



**Asia-Pacific
Economic Cooperation**

Advancing Free Trade
for Asia-Pacific **Prosperity**

Annex A

OVERVIEW OF 2017 AEPR CASE STUDIES

The following case studies by Viet Nam and Indonesia are highly pertinent. Viet Nam's Case Study focuses on reform of the education and health sectors, as well as access to water and information. Indonesia's case study focuses on the reform of its social security system, particularly in the areas of health and employment. This overview introduces the case studies, describes briefly the policies and structural reforms that were introduced and their impact, and highlights some lessons learned and challenges going forward with respect to structural reform and human capital development (HCD).

1. Overview of Viet Nam Case Study

Introduction: Viet Nam's transition from an agricultural to a modern, industrialized economy and from central planning to a more market-based system began in earnest in 1986 with the Doi Moi (renovation) reforms. Since then, well-being as measured by Viet Nam's score in the UN's Human Development Index (HDI) has risen continuously, reaching the upper end of the medium category in 2014. Viet Nam's social protection and poverty reduction system was based primarily on (i) social insurance, with policies to extend access to health and pension insurance for poor and near-poor individuals; (ii) geographically targeted development and anti-poverty programs as well as budget equalization mechanisms to channel resources to poor provinces and poor districts, and (iii) household-targeted anti-poverty and social assistance programs. However, due to the introduction of user fees and privatization and liberalization of some service sectors, by the early 1990s the quality and quantity social services provision (as measured by e.g. school enrollments and utilization of health services) no longer matched the pace of economic growth. The Viet Nam Case Study focuses on social services such as pensions, education, health and health insurance, and access to clean water and ICT services.

Policies and Impacts: To improve basic education Viet Nam passed the 2010 Education Law which gave priority to the poor, ethnic minorities, and economically disadvantaged areas and provided universal education from age 5 to the lower secondary level. Additional measures included subsidizing meals for students at schools and boarding schools and support for tuition fees for poor or minority students. Partly as a result of the reforms, Viet Nam has a high enrollment rate through junior high school, and social equity in education has improved as of 2015. Second, to improve Primary Healthcare, in 2013 the government adopted the National Strategy on the protection, caring and promotion of people's health for the 2011-2020 period, and implemented a series of domestic targeted programs related to health and community healthcare in areas such as disease prevention and reproductive healthcare. Viet Nam's Health Insurance Law, which came into force in 2009, increased coverage and provided a convenient

new health card for many categories of members. By 2015, nearly 75 per cent of Vietnamese were beneficiaries of health insurance, of which 78 per cent received coverage or support from the State. Third, to improve clean water access, especially for rural and underserved communities, the Prime Minister approved the National Strategy on clean water supply and sanitation in rural areas to 2020 and a domestic targeted program on clean water supply and sanitation in rural areas from 2012-2015. Targets for this program were met. Fourth, policies promulgated in 2011 and 2012 increased investment in ICT infrastructure and reduced the “information gap” for people in rural and remote areas, improving economic prospects and contributing to HCD.

Lessons Learned and Challenges Going Forward: Viet Nam’s experience of implementing reforms highlights the importance of a well-defined and evidence-based strategy with clear targets. While social outcomes have improved, many people in Viet Nam are near poor or risk falling back into poverty, and significant gaps remain. Social benefits are good for those in the formal sector, but very limited social assistance is available for the poorest and members of the ‘missing middle’ - the near-poor and those employed in the informal sector. Viet Nam’s challenges include consolidating its fragmented system of social assistance transfers. Due to fiscal constraints, Viet Nam will have to proceed cautiously as it extends health coverage, focussing on the most needy. Policies to improve the viability of Viet Nam’s generous pension system (VSS) could include raising the retirement age and increased co-payments. Viet Nam sees HCD reforms as being central to efforts to respond to the challenge of an ageing population and move to a sustainable economic model based on increasing productivity rather than high levels of capital investment.

2. Overview of Indonesia Case Study

Introduction: Indonesia’s Case Study focuses on its Social Security System in Health and Employment (Sistem Jaminan Sosial Nasional or SJSN). A vast economy of over 260 million people and more than 17,000 islands, Indonesia faces enormous HCD challenges. Despite being severely affected by the Asian Financial crisis, it has made great strides in social well-being in recent decades and now ranks in the medium category in UN’s Human Development Index (HDI, at .698). Indonesia has a decentralized governance system. Prior to the reform four state-owned enterprises provided healthcare and employment insurance, which covered only a limited portion of the population working for government or the formal private sector.

Policies and Impacts: The regulatory umbrella law for the SJSN, introduced in 2004, restructured health and employment programs into a single-payer program run by the state. Salaried workers pay a percentage of salary, non-salaried workers pay a flat rate and services for the poor are subsidized. However, political resistance and economic challenges delayed

implementation of the reforms. An important first step was to move away from unconditional cash transfers and especially fuel subsidies that were eating up a large portion of the state budget.

The government has opted for a staged approach in rolling out social security reforms, with biannual evaluations to ensure benefits are matched to contributions. Laws passed in 2011 created BJPS Health, which runs a National Health Insurance program (effective 2014) and BPJS Employment covering the benefits of old-age, pension, death and workplace accidents (effective 2015). Health coverage under BJPS is growing quickly, in part thanks to a convenient new health card and a cashless referral-based process.

In the short period since BJPS Health, there has been a large increase in access to healthcare by Indonesian citizens – especially of the poor and vulnerable - and increased awareness of the importance of having health insurance.

Lessons Learned and Challenges Going Forward: The first lesson from Indonesia's HCD reforms is that plans that only target the poor tend to be financially unsustainable, and are vulnerable to demand swings following economic shifts. Second, it is important to evaluate health and employment insurance contribution levels in light of macroeconomic objectives and make periodic adjustments. Third, partnerships with business and local governments are critical. Finally, it was important to manage demand shocks as they arose following the rollout of BJPS Health in Indonesia – a referral-based system for accessing health services can help in this regard. Remaining challenges include addressing the quality of services, which varies by area in Indonesia. Economic volatility and lack of confidence in the future inhibits participation in social security by individuals and businesses. Fiscal sustainability will be a primary challenge as the government seeks to expand social security coverage to all Indonesians while expanding the scope and improving the overall quality of health and employment services.

Common Lessons

The two case studies demonstrate the commitment of these APEC economies to improving the HCD of their populations. Rather than continuing with a patchwork approach to service delivery or opting for privatization, both economies have chosen comprehensive, coordinated reform approaches and have taken steps to get buy-in from workers to improve coverage, inclusion and effectiveness. For both economies, fiscal constraints are a major challenge to expanding social security and services. Indonesia's decision to end fuel subsidies enabled it to reallocate funds to health and other services. The case studies highlight the importance of innovation and careful planning in HCD reforms. Both economies are reviewing social protection policies to find efficiencies, and both have introduced electronic cards for health services. The two case studies show that structural reforms in HCD are an important complement to macro-economic policies. They are also critical to the well-being of people, through greatly improved coverage and quality of social security and services, and by preparing workers for more productive employment and making them more resilient to economic shifts/shocks.

INDONESIA: SOCIAL SECURITY REFORM IN HEALTH AND EMPLOYMENT¹

I. Introduction

Indonesia is among the most dynamic economy of Southeast Asia. With over 250 million population, over 60% of whom are in the working age of 15-64, good planning to enhance human capital development is imperative. In fact, human capital development is among the priority programs of the Government of Indonesia. In the administration, there are 3 dimensions of development priority:

- a. Human development, covering education, health, housing, mentality/character building
- b. Quality sector development, covering food sovereignty, energy and electricity sovereignty, maritime and fishery, tourism and industrial development.
- c. Bridging development across regions within Indonesia, across villages, remote areas, the outer islands and the Eastern part of Indonesia.

The case of structural reform in Indonesia's national social security system is worth noting as a best practice for APEC in which an emerging economy undergoes layers of fundamental transformation in the management and financing of its social security programs to broaden access of basic health and employment benefits to all citizens and workers. In the era where a lot of uncertainty follows a commitment to integration to global economy, being an emerging economy has been seen as a challenge to committing to such reform. But Indonesia sees this as an opportunity to invest in the well-being of human capital. This case suggests that reform to expand social security may go hand in hand just fine with the efforts to sustain stable macro economy and growth.

