected ((a) employees, constituting not less than 50 per cent. of all employees, and also their wives and children, (b) economically active population, constituting not less than 20 per cent. of all residents, and also their wives and children, (c) residents, constituting not less than 50 per cent. of all residents, (d) employees constituting not less than 50 per cent of all employees in industrial workplaces employing 20 persons or more, and also their wives and children), kinds of benefits (general practitioner care, essential pharmaceutical supplies, hospitalization, pre-natal, confinement and post-natal care etc.), duration of benefits (throughout the contingency covered, in case of a morbid condition, its duration may be limited to 26 weeks in each case.)
Part III	Sickness benefit	It defines the persons protected, the period of provision of sickness benefit, etc.
Part IV	unemployment benefit	It defines the scope of persons protected, minimum duration of contribution or employment, duration of benefits (where classes of employees are protected, to 13 weeks within a period of 12 months, or where all residents whose means during the contingency do not exceed prescribed limits are protected, to 26 weeks within a period of 12 months)
Part V	Old-age benefit	It defines the persons protected, minimum period of contribution or employment、start age of benefits etc.
Part VI	Employment injury benefit	Id.
Part VII	Family benefit	Id.
Part VIII	Maternity benefit	Id.
Part IX	Invalidity benefit	Id.
Part X	Survivors' benefit	Id.
Part XI	standard to be completed with by periodical payments	The standard percentage of benefits for each schemes is defined, for example, unemployment benefit is 45% of a basic income.
Part XII	equality of treatment of non-national residents	Similar standards as other parts.
Part XIII	Common provisions	Suspension, a right of appeal in case of refusal of benefits, financial resources of the cost of benefits, etc.
Part XIV	Miscellaneous provisions	
Part XV	Final provisions	Ratification procedures, etc.

[Outline of R202]

The R202 is the recommendation adopted by the ILO to provide guidance to member states to provide essential health care and benefits and income security for all members of society, considering the fact that only 1 per 5 persons of world population can be covered by sufficient level of social protection. The R202 states that national social protection floors should be financed by national resources. Social protection floors are nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion. Member states are recommended to formulate and implement national social security extension strategies, based on national consultations through effective social dialogue and social participation.

Members whose economic and fiscal capacities are insufficient to implement the guarantees may seek international cooperation and support that complement their own efforts. And also, the R202 stipulates social protection extension strategies should apply to persons both in the formal and informal economy and support the growth of formal employment and the reduction of informality.

References

- ILO Convention No. 102
  http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:C102
- ILO R202 - Social Protection Floors Recommendation, 2012 (No. 202)
  http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:3065524:NO
- List of Ratifications of ILO Convention No. 102
  http://webfusion.ilo.org/public/applis/appl-byconv.cfm?conv=C102&hdroff=1&lang=EN

Annex 5. Etymology and Definitions of Social Protection in Japan and Other countries

A. Etymology of “social security”

In Japan, *social security* has been used as an English translation of shakaihosho (社会保障) which started to be widely used after the World War II.The term, *Social Security*, is relatively new and was first introduced in the United States in the law “the Social Security Act” that was enacted in 1935, combining “social insurance” and “economic security”.

The English word "security" originates from the Latin word "se-curus." "Se" means "liberation" and "curus" means "uneasiness." That is, "security" originally meant liberation from uneasiness, or a peaceful situation without any risks or threats. The English word "security" has a wide range of meaning including "to feel safe," and "to be protected" and is used to describe a situation without any risks or worries. The Japanese word "hosho" is comprised of two Chinese characters. The first character "ho" (保) means a small castle, and the second character "sho" (障) means a fort. According to the "Kojien" dictionary, the word "hosho" has following meanings: 1) a castle and a fort; 2) to support for prevention; 3) to ensure that there will be no obstacles; and 4) to protect from damages or from destruction. Both the English word "social security" and the Japanese word "shakaihosho" mean "protection from risks through social systems."

B. Scope and Definition of Social Protection in Japan

In Japan, the expression of "shakaihosho" first appeared in Article 25 of the Constitution of Japan promulgated in 1946. The definition of "social security systems" that has been most widely accepted in Japan up to present is that made by the Advisory Council on Social Security in its report of 1950, where the purposes of social protection were stipulated. Those are a basis for the current social protection system of Japan.

Box.4-1. Basis for the Japan’s Current Social Protection System

（1）The Constitution Article 25

(Paragraph 1) All people shall have the right to maintain the minimum standards of wholesome and cultured living.

(Paragraph 2) In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.

The article 25 stipulates right to life and clarifies the obligation to implement social protection systems. In this article 25, social security, social welfare and public health are stipulated in parallel, however, social security has now a broader meaning including social welfare and public health.

（2）Definition in the 1950 report by the Advisory Council on Social Security

The Council defined the social protection system as follows. Social security systems mean the

systems to enable every citizen to lead a worthy life as a member of cultured society. Social security systems provide countermeasures against the causes for needy circumstances including illness, injury, childbirth, disablement, death, old age, unemployment and having a lot of children by implementing economic security measures through insurance or by direct public spending. Social security systems ensure the minimum level of living to the needy by public assistance, and they also promote public health and social welfare.

The government has the obligation to secure the living. The government must develop a comprehensive plan and implement it democratically and efficiently in collaboration with other governmental and public organizations. The system should target the entire population with a principle of equity and opportunity. AS long as the government takes responsibilities, the people shall also fulfill their social obligations necessary for the maintenance and operation of this system, with the spirit of social solidarity, depending on the individual capability.

C. Definitions of other countries

The definition of social protection (services or benefits) varies per country.

United States

In the United States, "social security" is often defined as income security such as pensions. Social security means pensions in a narrow sense, and social insurance and social assistance in a broad sense. The welfare services provided in Japan are called "human services." In the United States, "welfare" usually points to services that are funded by tax revenues and provided after the status inquiry, especially to the temporary assistance to needy families (TANF). The U.S. Social Security Act, however, is a comprehensive law, which provides for unemployment insurance, health services for fatherless families, human services for people with disabilities (Medicare), medical services for the elderly and medical assistance in addition to pension insurance for ensuring income (Medicaid).

United Kingdom

In the United Kingdom, social security means income security such as pensions and child allowances, while Japan's definition of social protection includes those called "social policy" or "social services" in the United Kingdom. The "social policy" or "social services" have a wide range of meaning: income security, medical care (called "national health service" in the United Kingdom), personal social services, housing policies, education and employment. Social insurance schemes are structured as a program including pensions and employment benefits targeting the entire population. A tax-based public health care is provided for free, in principle, for the entire population.

France

In France, social protection ("Securite Sociale" in French) means social insurance such as sickness insurance and old-age insurance. In addition to social insurance, social assistance

(provision of cash and services to the ill, people with disabilities or to the elderly who have cleared the income criteria), social services (other social welfare services provided without an income limit) and the minimum income level security system for independence are collectively called "Protection Social."

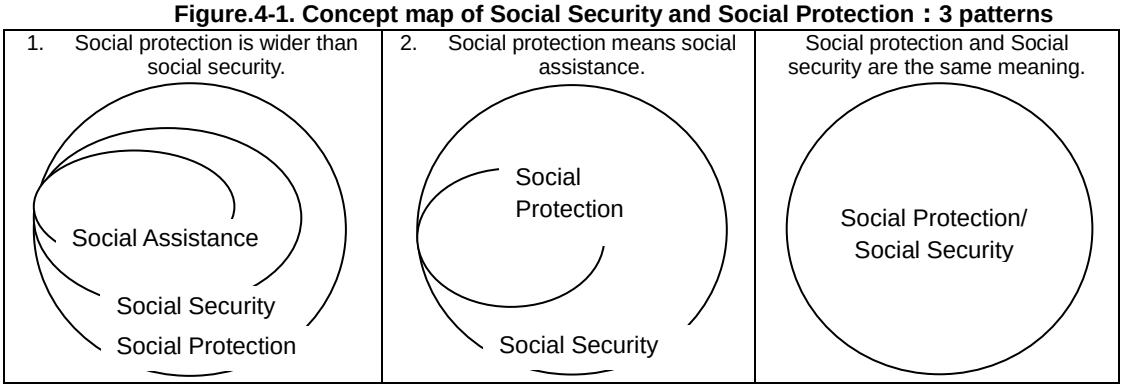
Germany

In Germany, social security ("Soziale Sicherheit" in German) includes social insurance, social compensation (for the war victims, etc.), and social support (social assistance or support to students). German people, however, do not often use the expression "Soziale Wohlfahrt" (social welfare). The social protection comprises of social insurance including pension, health care, long-term care, employment injury and unemployment, and child benefits, social assistance, and others.

D. Usage of Social Security and Social Protection

According to the ILO report, there are two different usages of social protection and social security. The first one is that social protection is often interpreted as having a broader and more comprehensive character than social security, and the second one is that it is also used in some contexts with a narrower meaning (understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society), but in many contexts the terminology “social security” and social protection” may be largely interchangeable.

Figure.4-1. Concept map of Social Security and Social Protection：3 patterns



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- Social Insurance Agency (2009) The textbook of social insurance http://www.sia.go.jp/infom/text/
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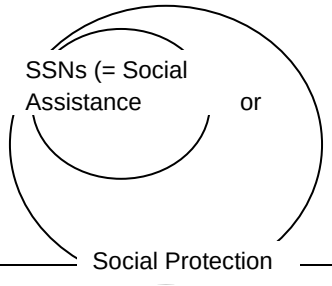
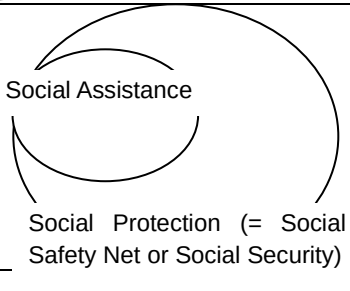
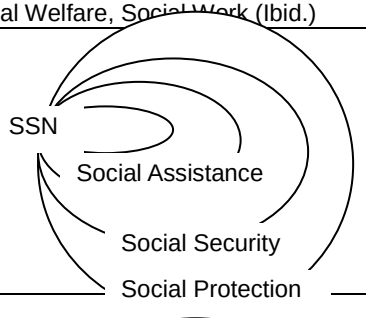
Annex 6. Definitions of Key Social Protection Terms in the World Bank,ADB, ILO

		World Bank	ADB	ILO
Social Protection (SP)	Definition	Social protection and labor systems, policies, and programs help individuals and societies manage risk and volatility and protect them from poverty and destitution—through instruments that improve resilience, equity, and opportunity. (WB, 2012, p101)。	The set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income.(ADB, 2001, p655)	The set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner), the provision of health care, and the provision of benefits for families with children. (ILO 2010, p13)
	Activities	Programs include safety net, social insurance, social assistance, labor related programs such as skills training, improvement of labor standards, social funds and other social services. (Ibid.)	Social protection consists of five major elements: (i) labor markets, (ii) social insurance, (iii) social assistance, (iv) micro and area based schemes to protect communities, and (v) child protection (Ibid.). The definition is narrower than that of WB.	It is often interpreted as having a broader character than social security including, in particular, protection (Ibid.) The ILO Social Protection sector includes the Social Security Dept. and the Labor Protection Dept.
	Synonym		Social Safety Net, Social Security (Ibid.)	
Social Security (SS)	Definition		The term is used to refer to comprehensive mechanisms in high income countries. The term is unlikely to apply to new concepts such as communities and micro level schemes. (Ibid.)	All measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from (a) lack of work-related income (or insuffi cient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) lack of access or unaff ordable access to health care; (c) insufficient family support, particularly for children and adult dependents; (d) general poverty and social exclusion. (ILO 2010 p13)
	Activities	Old age pensions, disability pensions, unemployment insurance, etc. (WB, 2012, XIII)		Contributory health insurance, pensions, unemployment programs and also non-contributory tax-based social assistance (Ibid.)
	Synonym		Social Safety Net (singular), Social Protection (Ibid.)	
Social Safety Nets (SSNs)	Definition	Non-contributory program targeting the poor and vulnerable (WB, 2008a, p514)	（singular）unclear term which can be defined in a broader sense and narrower sense. (Ibid.)	＊SSNs is considered as a part of social assistance, however, the concept of a social safety net is not clearly defined . (Paitoonpong,

				Abe, Puopongsakorn, 2008, p. 470)
	Activities/Approach	● cash transfer, child benefit etc. ● food distribution, school feeding ● public works ● CCTs ● free medical and education access (WB, 2008a, Chapter 7)		
	Synonym	Social Assistance（term used in European countries）, Social Welfare （term used in the USA）(WB, 2008a, p514)	Social Protection, Social Security (Ibid.)	
Social Assistance (SA)	Definition		Social assistance is programs aiming at achieving minimum standard of living and improving livelihoods for the most vulnerable individuals, families, households and communities. Cash or in kind benefits are provided financed by public funds on the basis of assets or means tested (ADB, 2001, p257)	Social assistance is the assistance provided by the government to the general public who are in need, particularly the elderly, the sick, invalids, survivors and the unemployed. Its main characteristics are: (1) a person does not have to join the program (by paying contribution) prior to receiving benefits; benefits are paid as a legal right in prescribed categories of need; (2) the entire cost of the program is met by the government; (3) eligibility is determined by a person's other income and resources (Paitoonpong, Abe, Puopongsakorn, 2008, p. 471)
	Activities/Approach	cash transfers and school feeding, food distribution, etc. (WB, 2012, XIII)	● food grants ● public housing ● exemption of health care cost ● public works ● cash transfers ● small scale loan ● long term care in home services ● mobile medical and educational services (ADB, 2001, pp293-295)	＊No examples are shown, but it is mentioned that social assistance comprises of poverty programs. (Ibid.)
	Synonym	Social Safety Net		Social Welfare, Social Work (Ibid.)
Relationship between terms (these images were developed by the author of the table.)				