The regulatory umbrella for Indonesia's structural reform in social security system is Law No. 40/2004 on The National Social Security System (referred to throughout as *Sistem Jaminan Sosial Nasional*, or SJSN). The law restructures the management and the financing of social security programs on health and employment (pension, old-age, death and work accident benefits). The

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spirit of the law is to create a single payer system that is state-based, providing quality affordable care to all which is financed by the contribution of workers and their employers (if they are in the salaried-workers) at the percentage of their reported salary. The non-salaried workers pay their own protection at a flat rate. Meanwhile, the poor, those living below poverty line, gets subsidy of their protection premium from the state budget (at national level and in some areas also from the local government). The social security contribution is managed using the principle of social insurance. Under the new system, the Government of Indonesia abandons the usual strategy to improve people's purchasing power through fuel subsidy by investing in the healthcare security contribution of the defined poor. The implementation of the Law in the healthcare security started in January 1, 2014 and in the employment security started in July 1, 2015.

This is a significant departure from the social security system that has been in operation since 1968 (for healthcare security) and 1977 (for employment security). Under the old system there are 4 State Owned Enterprises (SOEs) managing the contribution of civil servants, military and police officers and formal sector workers. The government did not provide any contribution to the social security provision of non-civil servants and non-military or non-police officers. Part-time workers in government offices, the self-employed, seasonal workers and the poor were un-insured. The principle for delivering benefits for formal sector workers was as saving, a provident fund system, meaning one only gets benefits as much as they contribute to their own saving account.

The case study elaborates the transformation process at the institutional (state) and individual levels. It sheds light on the key elements of structural reforms that the Government of Indonesia plans and the reality at hand that any government needs to consider when running a nationwide human capital development program. Indonesia is a fascinating case study for APEC due to the following reasons:

- Indonesia's SJSN aligns with the desire of the government to accelerate poverty alleviation, especially learning from the challenge during the Asian Financial Crisis of 1997 where the size of people falling under poverty line increased while the government capacity shrank.
- Indonesia is the world's largest archipelago and among the most populated economy; people live in over 17,000 islands that spread over three-time zones or over 5,150 kilometers from the Indian Ocean in the West to the Pacific Ocean in the East and from 6°04'30" NL to 11°00'36" SL under a system of decentralized governance at the district

level. Such physical distance could be a deterrent factor to reforming social security but it was not.

- Indonesia is an economy that adopts a democratic system with decentralized policy-making authorities at the district levels. It implies dynamic interaction among governments at various levels, especially in anticipation and during the election cycle.
- Indonesia is known to depend on *ekonomi kerakyatan* (people-based economy), among which is its large informal sector workers. While this factor keeps the economy resilient during global economic shocks, reform in social security needs to cater to the ability to reach out to workers in this sector.

The decision to deepen reform in social security is not without controversy, at the early stage of policy implementation and in the later stages. The national framework for poverty reduction as documented in the National Medium-Term Development Plan (known as *RPJMN*) 2015–2019 is relevant to this reform, mandating growth process to be more inclusive. The plan aims at closing the growing gap in consumption per capita between different income groups and regions while also reducing the incidence of hardcore poverty. Over the next 5 years, the government aims to boost the growth rate while fostering greater equity in opportunity and incomes between villages, border areas, and the economy's western and eastern regions. It also aims to open the economy to opportunities offered by the Association of Southeast Asian Nations (ASEAN) Economic Community and beyond.

Health was a priority in the earlier medium-term development plan of 2010-2014 and remains a priority in the current plan. The Indonesian Government recognized that the poor were often unable to use health facilities and risk catastrophic health expenditures, requiring a major initiative to ensure access. The objectives therefore are to increase communities' wellbeing to the highest possible so everyone can lead healthy and productive lives. In general, the low health status of poor and vulnerable people is due to the lack of financial resources to access health services.

Better health does not have to wait until the economy improves. In fact, investing in healthcare has been argued as leading to better health outcomes, which benefits the economy. This is the political commitment that went across administrations: improving healthcare access and quality for all.

In the employment front, the government of Indonesia focused on creating job opportunities. Of Indonesia's 258.6 million population, 125.44 million is in the workforce, 94% are employed, 6% unemployed and about 30 million or 12.5% of the total population is considered poor (BPS 2017).

To create job opportunities, the government is improving the investment climate for labor-intensive industries and small business through fiscal and non-fiscal measures, from providing tax incentive, access to soft-loan credits and improving services to cut down the time and cost of running business. In 2011, a master plan for infrastructure development was introduced to accelerate economic growth across the economy. This project continues and is enhanced significantly, namely to spur connectivity for people across places and support economic activity

and sustainable livelihoods in rural and border areas. By 2017 the total budget spent for infrastructure reached Rp. 387 trillion. There are 35 spots decided as strategic to boost the economy from tourism, special economic zone, to boost growth in border zones, urban as well as rural areas. This investment in infrastructure, according to the Ministry of Finance, is a way to anticipate the slowing down of global economy.

Investment in human development is a strategic target for Indonesia. Indonesia's Human Development Index value for 2015 is 0.689, which is categorized as medium category (UNDP 2016). The vastness of Indonesian region requires that any policy at the national level, especially any structural reform, interact and engage with local governments.

The SJSN provides this engagement across levels of government. Not only the national government is increasing the resources available to local governments for the provision of basic services, cutting back out-of-pocket costs that an individual must bear alone usually, stimulating improvement of the delivery of basic social services such as education and health to the poor and vulnerable in the regions, it also inspires local governments to take part in improving the well-being of their constituents. Tailoring social security schemes to attract and maintain various stakeholders, including greater use of conditional cash transfers² is a contrast to the earlier mode of intervention where the government chose to depend on subsidy of gasoline and disburse unconditional cash transfer every few months to the poor.

II. Pre-reform Situation

A major inflection point occurred following the Asian financial crisis of 1997. The lesson was to avert the worst possible social crisis emerging from prolonged economic crisis. The idea to reform the nation's social security system emerged, was incubated until a team of SJSN in 2001 was formed. A series of political process that give birth to the SJSN Law followed (Wisnu, 2012, p.99-128). The law now becomes the "mother" of subsequent reforms of social security across Indonesia.

The original idea of the reform was to create a single payer state-led system at the national level that would provide all kinds of social security benefits for all people, including for foreigners working in Indonesia for at least 6 months, but along the way there has been adjustments and moderation. Stages were created as a series of transition to allow for smoother institutional transformation and sensible fiscal adjustments (Wisnu, 2012, p.140-163).

The depth of reform can only be understood by knowing the pre-reform format of social security provision. In Indonesia, the right to social security is enshrined in the Constitution. It forms the social contract between the state and society, aimed at guaranteeing that every Indonesian citizen can live a dignified life. The constitution guarantees decent job and education, healthy living and

² Asian Development Bank, 'Indonesia 2016-2019: Towards a Higher, More Inclusive and Sustainable Growth Path', *ADB Country Partnership Strategy*, August 2016.

equal opportunity by all under the law. The foundation of the nation, *Pancasila*, also guarantees social justice for all Indonesians. All imply the right to social security and the duty of the state to guarantee it.

Not long after the independence, in 1952, Indonesia formed regulations on healthcare protection requirements for workers followed by obligations to companies in 1957 to provide allowance during workers' illness, take maternity-leave and when workers die. These rules continues to be revised until the formation of Law on Manpower (*Undang-Undang Ketenagakerjaan*) No. 14/1969 secured the rights of workers. Legally State Service Companies (*Perusahaan Umum* abbreviated as *Perum*) that seek no profit were formed to servicing the provision of Employment Insurance: *Perum ASTEK* providing health and employment benefits for private sector workers, *Perum Taspen* providing old-age and pension benefits for civil servants, *Perum ASABRI* providing old-age and pension benefits for military and police personnel, and *Perum ASKES* providing healthcare benefits for civil servants, military and police personnel. These providers in 1990s were transformed into state-owned companies (*Perseroan Terbatas* or *PT*) aimed at generating income and profits for state-led activities in health and employment sectors, which at that time solved the problem of income generation for providing protection for workers. *Perum ASTEK* becomes *PT Jamsostek*, while *Perum ASKES*, *Perum ASABRI* and *Perum Taspen* becomes *PT ASKES*, *PT ASABRI* and *PT Taspen*.

Under this plan, social security provision was fragmented and only covered a limited number of people who are either working for the government or in the formal private sector. The Asian Financial Crisis awakened the nation that Indonesia depends a lot on micro, small-medium enterprises rather than on large businesses. The poor don't stay idle, instead they take on informal employment such as subsistence informal jobs, secondary jobs and seasonal jobs. In fact, informal employment statistics suggest that the informal sector workers are not just those displaced from the formal sector, they include those who cannot be absorbed in the formal sector (BPS-Statistics Indonesia & ADB, 2010). In fact, companies also contribute to the growth of informal sector workers, e.g. by sub-contracting certain task, no wonder in nearly all sector of industry the informality grows. By nature, the existing social security programs are challenged to outreach to these group of workers because they are not registered workers or only work occasionally, often with unwritten contract and they don't have regular income.