Annex 7. Human Rights and Social Protection

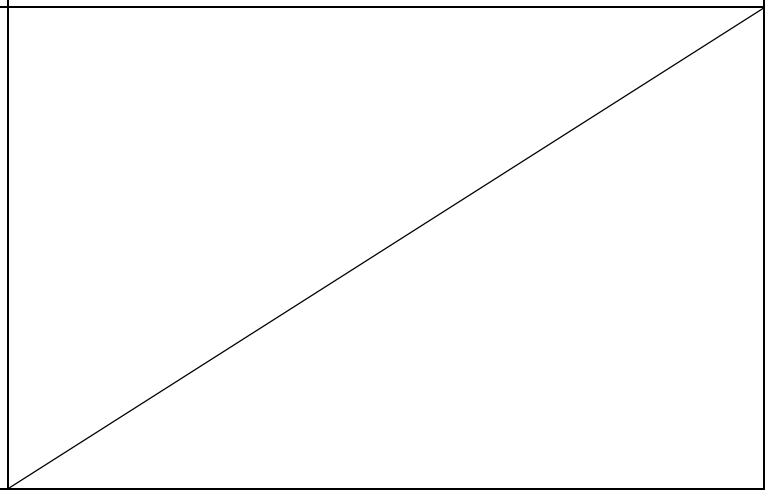
Social protection is a fundamental human right stipulated by the following international human rights instruments.

- Universal Declaration of Human Rights（Article 22 and 25）
- International Covenant on Economic, Social and Cultural Rights（Article 9 and 11）

  Convention on the Rights of the Child（Article 26 and 27）
- Convention on the Rights of Persons with Disabilities（Article 19 and 28）
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families（Article 27）

Table 4-5. International instruments stipulating that social protection is a fundamental human right

Authority	Social Security	Adequate living standard
Universal Declaration of Human Rights (1948)	Article 22 — Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each state, of the economic, social and cultural rights indispensable for their dignity and the free development of their personality.	Article 25(1) — Everyone has the right to a standard of living adequate for the health and well-being of their family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond their control.
International Covenant on Economic, Social and Cultural Rights (1966 - came into force 1976)	Article 9 — The States Parties to the present Covenant recognizes the right of everyone to social security, including social insurance.	Article 11 (1) — The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.
Convention on the Rights of the Child (1989)	Article 26(I) — States parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.	Article 27 (I) — States parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Article 27 (3) — … and shall in case of need provide material assistance and support programs, particularly with regard to nutrition, clothing and housing.
Convention on the Rights of Persons with Disabilities	Article 28 - Adequate standard of living and social protection 1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families,	Article 19 - Living independently and being included in the community States Parties to the present Convention recognize the equal right

	including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability. 2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures: a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs; b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programs and poverty reduction programs; c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counseling, financial assistance and respite care; d) To ensure access by persons with disabilities to public housing programs; e) To ensure equal access by persons with disabilities to retirement benefits and programs.	of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that: a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement; b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community; c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.
Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Article 27 1. With respect to social security, migrant workers and members of their families shall enjoy in the State of employment the same treatment granted to nationals in so far as they fulfill the requirements provided for by the applicable legislation of that State and the applicable bilateral and multilateral treaties. The competent authorities of the State of origin and the State of employment can at any time establish the necessary arrangements to determine the modalities of application of this norm. 2. Where the applicable legislation does not allow migrant workers and members of their families a benefit, the States concerned shall examine the possibility of reimbursing interested persons the amount of contributions made by them with respect to that benefit on the basis of the treatment granted to nationals who are in similar circumstances.	

Annex 8. Outlines of Japan's Social Protection System

Article 25 of the Constitution of Japan states that "all people shall have the right to maintain the minimum standards of a wholesome and cultural way of life." This is the so-called right to life, which serves as a basis for the current social protection system of Japan. Paragraph 2 of Article 26 stipulates that "in all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health," which clarifies the obligation to implement social protection programs. Therefore, in principle, the current social protection programs are mainly the ones established after the Second World War. It is worth mentioning that pension and health care programs are considered as a series of processes to achieve universal coverage in 1961, which is based on the prior achievement from the pre-war period,[115] while the system rests its legal basis on the post-war Constitution of Japan.

A. Health Care

(a) Historical Background

The current health insurance system (government-managed health insurance/association-managed health insurance) originated in the Health Insurance law of 1927, but the prototype of a health insurance system would be the occupational accident compensation-related systems such as the Mining Law that was enacted in 1905. Japan followed the German law, which had been adopted to ensure the health and lives of workers engaged in mining.

The Health Insurance Law is different from occupational accident compensation in a sense that it was established to ensure the health of employees even when the accident or illness was not occupation-related. Originally, the system was designed to cover businesses with more than 10 employees and adopted the flat and capitation payment system, which is similar in many ways to the ones currently adopted by developing countries.

The Community-based Health Insurance Law was enacted in 1938 to establish a nationwide health insurance system, including rural areas. Welfare administration made remarkable progress as a military-oriented policy, rather than the aspect of the health of the people, under the slogan of "Healthy People and Healthy Warriors," with the purpose of maintaining and improving their physical constitution and capability of the people. This was when the term "universal coverage" was born, and the origin of this term is "universal conscription." During the war, in 1941, the Health Protection Law was established for impoverished people.

[115] See Shimazaki (2013) about the experiences and lessons prior to the 1961 achievement of universal coverage.

After the post-war confusion and through the special procurement boom of the Korean War, Japan entered a period of rapid economic growth. Under such circumstances, Japan also embarked on a period of financial growth, and promoted universal coverage as a feasible policy. In 1958, the National Health Insurance Law was amended to require all municipalities to set up the National Health Insurance Society, finally achieving the universal coverage in 1961.

Later, in response to the development of the health insurance system for elderly persons by innovative municipalities, free provision of medical services for the elderly was implemented in 1973, (the free provision was later abolished), and the Long-term Care Insurance program was introduced in 2000. These systems have been developed as measures for the aging society. The Long-term Care Insurance Law was revised in 2005 in order to further respond to the aging society, and the establishment of a new health care system for the elderly would depart from the conventional health insurance contribution system for the elderly, is currently under consideration.

(b) Institutional Characteristics

The most notable characteristics of the health insurance system of Japan are the universal coverage and health insurance through free access[116]. All people in Japan are guaranteed the use of health care services through the public aid system, financed by either the health insurance system or taxation, and all people of Japan, in principle, are guaranteed to have access to health services provided by the medical institutions of their choice regardless of location and of the type of insurance program (free access). In developing countries, the realization of universal coverage and free access is regarded as a sort of ideal form, and the health care system of Japan possesses this significant aspect.

Another important aspect of Japan's health care system is the presence of various types of insurers. Japan's health care system is divided into a national health insurance system, health insurance system, seafarer's insurance, mutual insurance, the Mutual Aid Association of National Public Service Personnel, the Mutual Aid Association of Local Public Service Personnel and the Mutual Aid Association of Private School Personnel. The health insurance is further categorized into government-managed insurance and association-managed insurance.

Although other countries also categorize the insurers into similar groups, there are actually a large number of insurers in Japan; for example, health insurance associations consist of

116 Needless to say, health insurance is closely related to the health provision system, and discussion must be carried out on the health provision system as a contributing factor to free access or universal coverage. The health provision system is not directly covered here, since it is placed within the scope of "health and medicine" according to JICA's framework. Please refer to "Experience of Japan's Health Insurance: Perspectives of Social Insurance and Lessons for Developing Countries as a Later Starter," Yoshinori Hiroi, (2004) JICA, for the characteristics of Japan's health insurance system, including the health provision system.

approximately 1,500 associations and the National Health Insurance is composed of about 2,000 insurers throughout the nation.

A large number of insurers and free access encompass a broad range of very complex procedures for medical fees and payment operations. Assessment of medical fees does not take into account economic efficiency or statistics; instead, it assesses individual receipts, in principle, generating a huge volume of work. Nonetheless, the characteristic is that it is efficiently managed, without delays in settlement.

The last point is the establishment of a health insurance system based on local governments. The universal coverage of Japan's health insurance is realized by the establishment of a health care system in which local governments are insurers in order to cover those who are not insured by employment-related insurance. This type of health care insurance managed within a nationally uniform framework is unique in the world and would present an important insight into achieving universal coverage in developing countries.

B. Pension

(a) Historical Background

Pension plans for civil servants and military personnel were first introduced in Japan in 1923, but the introduction of the so-called pension plans for employees in the private sector had to wait until the enforcement of the Employees' Pension Law of 1942. This law, developed during the War, was a system that entailed strong intention to unify the nation to prepare for the warfare. Since the maturity of the pension scheme has yet to be reached at this point (only the contributions that were kept accumulated without disbursement), it may as well have aimed at procurement of military expenses and controlling wartime inflation.

After the Second World War, a payment scheme that included a flat-rate portion and earning-related component was adopted in 1954; it is the foundation of the current pension plan. Later, after the establishment of the old-age welfare pension system (1959), a universal pension system was achieved covering all but company employees with the introduction of the National Pension Plan of 1961.

No major change has been made since then, except for the change to the two-tiered system with a flat-rate portion of conventional employees' pension and mutual pension serving as a basic pension. In recent years, measures have been taken towards the aging society by increasing the premium rate and raising the age of the pension-payment eligibility.

Unpaid national pension premiums are becoming a social problem that may discredit the system, and measures are being sought to reduce the number of unpaid cases.

(b) Institutional Characteristics

Japan's pension plan has three tiers. The lower tier is a basic pension (national pension), which is the basis for benefits for all pensioners. The premium is flat-rated. The middle tier is the pension plan for the current working generation, consisting of Employees' Pension, National Public Service Personnel Mutual Aid, Local Government Officials Mutual Aid, and Private School Personnel Mutual Aid. The premium is proportionate to the gross pay of the person. The upper tier is the so-called "corporate pension," and participation is voluntary. It targets the Employees' Pension Fund and Tax Qualified Pension Plan.

National Pension resources include profits from managing accumulated insurance premiums in addition to insurance premiums and government contributions. The share of insurance premiums is approximately 70% and the government contributions 15%. Category 1 insured persons, such as self-employed persons, are responsible for all the insurance premiums, including the premiums for dependents (spouse). In the case of Employees' Pension, premiums are born equally by employers and employees (Category 2 insured persons), and the spouses (Category 3 insured persons) are exempt from the insurance premium of the National Pension Plan.

The Pension Plan is categorized into the pay-as-you-go system and the reserve finance system depending on the form of benefit and burden. In principle, it is designed based on the pay-as-you-go system, and contributions of the current working generation are not accumulated intact, but allocated to the payment of the current pensioners. However, since they hold reserves, it is in reality an eclectic system of both (modified reserve finance). Insurance premiums are initially set at a low level, and increase in a step-by-step fashion, and are called a step-up contribution system. Traditionally, Japan's Pension Plan has set the insurance premium on the premise that the relationship between the benefit and the burden will be balanced in the end (whole-future-balancing method), but a closed-period-balancing method was adopted in the review of the 2004 reform. The closed-period-balancing method stipulates that the time frame of the balancing period would cover the completion of payments to those who are already living. It is also stated that the assets at the end of this financial balancing period will function as a payment reserve. It is designed in such a way as to stabilize the future relationship between the benefit and burden by periodically assessing the financial balance and adjusting it accordingly.

C. Social Welfare

(a) Historical Background

Since social welfare is different from health care or pensions, the continuity from the system of pre-war Japan is weak, and it is fair to say that it has been formed under a certain leadership of the GHQ within the framework of the Constitution of Japan. In other words, it virtually placed

undue reliance on Article 25 of the Constitution of Japan, or the so-called right to life, and many related laws have been established between 1945 and the mid-1950's in the immediate post-war period.

The former Daily Life Protection Law of 1945 remained under the influence of the former Poor Relief Law of pre-war Japan, but a new Daily Life Protection Law of 1950 established a current democratized system of daily life protection. Besides this, a series of social welfare-related laws were developed under the guidance of the GHQ: for instance, the Child Welfare Law (1947), the Welfare Law for Physically Handicapped Persons (1949), and the Social Welfare Service Law (1951).

(b) Institutional Characteristics

From the point of view of social services, Japan's social welfare system is not sufficiently developed in terms of quantity. As it is often referred to as a "Japanese-style Welfare Society," Japan has established a social welfare system on the basis of a certain level of community bond or family function, and the system is not based on the concept of individualism as found in the Western world. Therefore, the social welfare system has been discussed in traditional practices; for instance, "three generations living together" is taken for granted even in old-age, and women are urged to leave their full-time jobs when they have babies. Thus, nursing care for the elderly has not been provided sufficient services until recently. It is also often pointed out that the amount of social welfare expenditures for family policies is much lower than in European nations.