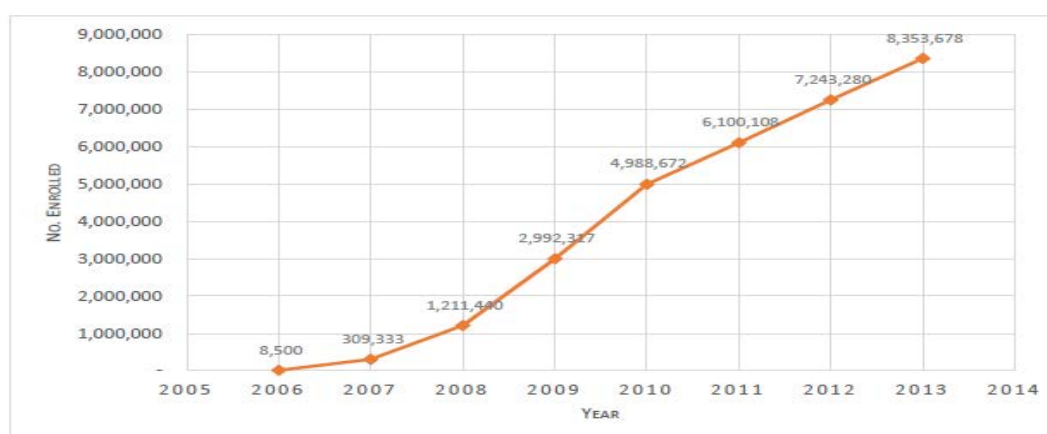
The social security reform wanted to accelerate the inclusion of all Indonesian in the social security programs, including these informal sector workers. This is a tough homework which generates an agreement that the right for social security must be provided, which was why the SJSN Law as an umbrella law for transforming the nation's social security system was adopted in 2004, but there are different ways of testing what is the best way to do so.

No wonder, there were years of inaction on the SJSN Law (Wisnu, 2012, p.129-163) where the government, chose to focus on poverty alleviation programs by disbursing social assistance, unconditional cash transfers and conditional cash transfers programs. This was the years where

fuel subsidies were eating up the national government's budget and limiting options for social spending, the competitiveness of a number of labour-intensive industries were declining, and the industrial relations environment was testing (Wisnu, Basri & Arya, 2015, p.327).

It was during this time when Regional Healthcare Protection (*Jaminan Kesehatan Daerah* or known in its abbreviation *Jamkesda*) bloomed across the 34 provinces and 514 districts across Indonesia, each model of financing and benefit packages vary depending on the will and local budget available. This blooming of *Jamkesda*, while debated at legal level, has increased access to healthcare; see figure 1 on the increased number of persons enrolled in *Jamkesda* from 2006-2013 (Center for Health Economies and Policy Studies Universitas Indonesia, 2014). Not only that, the provincial and district governments together have spent 56.1 trillion IDR – more than three times the national spending of that time – with the district share of that spending being 74.8% of total sub-national spending (Center for Health Economies and Policy Studies Universitas Indonesia, 2014, p.8).

Figure 1. Number of persons enrolled in *Jamkesda* from 2006-2013



Source: Center for Health Economies and Policy Studies Universitas Indonesia, 2014, p.4

In 2005, the government also launched *Askeskin* or medical assistance program for the poor, paid for and planned by the Ministry of Health, which is then transformed into *Jamkesmas* with some adjustments to planning, payment and monitoring process. But the critique to this program is that it does not quite develop a sustainable program that could help reduce dependence to state budget. Noting the fact that poverty rate may fluctuate during economic crisis and *Jamkesmas* cannot quite cover the near-poor who may also fall into poverty because of the crisis.

Indeed, the provision of healthcare benefits is the leading experimentation to improve basic protection for all people, which later, following the controversial adoption of Law No. 24/2011³ mandates the formation of BPJS, becomes the first national program to operate under SJSN Law with BPJS Health as executing agency. Effective per January 1, 2014 the BPJS Health runs the National Health Insurance program with a target to have universal health coverage by 2019 for all workers in any sectors including non-citizens who work in Indonesia for at least 6 months.

Meanwhile, the other social security program undergoing transformation according to Law No. 24/2011 is the employment benefit programs run by BPJS Employment covering the benefits of old-age, pension, death and work accident for all workers, effective per July 1, 2015. The exception of membership under BPJS Employment are the military, police and civil servants who are still served by *PT ASABRI* and *PT Taspen* until these schemes are integrated under BPJS Employment management by 2029.

III. Policy Response

Since 2014, deeper social security reform was done despite the web of economic, political and social challenges in doing such structural reform. The first commitment was to make permanent leave to the economy's dependence on gasoline subsidy to improve purchasing power, invest in infrastructure development, enhance conditional cash-transfer programs rather than the unconditional cash-transfer programs, and pressure the two BPJSs to expand memberships and evaluate its management for sustained acceleration towards social protection for all.

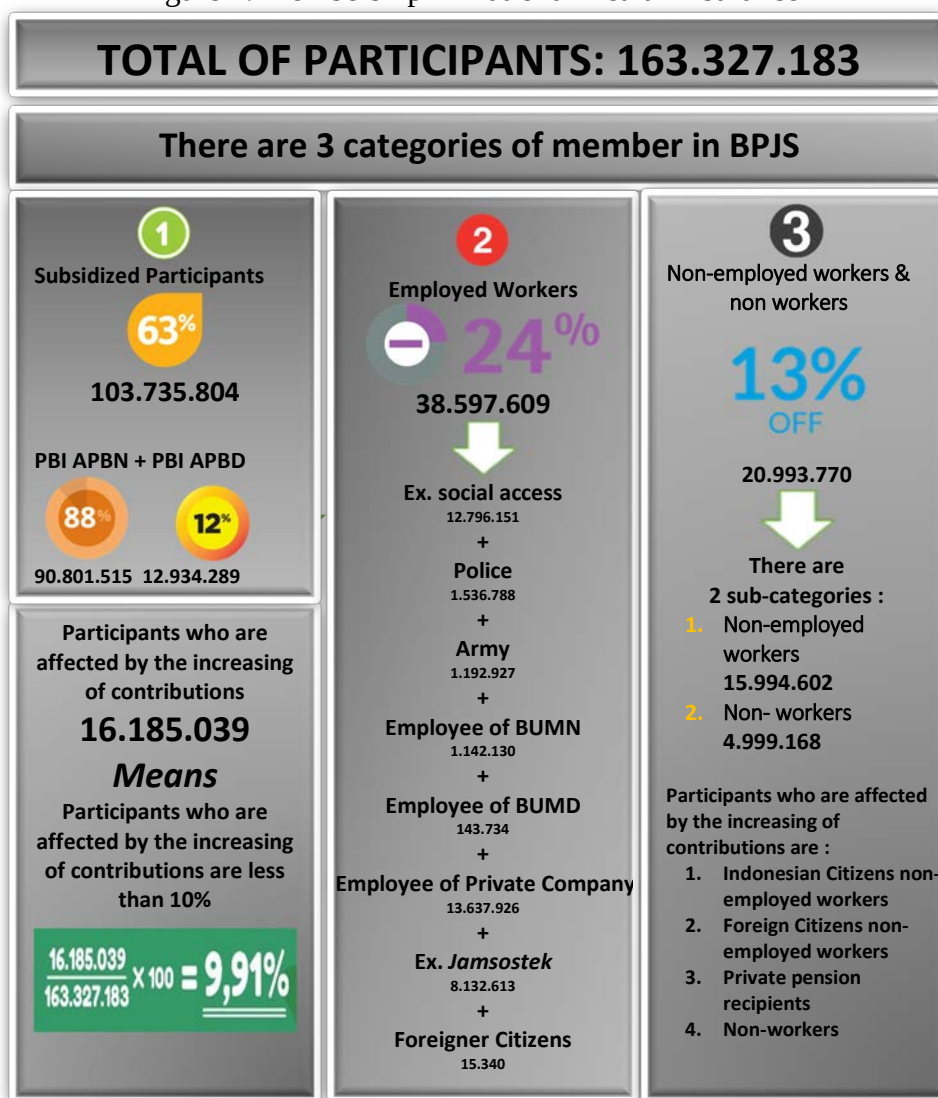
In implementing the National Healthcare System operated by BPJS Health, the government wants to increase the popularity of the program by promoting it as Indonesian Health Card (*Kartu Indonesia Sehat*). The administration also expands the number of subsidized participants in the National Healthcare System, or the so-called *Penerima Bantuan Iuran (PBI)* paid for by the national government using the national state budget (*APBN*), from 86.4 million people in 2014 to 92.4 million people in 2016. When President Joko Widodo was a Governor of Jakarta, he also initiated the integration of Jakarta's *Jamkesda* to the National Healthcare System, making all participants of *Jamkesda* participants of the National Healthcare System and adds more subsidy to the poor Jakartans. Some other local governments follow suit doing the same: subsidizing the poor in their area using the local state budget (*APBD*).

The National Healthcare System contributes to more people getting affordable access to healthcare services. If in the past most Indonesians paid out of their own pocket for their healthcare spending, or relied on private health insurance as provided by their employer or self if they can afford it. Now private sector workers whose employer are registered as legal to operate in Indonesia are required to enroll in the National Healthcare System. Those who are self-employed and working in the informal sector are given flat-rate scheme to pay independently for their own affordable

³ A. Suryahadi, Vita Febriany and Athia Yumna, *Expanding Social Security in Indonesia: The Processes and Challenges*, Working Paper 2014-14, United Nations Research Institute for Social Development: Switzerland.

healthcare service. The poor gets subsidy from the government. The number of Indonesians enrolling in the National Healthcare Insurance is captured in Figure 2.

Figure 2. Membership in National Health Insurance



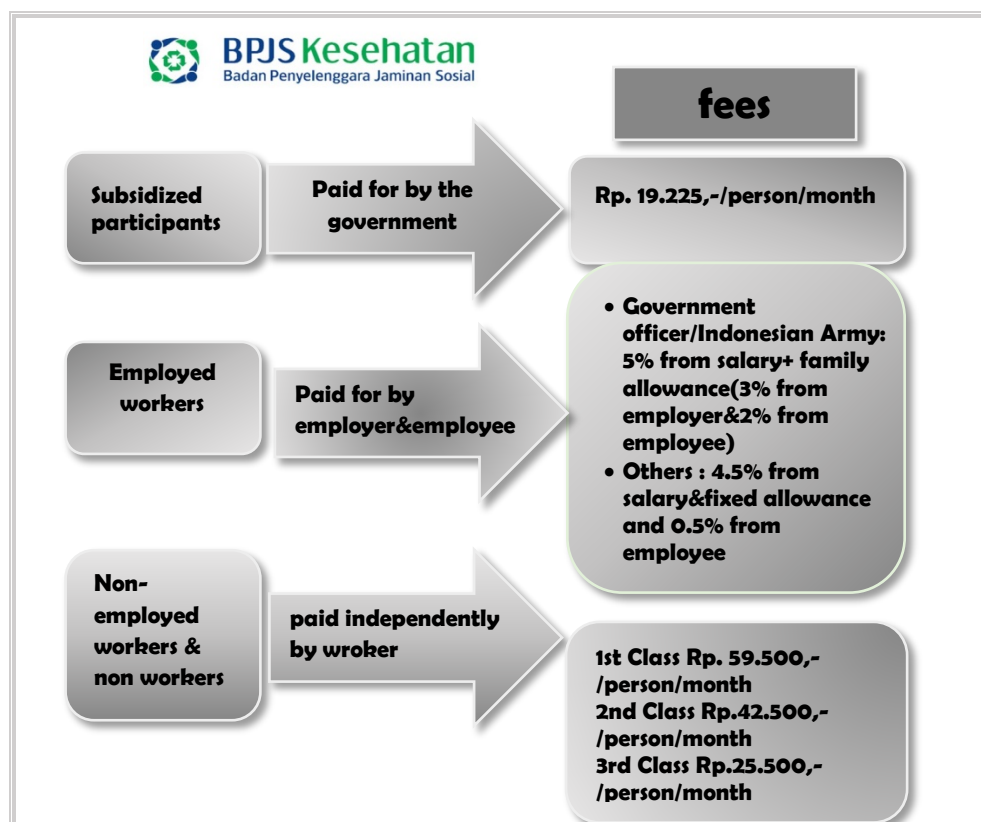
Source: <https://bpjs-kesehatan.go.id/>

In terms of benefits, the National Healthcare Insurance program offers comprehensive coverage to cure nearly all kinds of illness, from light to catastrophic illness such as cancer, bypass surgery, dialysis, etc. The idea is to reduce the past tendency of people dying of illness without getting any treatment. With the National Healthcare Insurance, a referral system is used to deter moral hazard and patients must first follow the regionalization of healthcare facilities, meaning that patients must first go to the primary care, then to secondary care nearby their residence before going to the tertiary care centers where specialists and sophisticated medical equipment for illness complications can be accessed. In every step, the patient only needs reference letter and diagnose from physicians in charge; it is a cashless process, which has been appreciated by

those in need. These benefits can be availed from both public and private care units accredited by the Ministry of Health and having cooperation with BPJS Health.

The National Healthcare Insurance program is a contributory scheme, meaning that one can avail all benefits if she pays monthly premium to BPJS Health. The rate of premium is differentiated by wage rate (for formal sector workers) and by desired level of room standard in in-patient care (for self-paying workers). The service provided is equal for all rate – all treated until cured. The list of rates is captured in figure 3.

Figure 3. List of Rates to avail benefits in National Health Insurance Program



Source: <https://bpjs-kesehatan.go.id/>

For monitoring and evaluation, the government of Indonesia is developing an integrated monitoring system with a dashboard, which is hopefully can connect all ministries and agencies relevant to the implementation of the National Health Insurance program. The example of data that is being built to be updated on regular basis in this dashboard is the membership data.

As per July 1, 2015 BPJS Employment is in operation covering the benefits of old-age pension, death and work accident for all workers, either paid by their employer or self-paid. The programs, run by BPJS Employment, is obligatory for all companies operating in Indonesia. The BPJS

Employment also develop programs for the informal sector workers called *PERISAI (Penggerak Asuransi Jaminan Sosial)* which act as a recruitment agent to attract informal sector workers as members. It also generates a movement called *Gerakan Nasional Peduli Pekerja Rentan* which is a movement to collaborate with companies to allocate its corporate social responsibility fund to finance the membership of vulnerable workers who cannot afford self-paying the premium for certain period of time. By June 2017 there are 3,000 workers protected through this movement scheme with over 18 companies agreeing to contribute to it.

As of 2016 BPJS Employment has active membership of individuals and companies as listed in table 1.

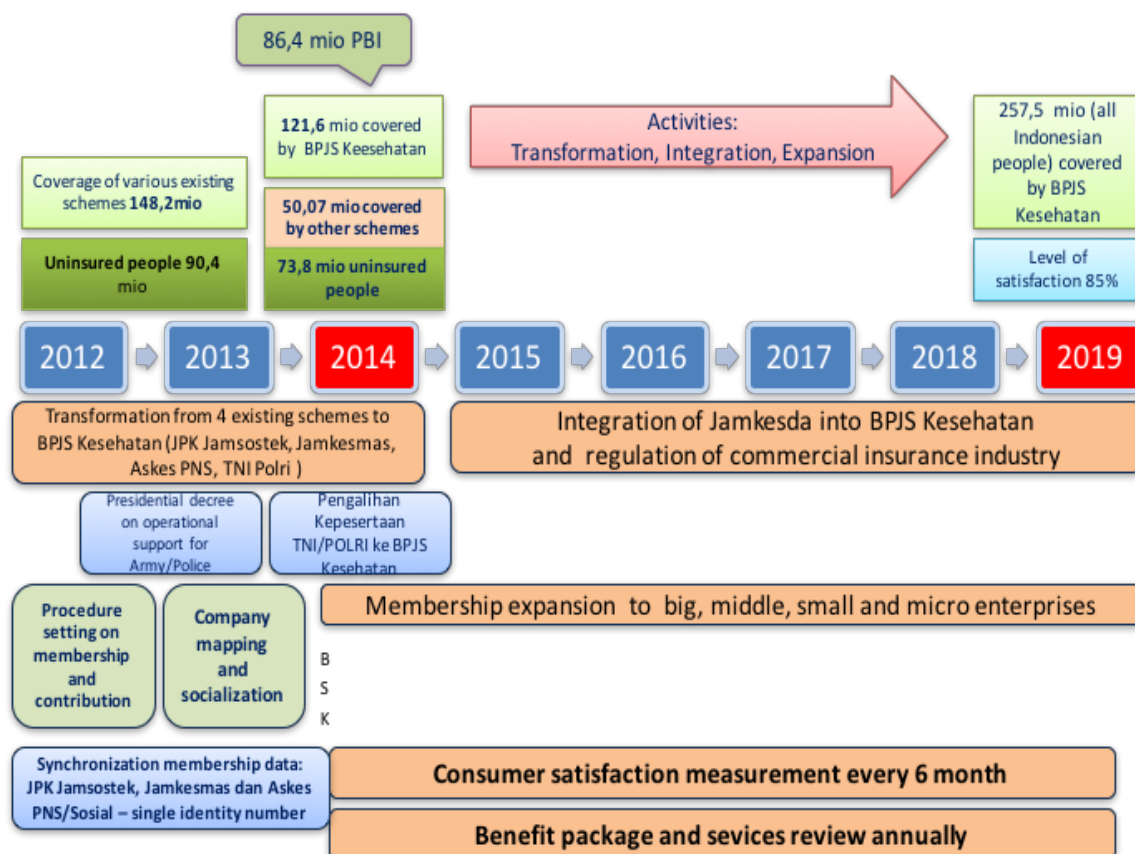
Table 1. Active Membership of BPJS Employment