Approximately half of the beneficiaries of Japan's daily life protection system are elderly persons, and it has served mainly as a supplementary system for partial pensioners of the retirement pension or uninsured pensioners. This tendency is somehow continuing in Japan where the development of the pension system was slow as compared with health insurance.

Table 4-6: Recent Movements of Social Welfare Policies

	Policy/Law	Description
1987	Enactment of laws for social workers and care workers	Establishment of national qualification as a social welfare specialist
1989	Formulation of Ten-Year Strategy to Promote Health care and Welfare for the Elderly (The Gold Plan)	Medium and long-term strategic plan for the health and welfare of the elderly, including specific numerical targets, with the launch of measures focusing on home care services
1990	Revision of eight welfare laws	Clarification of legal positioning of local governments in social welfare administration, with transfer of authority to local governments
1994	Formulation of the New Gold Plan	Review of the Gold Plan, with an objective to enhance home care services, such as training for care workers, and expansion of visiting nurse stations
1994	Formulation of the Angel Plan	Basic directions of measures for childbearing-support in the future were formulated based on the agreement reached among

		the Ministry of Education, the Ministry of Welfare, the Ministry of Labor, and the Ministry of Construction. At the same time, Five-Year Emergency Measures were formulated.
1995	Formulation of the Plan for the Handicapped	While based on the principle of rehabilitation and normalization, a new direction of measures for the handicapped is presented. Specific plans with numerical targets are to be formulated.
1997	Enactment of Long-term Care Insurance Law	Various nursing-care services that have been traditionally provided by administrative assignments were shifted to the contract-based insurance schemes.
1999	The New Angel Plan	A new five-year plan: revision of the previous Angel Plan and Five-Year Emergency Measures, including the women's employment, health, consultation, and education
2000	From Social Welfare Service Law to Social Welfare Law	Revision of Social Welfare Service Law to Social Welfare Law, obliging local governments (cities, towns, and villages) to formulate local welfare plans. This was revised as a part of the reform of the basic structure of social services
2000	Child Abuse Prevention Law	It clarified the responsibility of the central and local governments for child abuse and set forth the measures to protect abused children.
2002	Measures to Cope with a Lower Number of Children Plus One	It includes the necessity of countermeasures to the falling birthrate by reviewing the working practices of men as well.
2003	Assistance Benefit Supply System (welfare for the handicapped)	As the case of nursing care insurance, the services for the handicapped were shifted from administrative assignments to contract-based arrangements.
2003	Young People's Independence and Challenge Plan	Aiming at enhancing motivation to work and promotion of professional independence of young people, this plan was jointly formulated by the Ministry of Education, Culture, Sports, Science and Technology, the Ministry of Health, Labor, and Welfare, The Ministry of Economy, Trade and Industry, and the Cabinet Office.
2003	The Law for Measures to Support the Development of the Nest Generation (New-New Angle Plan)	This obliges municipal governments and businesses to formulate actions plans to effectuate the Measures to Cope with a Lower Number of Children Plus One
2005	Enactment of the Elderly Abuse Prevention Law	It includes compulsory reporting of the abuse to the authorities, calling for the promotion of efforts of the local governments.

The characteristic of Japan's daily life protection system is the provision of case work along with the assurance of income compensation, instead of a non-contributory income security system that simply ensures the minimum level of living standard. A wide range of social welfare services are available, by assigning case workers with the responsibility to assist families who are dealing with multiple problems, such as the disabled, children, and elderly members. On the other hand, case workers tend to take a generalist-oriented approach, impeding the development of specialist skills for assisting in different areas, such as disability, child welfare, and maternal and child household.

However, in recent years, a delay in the development of welfare services is becoming a major concern given the rapid aging population. Since the middle of the 1980's, Japan has been searching for a new direction to enhance social services through a series of measures: including, formulation of laws for social workers and care workers aiming towards the development of specialists in welfare, formulation of a Ten-Year Strategy to Promote Health care and Welfare for the Elderly (The Gold Plan) which presented specific goals in medium and

long-term measures for the elderly, and revision of eight welfare laws that stipulate the transfer of power to local governments and formulation of elderly welfare plans by local governments, and so on.

Recently, the Basic Structure of Social Services was reformed in 2000, and the Social Welfare Services Law was revised to the Social Welfare Law, in an attempt to reconstruct the user-oriented system by shifting from administrative assignments to contract-based arrangements. Furthermore, the aging population and fewer children resulting from the declining total fertility rate have become issues to be addressed. As an extension of the conventional support plan for childrearing, the Angel Plan, a number of laws were developed, including the Law for Measures to Support the Development of the Next Generation and Plans to Support Children and Childbearing (New-New Angel Plan). In addition, in response to a rapid increase in the unemployed and impoverished youth, efforts are being made to strengthen the youth-related measures, such as the formulation of Young People's Independence and Challenge Plan.

Reference

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Annex 9. Japan's Experience in Social Protection: Comparative Advantages[117]

It is important to consider Japan's experience in social protection system when considering which activities JICA should focus on.[118] The strengths and characteristics of Japan's social protection system were documented in a JICA's 2004 publication and featured in The Lancet published in 2011 a special issue cerebrating Japan's universal health care at 50 Years. This section will refer to those analyses and attempt to provide comparative advantages.

A. Comparative Advantage in the Aspects of Economy, Social Structure and Culture

From the aspect of accumulated historical experiences, Japan has a unique experience in the sector of social protection, including unsuccessful cases and lessons learned that are different from that of western nations.

First, in the history of establishing a social protection system, Japan was a late starter in terms of both modernization and social protection system compared to Europe. Therefore, Japan's social protection models adopted a unique form that was suitable for social, economic and environmental elements of Japan at that time, while using the western-style social protection systems as a base. One of the examples is the pursuit of a social protection system that fits the rural community. The social structure of Japan in the early 20th century was founded on rural communities with a high share of the agricultural sector, and history tells us that Japan actively attempted to incorporate this sector in the social security systems. The most representative case of this is the National Health Insurance System. This system can be regarded as an experience of responding to the most difficult challenge that developing countries are currently facing: specifically, how to include the informal sector effectively.

Second, similarities to Southeast Asia in a cultural kinship seem to be a large comparative advantage of Japan. Although there is a mixture of various religions in Southeast Asia, culturally, there is a tight regional bond that is characterized by strong familial ties. Japan's experience, therefore, has a certain advantage over the western-style of social systems, which are based on individualism.

Third, response to a rapid aging population is also a characteristic of Japan's social security development. Japan has experienced the aging of the population more rapidly than western nations.[119] Southeast Asian countries are also expected to age in an accelerated manner and measures for the aging society are essential from a mid- and long-term perspective.

[117] From the view point of comparative advantage, each country must choose appropriate programs according to its socio economic conditions. Therefore, it is not appropriate to consider comparative advantages of social protection systems. However, it is worth doing so by looking closely at each function and mechanism of a program and to study the suitability to specific conditions.

[118] See JICA (2004) Japan's Experience in Social Protection

[119] The period of time required to transfer from one aging society (the rate of aging 7% - less than14%) to another aging society (the rate of aging 14%-21%) is called the doubling time. The doubling time of Japan is 24 years, England, 47 years, Germany 40 years, Sweden 85 years and France 115 years. According to the UN population estimates, estimates are 22 years for Thailand, 25 years for Malaysia, 22 years for Indonesia, 23 years for the Philippines, and 25 years for China.

Particularly in urban areas, localized advancement of the aging population with a falling birthrate is predicted to occur more rapidly than Japan. Even difficulties and failures[120] that Japan experienced while dealing with the aging society may serve as useful lessons for these countries. For instance, Japan has achieved the development of a health insurance system at a relatively early stage, but the development of welfare facilities and services was slow, resulting in some problems in dealing with elderly persons, including the so-called "social hospitalization," "over-prescription/excessive use of medical tests" and "bedridden seniors." Asian countries are usually more prone to delays in development of these welfare services (or social services) since they tend to rely on family care, and it is furthermore important to exchange experiences about the appropriate sharing of roles among all stakeholders as caregivers: families, the government and the market (corporations).

In areas other than aging, difficulties that Japan experienced would serve as a good reference when considering assistance associated with maturity in developing countries. The fact that integration of insurers in the health insurance system did not make progress in Japan would provide many useful lessons for developing countries that have similar problems when it comes to an integration and unification of insurers. That the introduction of the electronic receipt did not go smoothly is another difficulty Japan faced. On the contrary, the fact that Japan maintained the system for a long time, while adopting payment at piece rates, which is considered difficult, to reduce the costs of health insurance, is not really a difficulty Japan had, but it is rather a challenge that Japan faced in determining how to manage the system while adopting the "sky is the limit" system of payment at piece rates. It is desirable for such historical experiences of Japan in social security systems to be effectively utilized.

B. Advantages in Information Management System/Operational Management

While pension plans and health insurance systems are compatible with very complex information management, a nationally unified operational system is adopted, contributing to the free-insurance access to health care services.

Specific systems (for example, computerized information management) and operational management capacities did not copy those of the western nations. Instead they are regarded as a unique know-how suitable for the Japanese systems, and many of them may serve as a good reference to developing countries[121].

C. Advantage in Social Welfare Sector

[120] In preparation for the aging society with falling birthrate, certain political measures are taken for the care for the elderly, but no effective measures are set forth against the low birthrate, causing concerns over the pension benefits in the future. Hiroi (2004) Japan's population transition (the change that countries go through when they progress from a population with short lives and large families to one in which people tend to live longer lives and raise small families) period was during the 1970's and 1980's and was able to experience high economic growth during the population structure, which had yet to mature. At the same time it has been pointed out that the cost burden associated with the aging society was postponed due to a sort of fiscal illusion. "Experience of Japan's Social Security: Perspective of System Development Process and Lessons for Developing Countries as a Later Starter in Social Security" Yoshinori Hiroi, (2004), JICA.

[121] Nonetheless, it must be noted that the electronification and DRG in health insurance have been introduced earlier in the western nations and some Asian countries than in Japan.

In the social welfare sector, Japan has accumulated technologies for social work and experience in professional systems, and would also be able to contribute to the developing countries in terms of know-how on facility management. Furthermore, welfare organizations have accumulated their own know-how in establishing local care systems, such as child-consultation offices and comprehensive regional support centers. In particular, the experience in regional welfare in Japanese society, which has been developed from rural communities, may greatly contribute to the Asian rural community-based countries.

The government has presented basic direction and a system framework for many of the social welfare systems of Japan, and the local governments assume the role of executing them. Thus, in order for the measures to become effective, it is necessary for the local governments to ensure the capacity to execute the measures. In the sector of social welfare, which is effectuated when the services are provided on a locality basis, an important element is to develop and maintain the level of capacity of local governments.

The Ministry of Health, Labor and Welfare, prefectural governments and municipal and township governments continuously carry out a series of operations from understanding the welfare needs in the region in various areas to the formulation of administrative plans. Such know-how would contribute to the improvement of study design and planning capacity of the counterpart countries.

D. Advantage in Redistribution System

Introduction of a wide variety of redistribution systems in the postwar recovery years in Japan has a significant meaning in the sense that it created a society where all Japanese believe that they are in the middle-class strata in the latter half of the 20th century, although it is a temporary mentality in the postwar years. As it is described earlier, the redistribution systems in Japan are not limited to the social security system. Because various policy fields are redistribution-oriented, it is very significant to structuralize the economic and social experiences after the 1960s and inform developing countries of it. In the years of economic development after the 1990s, Southeast Asian countries are reaching the stage Japan experienced in the rapid economic growth period and it has become important for them to examine the ways to introduce the redistribution systems of taxation, public works projects, various regulations and employment and industrial policies.

Reference

＊Lancet (2011) Japan: Universal health care at 50 years
http://www.jcie.or.jp/japan/csc/ghhs/lancetjapan/
＊JICA (2004) Japan’s experience on social protection

Annex 10. Development of Social Security Systems in Asia

Although examination of the situation in more countries would be more desirable in developing these guidelines, we focused on the state of social protection in Asia due to the following reasons. First, many requests for specific projects in the sector of “social security” are currently received from Southeast Asian nations. Second, JICA’s dispatch of long-term experts and projects has been implemented mainly in Asian countries. Third, following the proposals of then Prime Minister Ryutaro Hashimoto’s “Initiative for a Caring World,” working-level meetings are mainly held in Asian countries. Nevertheless, as explained in Chapter 3, some projects have also been implemented in Central and South America, and data collection on more target countries, including Central and South America, would be desirable.

A. Obsolete Pre-war Social Security Law System

Actual moves towards the establishment of social security systems in Asia have been gradually activated since the 1990’s and have considerably accelerated their pace over the past 10 years or so. There are some countries that showed enthusiasm for the development of social security systems soon after the Second World War. Thailand enacted the Social Security Law in 1951 and Myanmar also enforced the Social Security Law in 1956. Although many countries addressed the establishment of such modern social systems at the time of gaining independence after emerging from colonial rule, they failed to substantiate the efforts due to lack of economic and financial backgrounds. This structure was left unattended until recently in most of these countries.

Particularly, in some countries which were involved in wars and civil wars, national social and economic infrastructures were obliterated. It would take more time to have social security systems in place in these countries, which are still ranked among the least developed countries in terms of social security systems.

B. Financial Crisis and Establishment of Social Protection Systems

The rapid economic growth in the 1990’s and the following financial crisis brought about change in this situation. Prior to the financial crisis, the economic growth of such countries as Thailand, the Philippines, Indonesia, and Malaysia was remarkable and they were economically capable of establishing social protection systems and social welfare systems, while pursuing the development and accumulation of infrastructure. Even countries with less economic power than these countries experienced some economic growth benefiting from the economic growth of these countries.

However, the Asian financial crisis of 1997 shook the foundation of the economic growth of these countries. In response, the Japan Bank for International Cooperation, the World Bank,

and the Asian Development Bank took the initiative in taking emergency relief measures, and the concept of social protection spread rapidly. When stable economic growth eventually lost its ground, creating many unemployed people and other needy persons, serious discussions about the necessity for building a permanent social safety net (i.e., a social protection system) began to take place. Through this process, significant progress has been observed; for instance, expansion of social protection systems has been actively promoted particularly in Thailand and the Philippines, and the introduction of the Medical Saving Account (MSA) has proceeded mainly in the urban areas of China. Some changes were observed in countries ranked among the least developed in terms of social protection systems. Laos, although confined to the capital city of Vientiane, has been promoting the expansion of a social insurance system targeting employees. Some progress is also evident in Cambodia with the enactment of the Social Protection Law.

C. Characteristics of Social Protection Systems in Developing Countries and Development Models

All the countries share the common characteristic of social protection systems in a sense that it is established along with the industrialization and the progress of capitalism. However, specific forms that the system exhibits differ even among developed countries. Although the development of social welfare as defined by developed countries lags behind, health care and pension systems have progressed more than social welfare in most of the countries. The following is an overview of the characteristics of health care and pension systems, followed by development models.

(a) Health Care/Pension as a Welfare Program/Pension System for Military Personnel and Civil Servants

At the initial stage of developing social security, health care and pension schemes are generally developed as a welfare program for military personnel and civil servants. Some countries provide elderly veterans with housing and cars, and such support through payments in kind is used as a substitute for pension benefits[122]. Such programs can accumulate experiences in the management of contributory health care and pension schemes, which makes it possible to lead to contributory employees' schemes, however, these benefits are more of a fringe benefit in nature for civil servants rather than a pension plan, and they are, in some cases, regarded as being different from the pension system through social insurance, which is explained below.

Many developing countries set the income level of civil servants low and the payroll system is more vulnerable than that of the private sector. Civil servants however, are permitted to have side jobs, health care benefits are generous, and the pension plan is well developed. Thus it is not possible to measure their standard of living solely by the income level.

[122] Some countries consider a pension system for the privileged class to be "social welfare." However, here, it is used as a substitute for income insurance for the elderly and is included in the category of pension.

Nonetheless, even though access to health services is economically ensured as a fringe benefit system, the use of health services is not always fully ensured, since health care resources, such as medical institutions and professionals, are not sufficiently available. With respect to pension plans, beneficiaries are on a waiting list in a number of countries due to limited budgets. Even though a system is in place, it may not necessarily be managed with any stability.

(b) Employees' Social Protection[123]

The target group of a social protection system, following the pension for military personnel and civil servants as a fringe benefit, is its employees. It usually refers to compulsory participation on the part of the business entities in accordance with the number of employees. This system shares a characteristic with social insurance systems in a sense that business entities and employees, or the government in some cases, pay the benefits. Many countries define this employees' social protection as social protection, and they tend to distinguish it from pension for civil servants and military personnel described above. To avoid confusion, the definition given at the beginning of the guidelines will be used throughout this document.

Employees' social protection can be categorized into a comprehensive type and a separate type according to its target groups. In addition to health insurance, the comprehensive type covers pension, disability benefits, childbirth benefits, survivor's pension, and so forth under one scheme. In some cases, it even covers unemployment benefits. It may also include occupational accident compensation insurance. On the other hand, the separate type of insurance separates the health insurance from the rest of the security systems (income security system).

The Asian countries adopting the separate type of insurance are Malaysia and the Philippines, and the countries adopting the comprehensive type are Thailand and Indonesia. Vietnam used to adopt the separate type, but changed to the comprehensive type in the fiscal year of 2004. On the contrary, the Philippines changed to the separate type from the comprehensive type.

In developing countries, it was once advocated to separate the employees' health insurance from the comprehensive employees' social protection, and to incorporate the employees' health insurance into other health insurance programs, in order to integrate several systems during the process of promoting universal health insurance coverage. A similar movement was observed in Thailand at the time of the launch of the "30 Baht Scheme" in 2002[124]. There is a concept that health insurance is short term in nature while pension insurance is long term. So, some contend that they should use different funds instead of managing them in an integrated

[123] Generally, the "Hiyosha muke shakai hosho seido" refers to employees' social security in English, but this English term is not employed by all the systems. This term specifically refers to the insurance system assuming company employees (employed persons and employed workers) as target insurers. Nevertheless, these systems are not necessarily applied solely to employees, but in many cases applied to self-employed individuals as well as employers in the form of voluntary participation.

[124] It was not separated in the end, and a comprehensive type has been in place.

program. Selection between the comprehensive type and the separate type will be a strategy for the development of social protection in each country in increasing the number of those who are insured.

(c) Social Protection for the Informal Sector

Employees' social protection usually adopts compulsory participation of employees of business entities above a certain size, but many programs adopt voluntary participation for others such as students, self-employed persons, and those engaged in agriculture. The expansion of participation of informal sector workers is an important but challenging process of promoting the universal coverage of health insurance that is sought after as the Employees' social protection matures.

Box 4-2. Informal Sector

The scope of an "informal sector" in the context of the development of a social protection system is not always clearly defined. In principle, the term refers to people other than civil servants and employees of companies above a certain size, and specifically, the collective term "informal sector" is often applied to individuals without organizations who are outside the coverage of fringe benefits for civil servants or of social protection for company employees, represented by farmers, self-employed persons and students.

In the case of small- and medium-sized enterprises, the boundary between informal and formal sectors is controversial in terms of size, but generally, formal sectors often include companies within the scope of compulsory participation under social protection systems (such as companies with five or more employees).

Many developing countries do not have an institutional foundation for tax collection systems or collecting insurance premiums, and it is very difficult to grasp the income, particularly in rural areas where a money-based economy is not fully developed. Therefore, it is an extremely important strategy to determine whether the expansion of coverage in an informal sector is carried out through the expansion of Employees' social protection (in other words, a social insurance system) or through the establishment of a different system.

Malaysia and Thailand[125] have currently achieved universal coverage, at least in formality, and the Philippines and China achieved 60% coverage, and achieving universal coverage is within reach. Both Malaysia and Thailand however, have introduced a tax-oriented system, having virtually given up incorporating an informal sector into social insurance systems. Still, a tax-oriented system entails a heavy financial burden, and its sustainability remains questionable. It may also end up with a mere "security system for the poor," particularly in

[125] Nonetheless, "Coverage for All" is a system in which the government assumes a certain level of cost burden as a system in health care services and does not mean to equally provide health care services that are physically accessible in every region. In reality, the system is not used by the eligible entity.

health care as a result of the government restraining the budget. Some point out that a financial crisis is about to erupt in Thailand, and some health care institutions in rural areas are faced with financial difficulties. The Philippines has set a realistic level of coverage between 70 and 80%, and it has not presented any specific direction towards the realization of universal coverage.

Under these circumstances, there remain pressing needs for re-constructing the system to either a social insurance system or any other financing system.

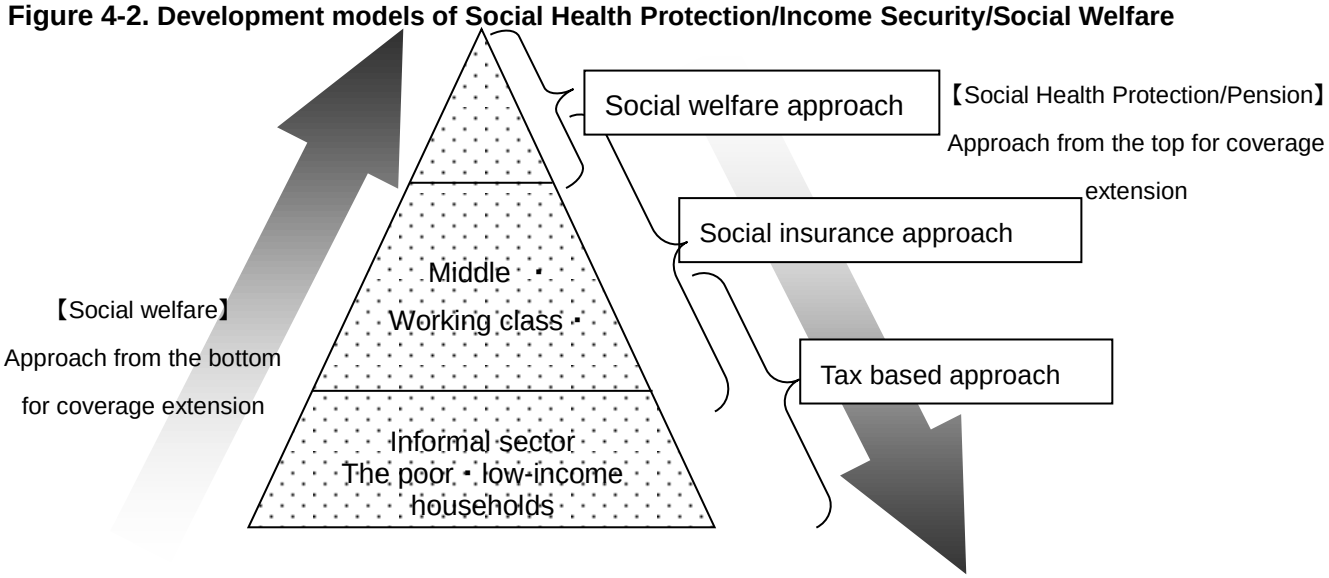
(d) Social Welfare

As described above, a general development model for social protection systems in developing countries is to gradually expand the coverage of health insurance/pension from military personnel/civil servants, to company employees, and finally to an informal sector, which is hard to grasp and includes the poor.

On the contrary, the opposite process is seen in social welfare systems. Social welfare generally targets the socially vulnerable, in principle. In the case of Japan, the development of social welfare started with the Poor Relief Law to help the poor people in the pre-war period, and Japan enacted the Livelihood Protection Law soon after the end of the Second World War. Later, the focus was shifted to the socially vulnerable, such as children. As welfare for the elderly develops, social welfare has become so general that it has finally covered all people, and it is not limited to the socially vulnerable. Nursery-related facilities, which are included in maternal-and-child welfare and child welfare, used to be more of a welfare measure, but now they are also for the wealthy class as a social system to support working women.

The relief of the poor, or the first step in the development of social welfare, is not fully implemented in developing countries. Some countries have established a system equivalent to a livelihood protection system. The right of receiving benefits, however, is not accepted as a permanent right in many countries, even if the benefits are available. Since the legal framework is underdeveloped, the right of every individual is not established and the provision relies on the discretion of respective administrations, whose financial resources are tight. The most serious issue is that the present financial resources would be exhausted within the next several years. This is because most of social welfare-related activities are incorporated into a project-based system due to the unavailability of permanent financial resources. Even when an income security system for low-income households with a certain level of compensation has been developed, there is a problem of arbitrary decisions by local potentates or politicians in granting compensation.

Figure 4-2. Development models of Social Health Protection/Income Security/Social Welfare



Various types of social work, which provide benefits in kind as a social welfare measure, are mostly provided by NGOs. In particular, in the least developed countries where the development of social workers has been insufficient, international organizations, such as UNICEF, and NGOs play an important role in the provision. While projects carried out by international organizations and NGOs may not necessarily cover the whole nation, involvement of local stakeholders in these activities would promote capacity development. However, the continuity of activities of NGOs is not ensured, and therefore, it is important, from a long-term perspective, to establish a system that provides services on its own responsibility of the beneficiary country.

Annex 11. Social Protection Initiatives of Major Donors

11-1. International Labor Organization (ILO)

A. Philosopies on Social Protection

ILO focuses on four major areas, which are employment, social dialogue, social security, and standard & basic rights. Their social protection initiatives aimed for a decent work condition are based on these four major elements. The operation is usually run by three parties, which are the government, workers, and employers. The team promotes protection of worker's rights and compliance with social security standards in member states. They focus on preserving human rights and take an approach called the "human rights based approach", which is based on three basic philosophies, which are universality, solidarity, and redistribution. In order to acquire income security, ILO integrates both elements of social security and labor market issues into their official initiatives.

B. Organizational Structure

At ILO, the Social Protection Sector implements mandate-based support programs towards member states[126]. The Sector is divided into two departments, the Social Security department and the Labor Protection department. The goals of the Social Security department are as follows.

- Expansion of coverage & effects of social security systems
- Protection of employment: Decent (rewarding and humane work) conditions of work (wage and working hours) and sanitary conditions of the workplace.
- Protection of the weak. (i.e.) Immigrant workers and their families, informal sector workers and their families, those suffering from AIDS, etc.

C. Recent Activities

Up until recently, along with the establishment of social protection systems, protection of organized/formal department workers was their main initiative. Today, their focus has shifted towards expansion of social security systems among informal department workers (Social Protection Floor Initiative), which was launched in 2009 with the United Nations. In 2012, they began their planning process for the launch of the 202th pact, an independent and separate initiative from the 102th pact. As seen here, they are very active in promoting support towards workers in the informal department. Expanding social security coverage is their top priority in recent years[127].