DESCRIPTION	REALIZATION IN APRIL 2016
Additional Employers	48.239
Additional Workforce	
Wage Earner	1.757.204
Non-Wage earner*	278.788
Construction services*	2.471.365
Active Employers	334.638
Active workforce	
Wage Earner	13.892.318
Non-wage Earner*	359.785
Construction Services*	5.006.029
TOTAL CONTRIBUTION	Rp14,05 Trillion

Source: <http://www.bpjsketenagakerjaan.go.id/page/Laporan-Kinerja/Active-Membership.html>

Both BPJS Employment and BPJS Health is building the reform bloc by bloc. Every two year there is evaluation for contribution rate against the benefit rate. At this point BPJS Employment is looking at improving the ability of participating members to avail the benefits of work accidents even if all through live they never experience work accident. The reform blocs is reflected in the roadmaps (Figure 4 for BPJS Health and Figure 5 for BPJS Employment).

Figure 4. Roadmap to Universal Health Coverage (UHC)



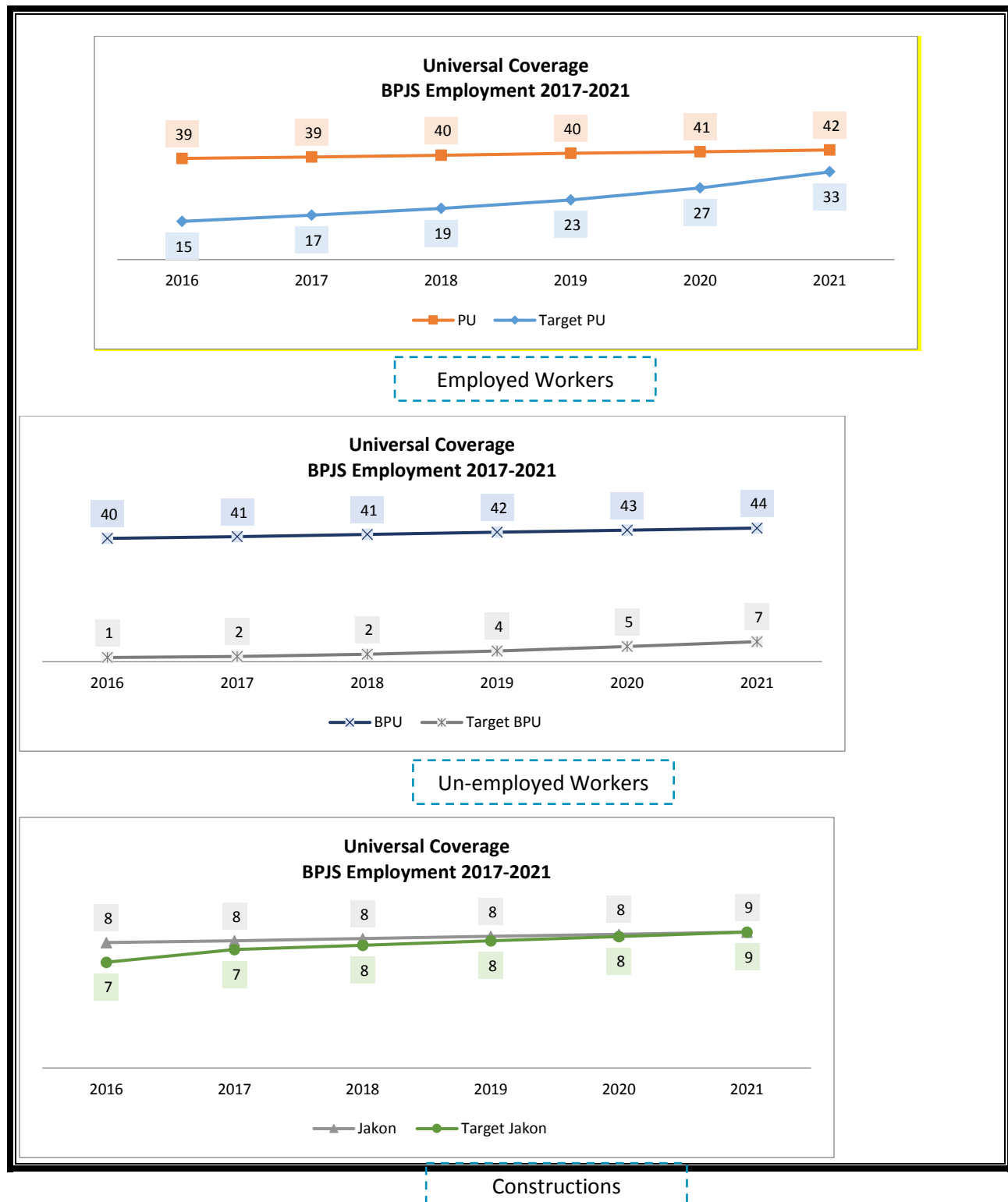
Source: National Social Security Council

BPJS Employment adopts a roadmap that would improve the participation and benefit coverage of employment protection programs. As captured in the Presidential Regulation No. 109/2013 there are stages in expanding membership, starting from all formal sector workers (beginning with large enterprises to smaller sized enterprises), construction workers, foreign workers working at least 6 months and then the informal sector workers. All workers who were members in *PT Jamsostek* becomes automatic participants of BPJS Employment. Membership expansion will start from the most populated areas and industrial/business zones, working together with the Coordinating Body of Investment (*BKPM*) and the Ministry of Law and Human Rights to track operating businesses and in collaboration with banks and information technology companies to ease the process of registration and payment. BPJS Employment is also campaigning the better rate of investment (up to 2% higher) for old-age by enrolling in the program than depositing money in banks. Numerous TV and radio programs and advertisement have been created to attract participation.

In this first steps, BPJS Employment adopts persuasive measures but eventually a stricter measure will be applied as allowed by Government Regulation No. 86/2013 which is to impose

administrative sanctions to enterprises failing to enroll their workers, from sending them note to stop giving them the public service. The roadmap for BPJS Employment is captured in Figure 5.

Figure 5. Roadmap of Employment Social Security, BPJS Employment



Source : www.bpjsketenagakerjaan.go.id. Note: PU = Penerima Upah, or salaried workers; BPU = Bukan Penerima Upah, or non-salaried workers; Jakon = construction service

The contribution rate for BPJS Employment is affordable. For salaried workers, the table of contribution rate is the following table 2, paid regularly before day 15 in the month. The non-salaried workers, such as street and market vendors, physicians, lawyers, artist should pay and register self at a flat rate of 1% of reported regular salary (to avail the work-accident benefit), Rp. 6,800,- for the death benefit and 2% of reported regular salary (to avail the old-age benefit).