The goal of the initiative is to promote the establishment of a social system that secures the

[126] Hereinafter, refer to the ILO website for more information. http://www.ilo.org/protection/lang--en/index.htm

[127] ILO is the only institution that has been implementing social protection initiatives worldwide. However, recently there are many who say there is a limit to what the ILO can do. This critique is based on the fact that ILO's social protection initiatives were originally planned for countries with some kind of system already in place. Consequently, their actions have not been as effective for developing nations with a weak social protection system. Mari Osawa (2004) Welfare Strategy in Asia p272 The international standards of ILO is created using European standards, but these may not work to well in developing nations.

minimal standards for low-income nations. They focus on initiatives that provide life-long support and empowerment for lower class workers. The minimal standards they seek to secure are: 1) Health coverage for all citizens, 2) Income security for children, 3) Supporting the unemployed/poor, 4) income security for the elderly/persons with disabilities. Their main approach is to begin with the establishment of minimal standards that best fit the country's needs, and then slowly expand coverage. They then seek to establish a higher and more sophisticated system such as social security and ultimately, their goal is to secure some kind of social protection for every single citizen (the principle of progressive universalism).

Table 4-7. Historical Development of the ILO Social Protection Programs

Year	Contents
Late 1990s	STEP Programme (Strategies and tools against social exclusion and poverty) Today, this program reaches over 40 nations. It focuses on helping the poor and those estranged from society in the informal economy & rural districts. They provide support in two fields, which are 1) expansion of social security in the health sector, 2) a comprehensive approach against social estrangements. STEP's approach method sees little precedent. Their community-based social security scheme development (such as microfinance, Mutual Health Organizations:(MHO)) programs are highly evaluated as an effective way to help the poor estranged from society in developing nations. STEP has a web platform called CIARIS (the Learning and Resources Centre on Social Inclusion), which functions as a database that allows them to share information regarding this topic with other professionals. It plays an important role as a network for human resource as well.
2003	Launched the "Global Campaign on Social Security and Coverage for All" The goal of this campaign is to expand coverage of social security systems in order to combat poverty and social estrangement.
2007, 2008	Discussed social security expansion initiatives at the ILO conference in South and Central America, Arab states, and Asia Pacific. Delegates representing governments, employers, and workers all participated in these meetings. Based on the essential social security systems necessary for a nation, a comprehensive two-sided approach was taken where they aim to expand social protection towards all citizens and provide a higher-level social protection through a gradual implementation.
2008	The "ILO Declaration on Social Justice for a Fair Globalization" was accepted in the 97th ILO conference. This declaration reconfirmed the necessity of the involvement from all three parties in order to actualize decent work conditions and expand such support initiatives towards all those who need it.
2009	At the 98th ILO conference, the important role social protection policies play in crisis management was reconfirmed. The "Global Jobs Pact" installed the basic "social protection floor" in each nation and requested that "appropriate measures to be taken in order to establish a social protection system suitable for all".
2010	At the high-level MDG summit, where topics regarding the millennium development goals were discussed, it was agreed "Promoting access to social services to all and providing the minimum amount of social protection necessary will strengthen profits gained by development programs. This will ultimately be an important element in achieving the final goal". The "Minimum amount of social protection required initiative", launched by the UN in 2009, was accepted.
2012	202th council on the minimum amount of social protection required was released.

D. Projects

(a) Provision of technology

They have provided technological knowhow to over 25 nations up to this day. They offer appropriate advice towards strategies/initiatives regarding social security schemes, expansion

of social security coverage, and review of present social security schemes, government expenditure, and business performance. These support programs, aside from technology provision towards a specific country, also include research/development agendas requested by the social security board of the local area. Below are some examples of this activity.

- Global campaign on social security and coverage: Kenya, Nepal, Jordan, and Senegal.
- Review of pension system and policy advice: Algeria, Ethiopia, Ghana, Libya, Jordan, Kuwait, China, Laos, Cyprus, Argentina, Chile, Central/Eastern Europe, and the Caribbean countries.
- Review of medical insurance system and policy advice: Botswana, Ghana, Cambodia, Tanzania, Thai, Peru, and more.
- Design/establishment of unemployment insurance system (Includes three-parties structure, financial review, policy advice, and support of drafting the new law): Bahrain.
- Thai (2003): Thai installed the UC system in 2001. ILO was requested to review the system's long-term financial situation and decide on a financial strategy. ILO gave an appropriate advice based on their evaluation of the financial situation. This advice can be seen from the document below. http://www.ilo.org/public/english/protection/secsoc/downloads/publ/995sp1.pdf

(b) Major projects in recent years

Below are some major projects of recent years.

Name of Project	Contents
Better Work Project	Partnering up with the IFC (International Finance Corporation), they established a corporative support framework called "Better Work". They established an operation group together (in which one representative from each party participates). This group reviews and discusses annual strategy, work projects, global program budget, and initiative distribution of Better Work. ILO contributes with its experience in the field of social dialogue and labor standards, while IFC utilizes its knowhow in the field of private sector development and investment clients.
Assessing and Addressing the Effects of Trade on Employment	This program helps increase competence of policy makers, researchers, and counterparts. Its aim is to increase employment by establishing an effective and comprehensive policy. ILO has received disbursement of funds from EU and EuroAid and works as the execution agency. This program is being conducted in 4 nations as a pilot project. (Bangladesh, Benin, Guatemala, Indonesia) (2009 – 2013).
Microinsurance Innovation Facility	This is a part of the ILO social financing program. It aims to protect the poor in developing nations from risks and provide high quality insurance in order to combat poverty. It received support from the Bill Melinda Gates foundation and began its operations in 2008. Today, it receives financial support from institutions like AudAID and Zurich foundation. Below are some examples of innovative facilities. ① Innovation grants: In the field of microinsurance, they provide financial support (donations) towards organizations seeking for innovation. They support insurance programs that prepare against a wide variety of risks, mostly agriculture, life insurance, and family assets. Demand for these insurance products usually exceeds available supply. ② Innovation Grantees: They encourage various institutions to get involved in microfinance using this support funding and challenge towards developing new products and partnerships. In areas like Africa, Asia Pacific, and Latin America, registered grantees (mostly NGO)[128], utilizes

[128] See link below for more details on grantee institutions and categories.
http://www.ilo.org/public/english/employment/mifacility/grantees/index.htm

	funds from ILO and conducts medical, agricultural, accident, and life insurance services. ③ Consulting and Capacity Building Programme：CCB Programme：This program aims to increase competence of service delivery abilities of consultants and insurance providers of microinsurance. In order to adapt to various microinsurance needs like region and natural resources, they offer 3 services (advice, specialist training, and resource center).
Cooperative Facility for Africa ： CoopAfrica	With financial support from DFID, ILO conducts technology provision and holds office in Dar es Salaam, Tanzania. They operate in 9 nations in the East/South Africa region.
International Programme on the Elimination of Child Labor: IPEC	Since its establishment in 1992, it deploys policies and programs in over 90 nations. It is the largest technology provision initiative in the world. It suggests alternatives for families who are forced to put their children to work.
ILO/WHO/GIZ consortium	A consortium with WHO and GIZ was established in 2004. It helps the establishment of medical insurance systems in developing nations through support from specialists and organized events.
Cooperative project with Universities	Targeting managers in the social security field, this project conducts and develops Skill up training programs. Since 2001, they teamed up with Maastricht University of Holland and University of Lausanne in Switzerland and began trial of the “good governance” methods, which is just one of the examples.
Establishment of unemployment insurance and employment services in ASEAN nations.	2010 – 2013 December. The Japanese government provides financial support. The project aims to strengthen and establish unemployment insurance and employment services in ASEAN nations. In a pilot project in Vietnam (unemployment insurance), it established a network among ASEAN nations (Indonesia, Malaysia, Philippines) through provisions of technology and increasing competence of policy makers. This is a cooperative project among the ASEAN office, ILO, and the Japanese government.

E. Recent publications and events

- Published the World Report on Social Protection in 2011.
- Organized various meetings regarding employment situations after the financial crisis of 2008. Hosted an ECOSOC meeting regarding the empowerment of women in June 2010.
- Globalization and employment: June 2010
- Workshop on combating employment crisis: March 2010
- Special seminar on the effects of economic stagnation on poverty and sustainable development. (China ASEAN forum): September 2009
- High-level region meeting in response to the financial crisis: Numerous meetings hosted in February 2009 and more.

F. Database on social protection

- Social protection database (Programme and Mechanism): Overview of social protection system in nations.
  http://www.ilo.org/dyn/sesame/IFPSES.SocialDatabase
- Social security fee database: Conducted research in 1997. It gives an overview of social security fees incurred in various countries from 1990 to 1996. http://www.ilo.org/dyn/sesame/IFPSES.SocialDBExp
- Knowledge database/platform of social protection: A website operated by the social protection sector. You can search recent news and documents related to social protection. http://www.socialsecurityextension.org/gimi/gess/ShowMainPage.do?ctx=0

11-2. World Bank

A. Philosophy on social protection and recent trends

In order to meet constantly changing needs in midst of the global financial crisis, WB released its "Social Protection & Labor Strategy 2012 – 2022". With its social risk management framework, it supports social security systems for the resilience, equity, and opportunity of individuals and society. The social risk management approach is a part of the strategy in the development of social protection and elimination of poverty. Not only does it prevent risks, but it also teaches risk management skills which ultimately leads to the empowerment of individuals (especially the poor). The advantage of this framework is that it covers a wider range of topics than social security. It actively utilizes Conditional Cash Transfer (CTT) services with medical/education services, which is proving to be effective.

B. Rapid Social Response / Funds

One of their central social protection strategies is the "Rapid Social Response (RSR) program". Recently, in order to deal with the rising price of food, natural resources (fuel), and the financial crisis, World Bank established the "Rapid Social Response (RSR) program" in 2000. RSR is a part of the Vulnerability Financing Facility (VFF). (Refer to table 2-1 below) Below are the 4 goals of RSR.

1) Promotion of Social Safety Net and the Labor Market Program, basic medical care, and education services for the community of the poor and weak.
2) Managing, monitoring, and reporting World Bank initiatives in the field of Safety Net, labor, and basic services.
3) Managing donations from other donors that could leverage IDA funding.
4) Prioritize initiatives towards low-income nations, especially those in weak & vulnerable conditions.

The total amount of funding through the RSR scheme reaches $1,200,000,000 (70 projects) in 2008, $4,300,000,000 (68 projects) in 2009, and $3,200,000,000 (80 projects) in 2010.

C. Offices that implement social protection initiatives of the World Bank

Social protection support of the World Bank, similar to education, medical care, nutrition, and population sector, is found in the Human Development network. The Social Protection & Labor sector is in charge. They work towards eliminating poverty and promoting continuous growth in poverty stricken nations. Established in 1996, it is the newest sector among the 19 sectors. In 1999, the Eastern Asia department of the same sector was established. In the field of social security, they focus on the below points.

- Disability
- Labor market and creation of employment opportunities
- Pension and income support for the elderly
- Social safety net
- Social funds and community-lead development

D. Total amount financed by the World Bank in the field of social protection

In the 2011 annual report of the World Bank, the total amount financed in the social protection sector was 5 times more than the amount before the financial crisis when the figure

hovered around $1,000,000,000. The amount has been increasing since 2009 and 2010, and it became a sector with the highest loan growth rate in the World Bank[129]. Most of that ($3,500,000,000) was put to 37 safety net projects implemented in 31 nations. The largest amounts loaned by categories were: Finance/private sector development ($5,600,000,000), environment/natural resource management ($5,000,000,000), and social protection/risk management ($4,000,000,000).

By country, Mexico received the most funds from World Bank. As a continuous support fund for the Oportunidades campaign, over $1,200,000,000 was provided. 580 families in the lower class of Mexico benefited from this. Other financing was put to improvement of labor market, pension support, disability support, and other social protection services.（Refer to http://worldbank.org/sp）.

Table 4-8. World Bank Lending for Social Protection and Labor (FY2002-FY2007)

（USD Million）

Region/Program	Social Funds	Safety Nets	Pensions	Labor Market	Total
East Asia・Pacific	19	189	0	38	246
Eastern Europe Central Asia	396	454	691	778	2,309
Latin America・Caribbean	36	1,737	993	1,452	4,218
Middle East・North America	90	71	65	103	319
South Asia	0	517	232	317	1,066
Sub-Saharan Africa	621	433	56	440	1,550
Total	1,142	3,401	2,037	3,128	9,708

Source: World Bank (2009a) *Social Protection and Labor at the World Bank, 2000–08,*p.7

E. Supporting the establishment of pension system by the World Bank

Among numerous international institutions, World Bank has been actively supporting the establishment of pension systems in developing nations[130]. Since 1990, World Bank has supported the establishment of pension systems in over 80 nations. Their experience and lessons learned can be found in their publications like “Averting the old age crisis: policies to protect the old and promote growth” in 1994, and “Old Age Income Support in the 21st Century” in 2005. When these two reports are compared, we can see that the core of the World Bank support initiatives has shifted from “Social Safety Net” to “Social Protection”.

F. Collaboration with other institutions[131]

- In 20011, World Bank has established an inventory for managing policies with the ILO. This initiative collects and analyzes 1,750 policies regarding labor standards in 53 developing nations and 22 high-income nations. Through these analyses, they have documented an improved policy to combat the effects of the financial crisis.

[129] WB (2012a)

[130] Ooizumi (2006b)

[131] Refer to World Bank website http://worldbank.org/rsr

- Furthermore, World Bank has teamed up with ILO, The youth employment network, German government, and Development banks in the United States and established a live-database for the youth employment program.

G. Recent publications and events

Sub-Category	Publications and events
Support for the disabled	● Report[132] on the review of policies and initiatives to support the disabled in the field of development. ● Paper that summarizes initiatives taken towards the support victims of the earthquake in Haiti. (World Bank and USAID have implemented a cooperative aid for both Haiti and the disabled[133]. ● In 2010, several seminars on combating poverty and achieving MDG were held in Mozambique[134]. ● Released the world report on poverty with WHO in June of 2011.
Labor market analysis	Released reports[135] and papers[136] on labor conditions in Middle East/North Africa and the financial crisis of 2008. In autumn of 2010, they opened a course on labor market analysis in the Middle East/North Africa with ILO.
Pension	Released "The World Bank Pension Conceptual Framework" in 2008[137]. They implement pension support based on their framework. They also opened a course on pension policies in Washington in 2010, where they teach their basic framework and analysis tools they use.
Social Safety Net	● WB (2011) Evidence and Lessons Learned from Impact Evaluations on Social Safety Nets ● Utilizing the network of the South-South Cooperation, they provide learning environments for developing and developed nations regarding the topic of social safety network establishment. In their workshop in 2010, they organized a study tour to examine public policies of Tanzania first hand.

H. ASPIRE （ATLAS of the Social Protection: Indicators of Resilience and Equity）

On their online database, you can see social/economic situations of 56 developing nations from 2005 to 2010. The database is updated twice a year.

http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/0,,contentMDK:22986320~menuPK:8117656~pagePK:148956~piPK:216618~theSitePK:282637,00.html

[132] Lord, et al (2010)
[133] World Bank (2010)
[134] Inclusive Poverty Reduction Strategy Plan Workshop - Focusing in the Process of PARPA II and Persons with Disabilities (Feb 22, 2010 - Feb 26, 2010) 3 workshops was hosted in total in Maputo and Mozambique combined.
[135] Diego et al (2010)
[136] Refer to World Bank (2009b) and others
[137] World Bank (2008b)

Recent initiatives on social protection and labor by the World Bank

Listed below are information on some of the projects implemented by the WB.

Country	Case	Amount Financed (USD)	Overview	Technology Provision by the WB
Health Insurance				
Argentina (2011-2015)	Development of medical insurance system in prefectures	$40,000	Implemented training to increase competence and monitoring/evaluation abilities in order to increase coverage of medical insurance on a prefecture level.	Skill up training programs, etc.
Philippines		$360,000,000	GPOBA program, a global partnership lead by World Bank. Financial support for the AUSAID. Increased maternal and child health services in eastern Visayas, southern Leyte, Samar, northern Samar, and eastern Samar. Aim towards increasing the coverage of National Health Insurance Program (NHIP).	
Social Welfare				
Congo (2010-2015)	Street children	$110,000,000	Support for establishing a system in Kinshasa to prevent/help street children.	
Pension				
Maldive (2011-	Pension/social protection projects	$120,000,000	A pension act was enacted in 2009 in Maldive with the support of World Bank. A follow-up program was conducted in 2011 in order to make sure that the new pension act gets installed smoothly and those who are in charge are well trained.	Skill up training programs, etc.
Afghanistan （2009-2013）	Pension system and safety net project	$750,000,000	In order to establish a sustainable pension system for the citizens, improve the pension system, and establish a basic safety net pilot program, WB implemented skill up training programs to increase pension management skills. Hosted by Ministry of labor, social affairs, martyrs and disabled.	Statistical analysis of pension, proposal enactment, drafting of new pension system, skill up training programs to increase competence, etc. Staff members from Project Coordination Unit conducted skill up training programs and consulting services.

Unemployment insurance				
Thailand (2000-2006)	Country Development Partnership for Social Protection		Based on simulations conducted on unemployment insurance payments, a proposal was drafted regarding insurance premium and payment. Technological support was also given to the Department of Labor Protection and Welfare.	Premium simulations Technology provision to the Department of Labor Protection and Welfare Pilot projects to test out competence WB, ILO, UNICEF and others
Labor				
China (2008-2012)	Support for migrant workers	$83,000,000	Support on technology development, employment opportunities, worker's rights movement, and policy analysis (ie. Labor style shift from rural to urban district) to aid migrant workers shift towards the urban work style.	Skill up training programs, policy analysis, etc.
Social Safety Net				
Pakistan (2009-2013)	Social Safety Net (SSN) Technology Cooperation	$60,000,000 Note: The preparation fund for this project was provided by the partnership donations of PHRD (Policy and Human Resources Development Fund).	Background/Goal: In 2008, the Pakistan government established the Benazir Income Support Program (BISP). This project provides information on SSN operation/management to the lower class citizens of Pakistan. Hosted by: PAKISTAN BENAZIR INCOME SUPPORT PROGRAMME Result: Project is on going as scheduled. Testing phase of the poverty score analysis table has been completed. The project has been released nationwide. 2,300,000 families have benefited from this. (Goal for 2011 is 5,000,000 families)	● Establishment of targeting system ● Support for SSN operation ● Support for the establishment of SSN management system ● Social protection policy and strategy monitoring ● Fieldwork is conducted by organizations picked out by the BISP. Technical assistance towards safety net reformation agendas of the Pakistan government (using DFID funds). For instance: ● Creating & publishing poverty score analysis and conducting test phases. ● Provision of organizational/technical tools for the establishment of a national safety net program and Benazir Income Support Program (BISP)

11-3. Asia Development Bank（ADB）

1. Outline

ADB offers a wide variety of technology provisions and loan programs in the field of social protection in countries in Asia. Both the World Bank and ADB actively utilize the Conditional Cash Transfer (CCT) system and have yielded good results. After enacting the "Social Protection Strategy (SPS)" in September of 2001, they have been actively providing support in the field of social protection in the Asia Pacific region[138]. With their Social Protection Index, they are able to analyze the current situations in Asia in an objective manner.

2. Strategy[139]

"Poverty Reduction Strategy (PRS)"(1999, 2004) of ADB prioritizes "pro-poor sustainable economic growth", "comprehensive social development", and "good governance". SPS is part of the second priority, "social development".

ADB takes the word "social protection" in a broad sense and its programs are wide in variety. ADB defines social protection as a "set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income." They have 5 sub sectors that deal with different initiatives.

1) Labor market policies: Improving working environments
2) Social insurance: Employment insurance, medical insurance, disability insurance, pension, widow's pension, etc.
3) Social assistance (welfare): Single-mothers, homeless, disabled, etc.
4) Secondary protection, protection by region: Secondary insurance, agricultural insurance, natural disaster donations, etc.
5) Child welfare: Support towards children (0-18) for their wellbeing.

They have set a "Social Protection Action Plan" upon the launch of their SPS program. As seen in table 2-4, they have set schedules and strategic partners and summarized them on a matrix.

Table 4-9. ADB Social Protection Action Plan

Topic	Plan	Schedule	Associated institutions
Prioritize social protection initiatives by countries	・ Prioritize needs of each countries based on the profiles of the lower class, labor market analysis, social expense reviews, and evaluation of organizational/political competence.	Begin in 2002	Nations registered to ADB, World Bank, ILO, UN

[138] Hereinafter, refer to the ADB website for more information. http://www.adb.org/SocialProtection/strat.asp

[139] ADB (2010) Enhancing Social Protection in Asia and the Pacific: The Proceedings of the Regional Workshop

	・ This initiative and its validity will be reflected towards the strategy/programs (CSP) for each nation.		
Funded/Non-funded projects	・ Based on the priority items below, ADB will provide funds or technology cooperation (TC). - Coverage - Social vulnerability and gender - Sustainability and good governance - Comprehensive approach towards social protection.	Begin in 2002	Nations registered to ADB, World Bank, ILO, UN, private sectors, and NGO.
Associated topics and safeguards ・ Make sure there are no negative effects towards the socially vulnerable due to ADB activities. ・ Promote successful precedents of social protection.	・ Determine the social vulnerability and labor issues through the evaluation of the social impact of the project. ・ Support victims of social risks and avoid the expansion of poverty. ・ Conduct initiatives based on core labor standards. ・ Take the country's labor law into consideration along with the core labor standards.	Begin in 2002	Nations registered to ADB, private sectors, NGO, and ILO.
Organizational topic ・ New technology and staff ・ Training ・ ADB strategic cooperation ・ Labor union ・Adjustment of social protection strategy	・ Assign at least 1 new social protection specialist in each sub-regional sectors. Assign 1 staff to the social development sector as well. ・ Conduct external/internal training. ・ MOU contract with ILO, World Bank, and UN. ・ Establish a NGO center for labor union meetings. ・ Create manual/guideline ・ SPS monitoring	Begin in 2002 Begin in 2002 2001-02 2001 Begin in 2002	Interaction of human resources of World Bank, ILO, and ADB. World Bank, ILO, and others ILO, World Bank, and UN.

Source) ADB Website (http://www.adb.org/socialprotection/actionplan.pdf)

3. Recent events

- April 2010: Regional meeting was hosted to discuss the true needs of ADB-registered nations in terms of social protection. Accordingly, current initiatives/policies were analyzed and their issues and room for improvement were discussed. They published the "Enhancing Social Protection in Asia and the Pacific: The Proceedings of the Regional Workshop" report.
- 2009: Hosted regional workshops on social assistance and Conditional Cash Transfer.
- September 2009: Hosted a symposium in Vietnam (Hanoi) entitled, "Poverty and sustainable development in Asia: The impact and reaction to the global financial crisis". Reactions of each country after the 2008 financial crisis and the role of unemployment insurance and medical insurance were discussed from a social policy perspective[140].

[140] Results of the symposium are summarized in the document: ADB (2010) Poverty and Sustainable Development in Asia: Impacts and Responses to the Global Economic Crisis

4. Recent cooperative projects by the ADB

Below are recent social protections projects conducted by the ADB.

Country	Case	Amount Financed (USD)	Overview
Social Insurance			
China （2009-）	Regional project on reformation of pension system	$500,000 (Technology Cooperation)	・Support the establishment of an effective regional pension system in order to secure a stable and basic income for the elderly living in that region
Indonesia （2008-） （2006-2010）	Project on reformation of pension and reserve fund systems (Financial governance and social protection reformation program phase II)	$800,000 $700,000 (Technology Cooperation) / $600,000,000 (Loan) / $500,000 (Donation)	・Dispatched 3 specialists to the Ministry of Finance and contributed to the strengthening of monitoring capacity in the field of social insurance and macroeconomics. ・Reformation of social insurance was added to the core strategy of the Indonesian government. Social insurance system is being discussed continuously.
Thailand (2003-2007)	Pension system	$600,000 (Disbursed amount is $386,000) (Technology Cooperation)	・ Prepare a basis for the installment and expansion of mandatory provident fund system ・ Support the establishment of independent managers/managing institutions ・ Support based on the government's need upon reformation of the pension system
Pakistan （2002-2008）	Strengthening of pension, insurance, and saving systems	$3,000,000 (Onerous technology cooperation)	・Strengthening of pension policy framework and organizational competence of institutions managing pension, insurance, and savings.
Mongolia （ Planned for 2001-2008）	Improvement of social protection sector	$12,000,000 ($8,000,000: Program loan, $4,000,000: Project loan)	・ Support for the development of a comprehensive anti-poverty policy (promote employment, basic social protection and insurance services). ・ Provide loan services for the elderly, disabled, unemployed, and the partially employed.
Social Assistance			
Nepal (2003)	Social assistance research	$250,000 (Disbursed amount is $204,000) (Technology Cooperation)	・Support the development of a national social assistance strategy for the socially vulnerable. ・Establish the basis for a government staff training program in the field of social assistance.
Pakistan （2008-）	Benazir Income Support Program: (BISP) Accelerating Economic	Part of the $800,000 (Technology Cooperation),	・Implemented BISP as a part of the AETP. Provided financial support from AETP to BISP and implemented support for the empowerment of women (giving a sense of social identity through various methods such as handing out ID cards

	Transformation Program: (AETP) (part of the sub program 1-5 implemented in 2008-2012)	$500,000,000 in total project (program loan, ADB loan amount is $200,000,000)	towards women).
Tajikistan （1999-2005）	Re-establishment project of social assistance system	$19,400,000 (Loan)	・Re-establishment of existing infrastructure, provision of daily products, and improvement of service accessibility for the socially weak to resume basic social services.
Tajikistan （1999-2004）	Re-establishment of social safety net	$900,000 (technology cooperation)	・In combination with the loan program above, technology cooperation was implemented in order to establish a more efficient/effective social safety net system. ・Rationalization of income system and improvement of system administration in order to strengthen organizational competence of social protection for the poor. ・Strengthening of targeting ability of the poor, licensing of social workers in orphanage, and research of street children and homeless.
Vietnam (2003-2007)	Social protection system enhancement project	$555,000 (technology cooperation)	・Dispatch MOLISA international/domestic specialists to support the drafting of social protection laws and consulting. ・Research the social protection situations of business owners and employees of small and medium-sized enterprises and non-state enterprises ・A specialist conducted an evaluation of social protection system and published a report on financial inspection of social protection funds and provided advice accordingly.