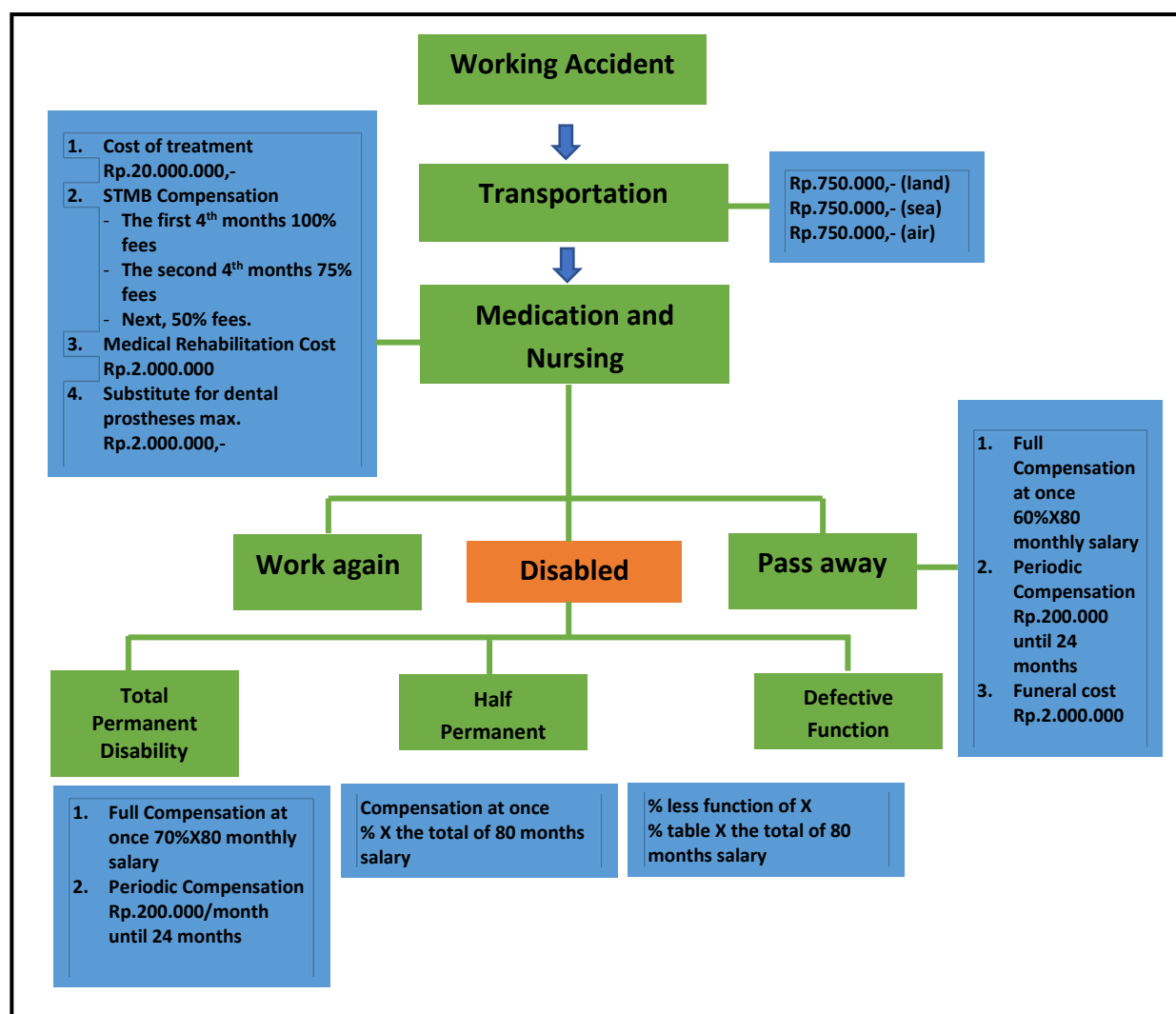
Table 2. Contribution rate in BPJS Employment for salaried workers

Programs	Paid by Employer	Paid by Worker
Old-age protection	0.24%-1.74% depending on risk level of work environment	-
Death protection	0.30%	-
Pension	3.70%	2%

Source : www.bpjsketenagakerjaan.go.id

The benefits for BPJS Employment is captured in Figure 6.

For old-age benefit, the lump-sum cash can be availed by pension age, which is 55 years old or if she dies before pension age, experienced permanent disability, changed work to become civil servants/military/police, foreign workers who completed the duty and not coming back to Indonesia, or get laid off after enrolling for at least 5 years in BPJS Employment program. The waiting time for the laid-off workers who wish to cash in the old-age benefit is 1 month. For work accident benefits, it must be claimed within 2 years counting from the day the accident happened. When work accident happens, the worker will get any medical treatment and cure as needed, also flat-rate cash allowance to reimburse the cost of transporting the sick, to replace income during the months of illness, and when disabled the worker will also get certain percentage of their monthly salary as a lump-sum. BPJS Employment also provide “Return to Work” benefit, which includes all sorts of treatment and rehabilitation service that can bridge the worker to get back to work. Some education allowance for the children of the ill worker is also provided, up to Rp. 12 million per worker if the worker experience permanent disability due to work accident.

Figure 6. Benefits of Work Accident Insurance of BPJS Employment

Source : www.bpjsketenagakerjaan.go.id

IV. Impact

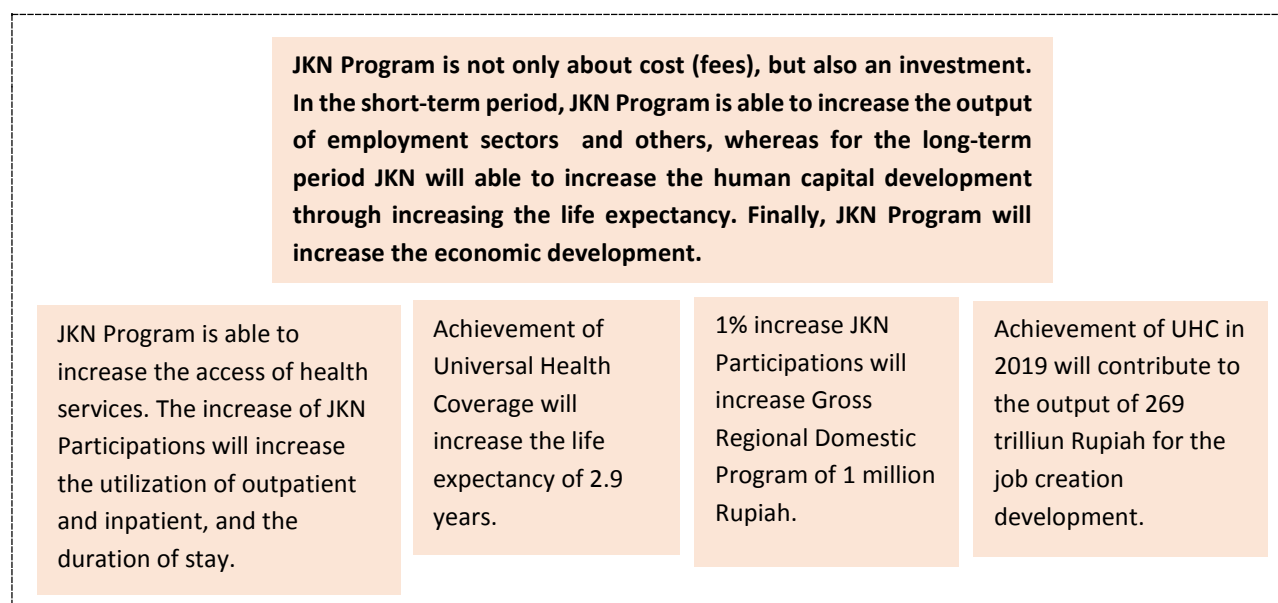
In any structural reform changes do not happen overnight. In fact, the need for structural reform implies the presence of structural problems needing serious commitment for averting the worst scenario. In that context, the case of Indonesia's reform in social security system is a reminder that any substantive shift of policy needs time. The approach across the board is to enhance monitoring and evaluation mechanism for generating feedback that could improve the service and benefits to participants.

In the field of healthcare, the implementation of National Health Insurance is only less than 5 years. In this relatively short period there are the following achievements:

- a. Increased access to healthcare to Indonesian citizens, especially the vulnerable ones.
- b. Increased awareness on the importance to have healthcare insurance.

The claims for National Health Insurance benefits is recorded high (in 2016 as claims paid reached a value of IDR 58 trillion). Just as predicted years earlier, the implementation of this program would significantly increase the usage of health facilities. Consequently, challenges to providing comprehensive healthcare benefits are being revealed and evaluated, such as the need to review the rate of contribution and to add healthcare facilities. And this is a process that the Indonesian government accept as a reality that follows a commitment for such structural change.

Figure 7. The impact of National Health Social Security(JKN) to Economic Growth



Source: Research is conducted by LPEM FEB UI, December 2016

At the macro level, the social security reform has provided positive impacts to the Indonesian economy. To date the National Health Insurance System have contributed 152.2 trillion IDR to the economy and is expected to continue growing by 289 trillion IDR by 2021 (LPEM FEB UI, 2016). Sectors positively affected by the National Health Insurance System is the healthcare service (hospitals and primary care units), pharmacies, medical equipment, also food and beverages. It creates jobs (up to 1.45 jobs in 2016 and may increase to 2.26 million by 2021) and demands important to push economic growth up. The breakdown of the contribution to the economy is available on table 3 and 4. In the longer run, the impact will be in the human capital development: healthier workforce, longer-living ones with higher productivity and life-expectancy.