Source):ADB website (http://www.adb.org/socialprotection/actionplan.pdf)

11-4. European Union（EU）

The Social Protection Committee (SPC) of EU has released “The social dimension of the Europe 2020 strategy - A report of the Social Protection Committee” in 2011. The report picks up topics such as promotion of social inclusion and initiatives to decrease poverty.

A. Strategy

EU holds its own goals (support funds based on GNP ratio, standards of conduct in division of labor, and setting goals for indexes used upon monitoring the effects of the Declaration of Paris) and sets various strategies/policies to achieve MDG in 2015. From a social protection perspective, they put much weight on the “Social Cohesion and Development” and implement numerous support programs for women and young working poor in a constantly changing environment. Furthermore, after the global financial crisis of 2008, they declared to provide support towards young and migrant workers, find homes for the homeless and poor, and improve health care, pension, and governance systems[141] as part of their development policies. Regarding employment, they began to promote labor standards (especially education, child labor, international trade, competence development, and training), CSR, social dialogue (ILO-PRODIAF program), immigration, and social protection with ILO in 2004. They also host high-level EC-ILO meetings and provide an environment where both institutions can exchange strategies and ideas.

B. Achievements

Their support includes: a) adjustment of social safety, b) gender equality, c) social protection and inclusion, d) diversity and anti-discrimination, e) elimination of poverty and social exclusion, f) employment, g) employment in other nations within the EU, h) wage payment, i) worker’s rights, j) partnership, k) internationalization, l) revised social agenda, and m) social initiatives to combat the financial crisis.

Cooperation by the EU in the field of social protection

Region	Case	Amount Financed (Euro)	Overview
Latin America (2004-2009)	EURO social	€ 30,000,000	Improve public policy management, education, medical care, judicial administration, taxation, and employment.
Fiji (2002-2005)	Nurse school human resource development program	€ 75,000,000	Construction of nurse school, dormitory, and library.
Niger (2000-2004)	Employment training school support（NIGETECH2）	€8,400,000	In order to provide appropriate technology befitting to the market needs, training staff is dispatched to each location and provided around 400 courses to over 30,000 employees, women, and unemployed.
Russia	Democratization	€2,900,000	About 800 regional staffs of government,

[141] Council of the European Union (2010) *Draft Joint Report on Social Protection and Social Inclusion 2010*.

(2002-2004)	support through social NGO		non-government, and private institutions took courses to improve their social service competence and their ability as social workers.
Zambia (2009-2012)	Rural district education/training improvement project	€625,000	Provision of education/work training opportunities for those who dropped out of school in order to improve conditions in rural districts suffering from poverty.
China (2006-2009)	Economical/social support for migrant women workers in Beijing	€757,246	Provision of support initiatives including CSO competence support towards the Chinese government to develop/strengthen worker protection policies, employment opportunities for women, and improved accessibility to protection services.

Source: EC Website (http://ec.europa.eu/europeaid/what/social-protection/index_en.htm#)

C. Recent publications and events

- Hosted a workshop on "wage payment and social protection in the field of medical insurance in developing nations" on March 2009 towards 18 nations in Africa and Asia. They provided opportunities to share experience and learn about implications of EC's medical insurance policies[142].
- Published the "Social Protection for inclusive development" report in 2010[143].

11-5. United Nations International Children's Emergency Fund (UNICEF)

A. Outline

UNICEF released its social protection strategy framework to protect children in March 2012 where an inclusive social protection is promoted from a human rights perspective. Their activities include the establishment of a universal college system. Regarding inclusive social protection, when conducting/evaluating programs they look at it from three different perspectives (gender, ethnicity, and disability)[144]. They often cooperate with other institutions. For instance, in Kenya they teamed up with the World Bank to provide cash transfer towards orphans and families living with a disabled child. In Zambia, they worked with DFID and Irish Aid and conducted a pilot project to support families who cannot meet basic living standards[145]. In Myanmar, the first social protection seminar on the protection of children was hosted in December 2008. In April 2009, led by UNICEF leadership, the Inter-Agency Working Group for Social Protection of Children was established. In the research field, they teamed up with Irish Aid and the social protection center of Institute of Development Studies and analyzed social protection program cases implemented in Kenya,

[142] EU (2009)
[143] EU (2010)
[144] UNICEF (2012) p81
[145] Refer to the website: http://www.unicef.org/infobycountry/zambia_59436.html

Zambia, and Mongolia and examined how they can prevent intergenerational poverty[146].

B. Project Examples

Country	Project Name	Overview
Macedonia	Day care center for children with special needs	Goal: Unification of children with middle to heavy disability in homes and/or regions. Prevent children with middle to heavy disability from entering institutions. This project began in 2002. Today, Ministry of labor and social services operate and manage this project. In 2005, they established a day care center without the help of UNICEF. By 2008, there were 17 institutions in total. Day care centers are open 6 hours a day, 5 days a week. Children can play, learn, and improve other skills in these institutions. Results of this project: ・ Increase in the communication/learning abilities of children, which allowed them to join in normal schools. ・ Established a licensing system for social workers for day care center operations. ・ Each cities/towns created local activity plans in order to strengthen the social welfare projects of each region.
Kenya 2002～	Cash transfer for Orphans and Vulnerable Children[147] Periodical cash transfer, once every two months. Payment through postal office.	Target: Over 100,000 orphans and families living with frail children. (Expected to reach 125,000 families in 2013) Field: Social assistance Counterpart: Department of Children's Services Project Goal: Development of human capital. Increase buying abilities of the target and improve education, health, and nutrition situations through citizen registration. Provide continuous care for orphans and frail children and promote basic education, health, nutrition, and birth registration to promote development of human resource. It's currently being expanded into a national social protection program. Support donors: UNICEF, WB (Total financial support by the WB is $50,000,000 USD from 2010 to 2015). Most of the finance for the current program comes from tax of Kenya. Donors that contributed to the design of this program are, WB, DFID, and SIDA. Result: Development of human capital, improved living, increased attendance in schools, and improved health/nutrient situation. Increase in business activities (improved nutrients lead to better health and more workers) and buying power contributed to improved living standards. Reason for success: 1) Targeting, 2) Inclusion of communities, 3) Increased competence.

[146] Jackson, C. et al.(2011)

[147] Refer to Jackson, C et al (2011)

11-6. United Nations Development Programme (UNDP)

UNDP clearly sets forth its intentions towards the support of social protection. This is based on 8 MDGs agendas, one of them being social protection support. The 8 MDG agendas are: 1) Support towards developing nations in the field of government-lead development and effective governance, 2) Promotion of economic growth in the lower class, 3) Increased investment in education, health, water, sanitation, and infrastructure, 4) Investment to increase opportunities for women an promote economical, legal, and political empowerment, 5) Promote government participation in the field of social protection and employment programs. 6) Support adaptability towards weather and promote the development of low carbon society by increasing energy accessibility, 7) Speeding up domestic resource mobility, 8) Securing an environment to achieve MDG through international partnerships (ODA commitment performance, financial support, free assistance, taking over debts, reformation funding, unified trade and political policies, and ODA supplement through international institutions[148].

In 2004, they cooperated with the Brazilian government and established the International Policy Centre for Inclusive Growth (IPC-IG) in Brazil to promote inclusive growth. It functions as a global forum that aims to share knowledge, promote policy dialogue, education, and South-South cooperation. Social protection is one of the initiatives of this institution. Their "South-South Learning on Social Protection Gateway"[149] is an online knowledge database that makes it possible to share knowledge with other institutions. Furthermore, they have published "Sharing Innovative Experiences – Successful Social Protection" in 2011 with the ILO[150]. This report summarizes and analyzes good practices of the Social Protection Floor, a cooperative project with the ILO. 18 successful cases around the world are summarized in this report.

11-7. Deutsche Gesellschaft fur Internationale Zusammenarbeit（GIZ）

A. Philosophy on social protection

At GIZ, social protection system is something that eliminates poverty and contributes to sustainable social/economical development. Additionally, medical insurance schemes and basic social protection systems help those suffering from poverty obtain ability to support themselves and cushion the impacts and confusion brought on by social crisis such as the economy[151].

B. Policy agreement with Germany

Support towards social protection is being implemented in accordance with the "German

[148] UNDP、UNESCAP, ADB (2010) *Paths to 2015, MDG Priorities in Asia and the Pacific, Asia-Pacific MDG Report 2010/11*
[149] Website http://south-south.ipc-undp.org/
[150] ILO/UNDP (2011)
[151] Information on GIZ http://www.gtz.de/en/themen/soziale-entwicklung/soziale-sicherheit/895.htm

Federal Government's Program of Action 2015". Strengthening of social protection and securing basic social services is one of the government's poverty elimination policies.

C. Organizational Structure

The "Education, Health, and Social Protection sector" handles social protection matters.

D. Objective

Support the establishment of a comprehensive social protection system and expand support towards those who weren't fortunate enough to receive them before. There are 2 priority issues in the establishment of social protection system. The 1st is the establishment of a social insurance system, and the 2nd is the establishment of basic social protection system.

E. Target

Lower class families, especially families suffering with the elderly, the disabled, and HIV/AIDS victims[152].

F. Support method

Major methods of support are giving advice, technology training, general training, and establishment of domestic/international network, creating strategies, and managing knowledge.

- Taking existing program/structure into consideration, they offer advice towards policies regarding the installment/reformation of social protection systems. They have provided advice towards 25 nations to this day. These countries include Bolivia, Cambodia, China, Chile, El Salvador, Guinea, India, Indonesia, Kenya, Paraguay, Philippines, Rwanda, Tanzania, Thailand, Vietnam, Zambia, and more.
- Technological support towards the low class and the socially excluded in order to expand coverage of the existing social assistance system.
- In accordance with subsidy and core elements of social protection, they aim to develop a stronger mechanism of solidarity principle.
- Increase competence of policy makers and officials through seminars, training programs, and international meetings.
- Development of management tools for specialists and officials, such as InfoSure, SimIns, and CHIC.

  InfoSure（Health Insurance Evaluation Methodology and Information System）: A tool used to evaluate and analyze medical insurance systems. Countries like India, Indonesia, Philippines, Bolivia, Paraguay, Peru, El Salvador, Togo, and Senegal have used this program.

  SimIns: A tool developed by the WHO and GIZ. It simulates and analyzes financial mechanisms of medical insurance.
- Sustainable observation and evaluation of social/medical policy development in various countries.

[152] GIZ (2007)

- Documentation of support project experiences.

G. Support contents

Their main initiatives of social protection are 1) Establishment of health/social protection sector network, 2) Support towards the disabled, 3) Support towards the establishment of social protection systems. Recently, they also provide support in cooperation with public-private partnerships (PPP). Below are further details on their support programs.

(a) Health/social protection sector

- Public-private partnerships (PPP): Cooperation with European private firms to promote support for HIV/AIDS victims.
- Social insurance system: In collaboration with ILO and WHO, they promote the installment and reformation of social protection/insurance systems in many countries like Kenya (2004-).
- Cooperation program with the WHO in South Eastern Asia (SEARO): Initiative with the WHO to strengthen regional cooperation in the field of medical insurance sector.
- Health/social protection sector network in Asia and Eastern Europe: Over 40 projects in this field have been implemented in 19 countries up to this day. In this network, it makes it possible for specialists of health and social protection to interact with one another regardless of which project they are attending to. As a result, quality of existing/new projects and GIZ service package has improved. Furthermore, it offers opportunities for specialists to talk about new issues, especially issues that crossover on numerous categories. In recent years, issues like health and methods on how to increase support effectiveness, medical financing and good governance, agricultural development and social security, and health/social protection based on economic growth is being discussed.
- Installment of medical insurance system: Characteristic: This is based on the principle of solidarity. It mostly targets the lower class and actualizes affordable services in order to increase accessibility towards higher quality medical care. This support is deployed in regions like Africa, Asia, Latin America, and Eastern Europe. Support initiatives include advice on policies, installment/reformation of medical insurance system, development of law and standards, evaluation of existing medical insurance system (using InfoSure system developed by the GIZ), feasibility research, and development of social insurance approach method: supporting the installment of insurance system that fit the community needs and training program to increase competence (1 week medical insurance management seminars, etc.), support the establishment of network: support the establishment of Centres of Health Insurance Competence (CHIC) (Precedent in Tanzania). As their resource, they teamed up with Federal Association of the AOK (organization under the largest legal medical insurance institution in Germany).

(b) Support towards the disabled

Germany, in their “The German Federal Government’s Program of Action 2015”, targets those have no access to social protection systems and medical/education services. To

eliminate poverty, they provide support programs towards the disabled as mentioned below. In addition to GIZ, the Federal Ministry for Economic Cooperation and Development (BMZ) also supports the disabled.

- Infrastructure and the disabled (GIZ/STAKES): Comprehensive support towards the development of low-cost infrastructure for the disabled.
- Special care school support (Ghana): Installed special care classes in schools of Ghana.
- Development for All: Initiative that encourages the disabled to participate in activities as a member of the community.
- Transition from school to work: supported the publication of a handbook that helps parents and teachers taking care of a mentally disabled child trying to get a job.