Table 3. The Contribution of National Health Insurance to Indonesian Economy (2016-2021)

**THE CONTRIBUTION OF NATIONAL HEALTH INSURANCE TO
INDONESIAN ECONOMY
(2016-2021)**

	2016 (Rp)		2021 (Rp)
Government Health Services	57.9 triliun		110 triliun
Pharmacy Product Industry	10.1 triliun		19.1 triliun
Food and Beverages Industry	17.2 triliun		32.6 triliun

Source: LPEM FEB UI

Table 4. The Contribution of National Health Insurance to Employment Creation in Indonesia (2016-2021)

THE CONTRIBUTION OF NATIONAL HEALTH INSURANCE TO EMPLOYMENT CREATION IN INDONESIA (2016-2021)			
	2016 (person)		2021 (person)
Government Health Services	864.000		1.35 million
Pharmacy Product Industry	27.200		42.500
Food and Beverages Industry	34.100		53.200

Source: LPEM FEB UI

No less important is the impacts of the reform to the individual levels. BPJS Health and BPJS Employment are among talks of the day when Indonesian citizens experience illness, work accident and death, or entering into pension age. Seeking medical treatment is now better-known by Indonesians, which in the past prefer to contact uncertified midwives for delivering baby, *dukun* (traditional psychic) and herbal cure. The top case-based groups for in-patient treatment using BPJS Health is captured in Table 5. Awareness-raising on prevention of illness such as vaccines, nutrition, hygiene and physical exercise are commonly found in mass-media news and coverage, which helps the implementation of both the health and employment protection programs. In employment protection program, prevention to work accident becomes more broadly known across work-sectors.

Table 5. Top 10 Case-based groups for in-patient treatment using BPJS Health (2014-2016)

No.	CBG's Code	Description	2014	
			Case	Rp
1	2	3	4	5
1	O-6-10-I	CAESAR LIGHT SURGICAL OPERATION	251.240	1.178.796.166.460
2	O-6-13-I	VAGINAL DELIVERY OF LIGHT	163.755	374.181.473.161
3	K-4-17-I	ABDOMINAL PAIN & GASTROENTERITIS MISCELLANEOUS (LIGHT)	163.740	467.902.151.802
4	A-4-14-I	INFECTIOUS DISEASE BACTERIA AND PARASITES OTHER LIGHT	148.703	486.931.884.903
5	K-4-18-I	DIAGNOSIS OF OTHER DIGESTIVE SYSTEM (LIGHT)	146.322	480.187.534.894
6	A-4-13-I	NON INFECTIOUS BACTERIA LIGHT	117.898	299.891.942.804
7	I-4-17-I	LIGHT HYPERTENSION	70.218	270.409.264.397
8	W-4-16-I	INTERRUPTION OF LIGHT ANTERPARTUM	66.288	158.621.326.616
9	W-I-11-I	DILATATION, CURETTAGE, INTRAUTERINE AND CERVICAL PROCEDURE LIGHT	65.115	204.777.155.811
10	D-4-13-I	INTERRUPTION OF RED BLOOD CELLS APART CELL ANEMIA SICKLE CRISIS LIGHT	62.133	175.218.081.070
Total			1.255.412	4.096.916.981.918

In the longer run, BPJS Health expects the National Health Insurance program to reduce poverty rate, reducing out-of-pocket cost for healthcare and increasing cashless transaction. To date in 2017, there are over 171 million people covered by BPJS Health and 117 million of them have availed benefits from the schemes. Nearly all healthcare facilities have handled BPJS Health patients and the number of hospitals and primary healthcare accredited to cooperate with BPJS Health have increased over time. The use of case-based group (INA-CBGs) to pay healthcare facilities helped control the price of healthcare. Doctors can no longer arbitrarily determine treatments, frequency of lab checks or types of medicines; there are case-based groups by disease that must be used as reference. The quality of medicine and service are monitored by this method.

BPJS Employment also reach out to younger children of elementary schools to raise awareness on the importance of safety and health in occupation. The Ministry of Manpower is also undergoing an evaluation of claims on work accident to improve service and to coordinate claims with BPJS Health. Both BPJS Health and BPJS Employment are doing regular monitoring of customer satisfaction survey to track service quality.

V. Challenges and Way Forward

The challenges for implementing the expansion of social security coverage to the entire population as mandated by the SJSN Law are not to be overstated or undermined, for that matter. Indonesia's vast geography, big population with large vulnerable workers, large informal sector workers, diverse availability of healthcare facility and infrastructure implies that the implementation of SJSN to cover the entire population requires continuous innovation and collaboration with various stakeholders. Government to business cooperation is one thing, but a cooperation between central government and local government is also necessary.

It should proceed very cautiously and involve all stakeholders, including the local governments, employers, employees and the implementing agencies (BPJS Health and BPJS Employment) as well as service providers. For example, to avoid confusion, it is important to make sure that the roles of local governments in social security provision are stipulated in further details. The Ministry of Health could bridge this cooperation.

To anticipate the problem of supply side availability, coordination between various levels of government and multiple agencies needs to be clearly designed. It is also critically important to assess the fiscal sustainability of the system on regular basis, which requires a political commitment to ensure this. Since universal coverage would also have an impact on the demand side, managing the demand shocks, especially at the first stage of implementation, will be very critical, particularly in the health program. To achieve this aspect, the government needs to develop a clear and strong referral system and make sure that the system works efficiently.

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VIET NAM

1. Introduction

Viet Nam has made remarkable achievements in human development and inclusiveness since the launch of Doi Moi (Renovation) in 1986. The most fundamental change over the last 30 years was a shift of employment from the agricultural sector to wage employment in manufacturing, construction and services. During recent decade, Viet Nam has experienced rapid economic growth¹ (Figure 1), which has brought the economy to its middle income status in 2010 and has contributed to a fast decline in poverty, from 37.4% in 1998 to 7% in 2015 (Figure 2). Those achievements have been associated with substantially increasing in labor productivity, from VND 21.4 million/person in 2005 to VND 84.5 million in 2016, almost 4 times bigger after 10 years and average growth of 3.89% per annum (VNPI, 2016). In addition, GDP per employed person more than doubled between 1990 and 2010 resulting from improvement of agricultural efficiency employment shift from low productivity industry to higher productivity industry.

Figure 1: GDP growth rate, 2005-2016 (%)

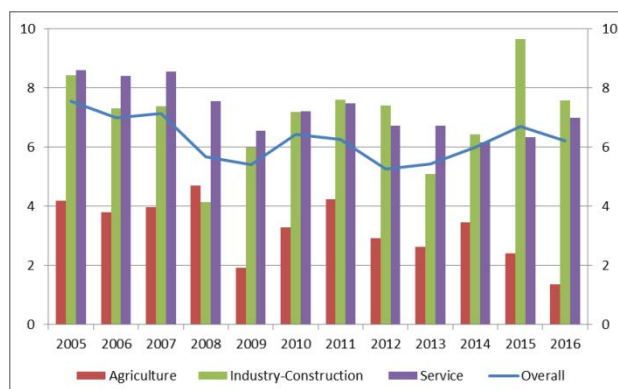
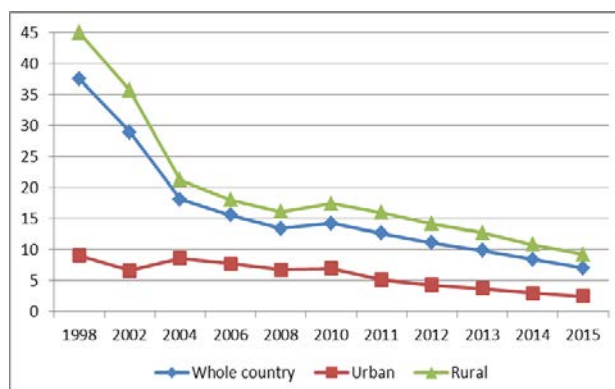


Figure 2: Poverty rate by rural/urban



Source: General Statistics Office.

Inclusive and equitable economic development aims at rapid and sustainable growth that leaves no one behind, ensuring that all people achieve their potential, live in dignity, and enjoy prosperous and fulfilling lives. It promotes opportunities and active participation in the economy by all groups of people and that achieves both accelerated growth and an equitable distribution of benefits (UNDP, 2016). The Agenda 2030, which agreed by all United Nations Member States, commits to leaving no one behind, and makes equality a central principle. Among its 17 interlinked Sustainable Development Goals (SDGs), Goal 8 calls for “promot(ing) inclusive and

¹ Data from GSO showed that average growth was 6.32% per annum in 2006-2010, and lowered to 5.91% in 2011-2015.

sustainable economic growth, employment and decent work for all,” and specifies “inclusive and sustainable economic growth” as the pathway to end poverty and hunger, in its all dimensions.

In Viet Nam, there are three policy areas contributes to an inclusive growth strategy, including (i) delivering productive employment opportunities; (ii) provision of quality social services (particularly education and health care); and (iii) securing access to effective social protection.