(c) Support on designing basic social protection systems (safety net)

Types of systems

- Cash transfer (Pension, social welfare, child allowance, conditional cash transfer, etc.)
- Payment in kind (free medical service, scholarships and tuition exemption, provision of food, school meal programs, free medical care towards infants, etc.)
- Public projects (Cash or Food for work programs, etc.)

Promotion contents

- Comprehensive approach
- Analyze existing systems and examine compatibility with other systems
- Collaboration with safety net and other social development issues (education, health)

Increase knowledge: As part of their social protection support network, they operate a website called GIZ-Community Health & Social Protection. There, you can search the medical/social protection database, download reports and references, and read news and newsletters regarding various events[153].

Cooperation: They formed a consortium with ILO and WHO in 2004. Utilizing their financial and human resource assets, they aim to create synergy effects in the medical system support initiatives in developing nations. This consortium has successfully dispatched specialists in Cambodia, Guinea, Indonesia, Kenya, Philippines, Rwanda, Tanzania, Vietnam, and Yemen. They've also established an insurance system and hosted international meetings in Berlin (2005) and Manila (2006).

Support contents: Analysis of existing concepts of safety net systems, evaluation of new ones (examine the possibilities of new concepts through pilot projects), comprehensive support of safety net establishment, helping the poor, targeting methods, increasing management competence, training, cultivation of financial resource (such as Global Fund and other basis for funding), and education.

H. Overview of recent projects

Refer to the website below for further information on medical insurance and health sector of GIZ. http://www.german-practice-collection.org/

[153] http://www2.gtz.de/network/sn-hesp/oc-hesp/

Country	Case	Overview
Vietnam	Social security institutional strengthening	With the help from the Germany pension system, they promoted policy dialogue, hosted training sessions towards the staff of VSS in Vietnam, and held a 3 month training program in Germany, etc.
Cambodia (2009-2018)	Support of reformation of the health care system	With the help of WHO, ILO, and AFD, they hosted workshops, training, and assistance by specialists in the reformation project of Cambodia's health care system. www.giz.de/themen/en/30441.htm
India (2007-2011)	Social security benefits for unorganized work	The project aims to improve and establish system delivery functionality. They target factory workers, home workers, agriculture workers, and the self-employed. Approach: Establishment of a monitoring system that encourages unorganized groups to constitute a social protection system and an effective system delivery structure. It also encourages subjects to be actively involved in these initiatives, from planning to execution. Result: 1) 25 worker facilitation centers are currently running with data on 3,000 families. 2) Training module completed, 3) Training instructors, 4) Development of educational communication tool. This is one of the 18 successful cases published by the UNDP/ILO www.giz.de/themen/en/24048.htm
Indonesia	Reform of social security systems	Analysis of legislation and strengthening bonds between those involved to reformation projects.
Philippines	Microinsurance Innovations Program for Social Security (MIPSS) 2009-2012	The program targets informal departments and small enterprises. Target regions are Caraga and Visayas. It aims to protect the poor from risks and increase competence of microinsurance providers. Training to increase efficiency and sustainability through higher visibility and data collection/research. The Ministry of finance through the National Credit Council operates the project. PhilHealth, Ministry of health, runs the insurance sector.
Tanzania 200,000 Euros was funded.	Support towards tea manufacturers in Northern Tanzania to combat AIDS, tuberculosis, and Malaria (PPP support)	A cooperative project between a tea manufacturer, Tanzanian government, and GIZ. Distribution of mosquito nets, education on how to prevent AIDS, treating tuberculosis, and provision of medical goods. Ultimately, management of funds will be transferred to C/P.
Kenya	Medical	Cooperation of WHO and ILO, Kenya medical care (as an example of policy advice) Improved the national medical insurance system installed in 2004. Regarding the national hospital insurance fund started in 1966, the funds have been restricted for formal sector employees only.
Zambia	Cash Transfer Project (2003-2005)	Through pilot projects in Kalomo region, they support small-scale cash transfer projects.
El Salvador	CCT	Through policy dialogue, they support the distribution of central power to rural regions.
Kyrgyzstan	SWAp Kyrgystan: National healthcare reform	Support the expansion of social protection systems sponsored by multiple donors.

I. Recent publications and evens

In their report, “Making Poverty Reduction Inclusive”, published in 2008, you can find information on their comprehensive support to combat poverty, root box development, and past cases based on their poverty reduction strategy (PRS) deployed in Cambodia, Tanzania, and Vietnam.

Annex 12. Statement of Social Protection in Major International Meetings

In major international meetings such as the annual G8 leaders' summit（G8）and the G20 Leaders' Summit, social protection is acknowledged as an important issue. The followings are mentions on social protection in recent major international meetings.

Table 4-10. Statement of Social Protection in Major International Meetings

Name of meeting・Date・Place	The mentioning of social protection
G20 Los Cabos summit June 2012	The followings are acknowledged: the importance of establishing nationally determined social protection floors was acknowledged, the importance of fostering inter-agency and international policy coherence, coordination, cooperation and knowledge sharing to assist low-income countries in capacity building for implementing nationally determined social protection floors.(G20 Leaders Declaration)
United Nations Conference on Sustainable Development (Rio+20) June 2012 Rio de Janeiro	The need of providing social protection to all members of society, fostering growth, resilience, social justice and cohesion, including those who are not employed in the formal economy was stressed. The importance of supporting developing countries in their efforts to establish social protection floors was also reaffirmed.
Fourth high level forum on Aid Effectiveness, Busan, Republic of Korea, Nov/Dec 2011	To reach common goals, the importance of partnering to invest in shock resistant infrastructure and social protection systems for at-risk communities was acknowledged.
2011 G20 Cannes Summit, France	The importance of investing in nationally determined social protection floors in each of our countries, such as access to health care, income security for the elderly and persons with disabilities, child benefits and income security for the unemployed and assistance for the working poor was acknowledged. They will foster growth resilience, social justice and cohesion.
2010 G20 Seoul Summit, Republic of Korea	The importance of social protection was acknowledged in leaders' declaration, "We recognize the importance of addressing the concerns of the most vulnerable. To this end, we are determined to put jobs at the heart of the recovery, to provide social protection, decent work and also to ensure accelerated growth in low income countries." [154] In contrast with the older Washington Consensus highlighting the importance of privatization and deregulation, the Seoul Consensus highlighted the importance of social protection, as well as infrastructure, strengthening financial regulation and supervision, strengthening G20 governance, opening trade and investment,

[154] http://www.mofa.go.jp/policy/economy/g20_summit/2010-2/declaration.pdf

	global food security and others.
the 18th APEC Economic Leaders' Meeting Yokohama, Japan Nov 2010	Most discussions were about facilitating trade and investment in order to increase growth within the APEC region. The importance of social protection was mentioned, "Under our human resource and entrepreneurship development agenda, we will implement policies that will enable us to create more and better jobs, enhance education and training with equal opportunities for women, youth, the elderly, and all other sectors and improve social safety nets." [155]
UN Summit on MDGs New York, Sep 2010	Social protection was one of major topics in the UNESCAP/ADB/UNDP report of the Asia Pacific region published before the UN Summit on MDGs in 2010. In particular, Chapter III is about securing the MDGs through stronger social protection, stressing that the crises that have hit Asia and the Pacific in recent years – and threatened the achievement of the MDGs – have highlighted the need for stronger systems of social protection. It is acknowledged that social protection has strong connections with all the goals and establishing social protection for the vulnerable will contribute to achieve the MDGs.[156]
G8 2010 Muskoka Summit	In the summit, social protection was not much discussed, however, Japan highlighted the New Growth Strategy and financial management strategy to decide the way of fiscal disciplines in the middle-long term toward achieving strong economy, strong finance and strong social protection. It was also stressed that the ageing of the population in developed countries should not be taken negatively for social expenditures, but positive aspects should be looked which will contribute to growth in long term care and health care sectors. The importance of policies to create employments and to increase incomes and tax revenues was also stressed. [157]

[155] APEC Yokohama Vision – Bogor and Beyond
http://www.meti.go.jp/policy/trade_policy/apec/about/pdf/101114aelm-declaration_e.pdf

[156] UNDP、UNESCAP, ADB (2010) *Achieving the MDGs in an era of Global Uncertainty*, Asia-Pacific Regional Report 2009/10

[157] More on the Ministry of Foreign Affairs website
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Annex 13. Basic Check List

Basic check items in studying a social protection system of a country are as follows.

【Standard Study Items】

1. Situations of a social protection system（Social insurance, other public health and income protection programs, social welfare services）

（1） Rationales of the need of social protection
For example: Changes in societal structure, declining of birth, ageing, and frequency of natural disasters

（2） National policy/plan on social protection （Basic frameworks）
Definition/concept of social protection in constitution, related documents on social protection （Concept, policy goal）、Legislations on social protection

（3） Basic indicators on social protection
GDP per capita, economic growth rate, percentage of population working age (15-64), percentage of population aged 65 and over, life expectancy, total fertility rate, projected population size by age, people's burden rate on social protection, unemployment rate, population rate between urban and rural, population rate between informal and formal sector, poverty rate, Gini coefficient

（4） Basic framework on social protection
Definition, historical development, development level of social protection system, overview of social protection system （pensions, health protection programs, unemployment program, public health care, public assistance, social welfare services, etc.）

（5） Administration
Institutional arrangement （Central／local）, coordination between ministries, shared responsibility between central and local

（6） Finance on social protection
Budget on social protection (per scheme）budget breakdown, financial resources central／local, tax／social insurance, pay-as-you-go method／funded system, employer contribution/target/contribution rate, subsidies/target/subsidies rate) 、contribution rate, benefit rate, medical payment methods（fee for service system／prospective payment system）, decision making mechanism of benefits rate and contribution rate, fund size and management, provision of pharmatheutical products and others

（7） Enrollment/Benefits
Targets, Voluntary/Compulsory, minimum enrollment period, period of benefits receive/level of benefits, procedure, out of pocket, etc.

（8） Implementation
Role of Implementation agencies/insurers、financial responsibility, human resources, coordination among ministries/stakeholders, actual coverage rate, benefit rate,

overlapping/fragmentation among programs, coordination, population not covered, beneficiary information management system etc.

（９） Role of private insurance
Position, coverage

（１０） Role of communities
Family, community, religion, volunteers, micro insurance

（１１） Reform of social protection
If there is a reform plan, the plan, rationales, discussions, schedule etc.

（１２） Others
Researchers or institutes in social protection, Public awareness on social protection, social protection education programs, labor/industry policies etc.

2. Trend of International Cooperation on social protection

（１） Trends of international donors: International development agencies, bi-lateral aid agencies, NGOs, etc.

（２） Trends on partnerships with donor agencies

（３） Japan’s assistance in the past

3. Issues on social protection and Expectation to JICA

Note: Study perspectives and study items should be based on the above, however, study items may be adjusted according to discussions with related sectors in charge.

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3. Useful websites
(Academic institutes・Knowledge platforms)
GSDRC
http://www.gsdrc.org/go/topic-guides/social-protection

Overseas Development Institute (ODI)

http://www.odi.org.uk/programmes/social-protection

Institute of Development Studies (IDS)
http://www.ids.ac.uk/idsresearch/social-protection

UNDP International Policy Center on Inclusive Growth
http://www.ipc-undp.org/

UNDP South-soutn learning on Social Protection
http://south-south.ipc-undp.org/

(International Organizations)
International Social Security Association (ISSA)
http://www.issa.int/

ILO Social Protection Sector
http://www.ilo.org/protection/lang--en/index.htm

WB Social Protection and Labor
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/0,,menuPK:282642~pagePK:149018~piPK:149093~theSitePK:282637,00.html

(Indicators)
ADB Key Indicators for Asia and Pacific
http://www.adb.org/publications/series/key-indicators-for-asia-and-the-pacific
ECLAC: Data Base of Social, Economic and Environmental Indicators for Latin America and the Caribbean

OECD Social Expenditure Database (SOCX)
http://www.oecd.org/social/soc/socialexpendituredatabasesocx.htm

WB, ASPIRE （Atlas of Social Protection, Indicators of Resilience and Equity）
http://data.worldbank.org/data-catalog/atlas_social_protection

WB World Development Indicators
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（Databases）
Barrientos et al (2010) Social Assistance in Developing Countries Database
This is the database of social assistane programs in low-middle income countries.
http://www.chronicpoverty.org/uploads/publication_files/social-assistance-database-version-5.pdf

ILO Global Extension of Social Protection (GESS) : a global knowledge sharing platform
This is the website run by the ILO Social Security Department. It provides evidences on the impact of social transfer programs such as non contributory social pensions and CCTs. Lists of programs and literatures on social transfers can be searched.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=20840

Social Security Programmes throughout the World.

This is the database run by the US Social Security Administration. Information on social protection system of different countries can be searched. The databse is updated every two years.
http://www.ssa.gov/policy/docs/progdesc/ssptw/

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Information available in the Annex on CCTs for children from low-middle income countries
http://www.childhoodpoverty.org/index.php/action=documentfeed/doctype=pdf/id=84/

World Bank: Information on CCTs from different countries
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTSAFETYNETSANDTRANSFERS/0,,contentMDK:22055402~pagePK:148956~piPK:216618~theSitePK:282761,00.html