In terms of productive employment, the share of agricultural employment decreased rapidly (from nearly 80 per cent during the initial years of Doi Moi down to just 44.3 per cent in 2015), with the labor force moving to industrial and service sectors. Within the agricultural sector, positive structural change, with increased shares for more productive and higher income sub-sectors were recorded. The share of formal employment also increased, from 28.2% in 2007 to 33.7% in 2014. As a result, Viet Nam successfully reduced its relative gap in labor productivity vis-a-vis other economies in the region, although the absolute gap remained significant.

Health and education are among key components of human development, and central to livelihoods and the economy. Better educated and healthier workforces are equipped with capabilities that allow them to seize opportunities and become more productive. Viet Nam performs well in both areas on aggregate measures such as the Millennium Development Goals (MDGs). The noteworthy achievements included high enrolment and completion rates in primary education, and gender parity in primary, lower secondary and upper secondary education, however, the economy also need to take into consider issues related to quality, coverage and equity of provision because of the emergence of serious disparities. Moreover, pre-primary schooling, vocational training and higher education are fundamental for inclusive growth, yet there is evidence of social stratification and exclusion at these levels.

In terms of health, Viet Nam compared very favorably with most economies of similar per capita income levels. Life expectancy, a key component of HDI, increased from 67.6 years in 1980 to 75.9 years in 2013. Similar disparities can be seen in different income group’s abilities to manage catastrophic health expenditures, with the poorer groups faring badly. In short, the performance on healthcare targets in MDGs was generally positive, particularly the reduction in child and maternal mortality rates, tuberculosis control and malaria prevention. There are also major geographical variations in the supply and quality of education and health services.

Like education and health, social protection fosters the equity, efficiency and resilience of growth and development. It provides for the poorest, ensuring they do not fall beneath a minimum standard of living. It also offers middle-income groups, who may have attained only a tenuous level of income security, a hedge against vulnerability. Social protection enables families to invest in their futures, which provides a boost to the wider economy.

In the field of social protection, there were also significant achievements. Viet Nam Social Insurance (VSS) had 11.4 million contributory members and provided pensions to 2.2 million

retirees. Nearly 1.6 million people of 80 years of age and older were provided with monthly social support from the State budget. By 2015, nearly 75 per cent of Vietnamese were beneficiaries of health insurance. Nearly 800,000 disabled people with no working capacity received monthly social assistance. Hundreds of thousands of other vulnerable people – elderly, orphaned children and children in difficult circumstances and persons living with HIV – were provided with cash assistance and social care. Poor households and ethnic minority households and their children were provided with cash assistance, exempted from school fees, given assistance to promote productive activities and received vocational training.

The Human Development Index is a summary measure for assessing progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living. A long and healthy life is measured by life expectancy at birth. Knowledge level is measured by mean years of education among the adult population, which is the average number of years of education received in a life-time by people aged 25 years and older; and access to learning and knowledge by expected years of schooling for children of school-entry age, which is the total number of years of schooling a child of school-entry age can expect to receive if prevailing patterns of age-specific enrolment rates stay the same throughout the child's life. The standard of living is measured by Gross National Income (GNI) per capita expressed in constant 2011 international dollars converted using purchasing power parity (PPP) conversion rates.

Viet Nam's HDI has risen continuously over the past 24 years. In 2014, the economy ranked 116th out of 188 economies; it is at the upper end of the medium human development category. Improvement has been uneven, however. During 1980 and 1990, the HDI rose on average a weak 0.26 percent per year, then accelerated to 1.92 percent per year between 1990 and 2000, before slowing to 1.33 percent per year in 2000-2008 and further to 0.69 percent per year since 2008.

Table 1: Viet Nam's HDI trends

	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP\$)	HDI value
1990	70.5	7.8	3.9	1,410	0.477
1995	72.0	9.3	4.6	2,020	0.531
2000	73.3	10.6	5.4	2,615	0.576
2005	74.3	11.3	6.4	3,423	0.617

2010	75.1	12.0	7.5	4,314	0.655
2011	75.3	12.2	7.6	4,513	0.662
2012	75.5	12.3	7.8	4,707	0.668
2013	75.6	12.5	7.9	4,899	0.675
2014	75.8	12.6	7.8	5,098	0.678
2015	75.9	12.6	8.0	5,335	0.683

Source: UNDP, 2016

Table 1 shows that Viet Nam's 2015 HDI of 0.683 is above the average of 0.631 for economies in the medium human development group and below the average of 0.720 for economies in East Asia and the Pacific. From East Asia and the Pacific, economies which are close to Viet Nam in 2015 HDI rank and to some extent in population size are Philippines and Thailand, which have HDIs ranked 116 and 87 respectively. Selected sub-indexes of HDI have been improved over years.

It can be said that the transition from central planning to a market economy, started in 1986 with Doi Moi (renovation) reforms, is much advanced, but not yet complete. The economy has been in transition from an agricultural to a modern, industrialized economy. Human capital, in Viet Nam, has been counting on one of its biggest assets – its abundant young workforce. However, Viet Nam is at a demographic turning point, facing a slowdown in the growth of the labor force and a sharp expansion of the old-age population. The old-age dependency ratio—a common measure of the age structure of the population—has been roughly constant for decades in Viet Nam but will climb from 10 to 22 between 2015 and 2035 and continue to rise in the following decades (World Bank, 2016). In other words, Viet Nam will soon have many more old-age people to support for every person of working age. Moreover, as the economy is moving up the development ladder of becoming an upper-middle income economy, it will be likely for Viet Nam to expand their social protection systems to respond to the demand of a growing middle class.

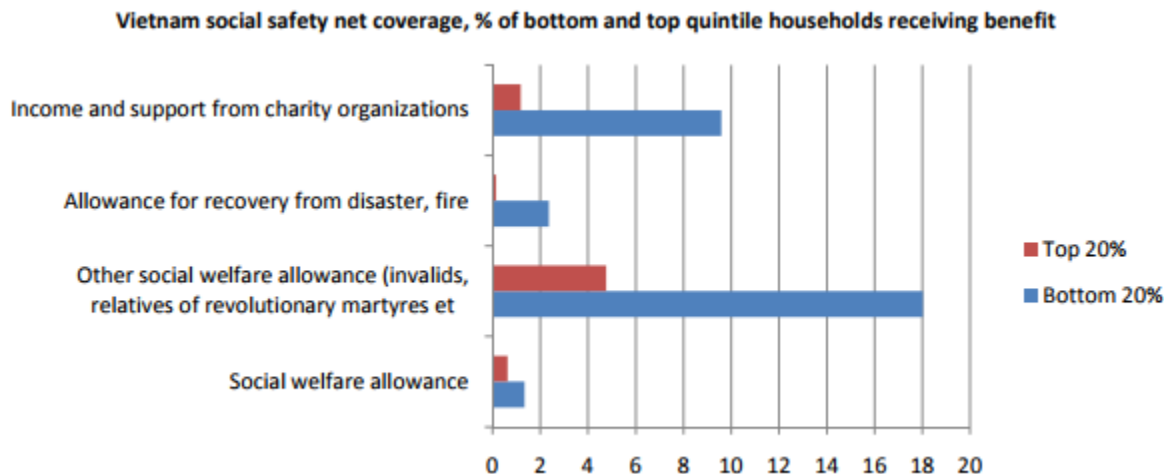
In this context, it is also of necessary to ensure the basic access to social services for people at the bottom of the pyramid, i.e. people living in poverty, in disadvantaged and remote areas, people with disabilities, etc. As a case study, this paper will focus on the access to basic social services, as one component of the social protection system in Viet Nam, in order to seek out how reform implemented, which policy responses during that process and its impacts on human capital development, as well as to find out challenges and way forward for the system.

2. Pre-reform situation

During the initial period of reform, the social protection and poverty reduction system in Viet Nam is based broadly on three mechanisms: (i) social insurance, with policies to extend access to health and pension insurance for poor and near-poor individuals; (ii) geographically targeted development and anti-poverty programs as well as budget equalization mechanisms to channel resources to poor provinces and poor districts, and (iii) household-targeted anti-poverty and social assistance programs. In the early 1990s, the quantity and quality of social service provision showed signs of deterioration both in terms of quantity and quality indicators. With regards to education, this was evident in the falling of school enrollments, particularly in the secondary level, falling by around 20 percent (World Bank, 1997). And at high school level, enrollments fell even more sharply by almost 50 percent from 0.93 million in 1987 to only 0.52 million in 1991. The explanation for this decline must lie in some change in the determinants of school enrollment. The full private costs of education to the family includes not only the schooling costs that are formally passed on in terms of official fees, but also the hidden costs of unofficial parental contributions, learning materials, uniforms and transportation, plus the opportunity costs of time associated with school attendance. When costs were too high, the poor family could not afford for their children to continue in school.

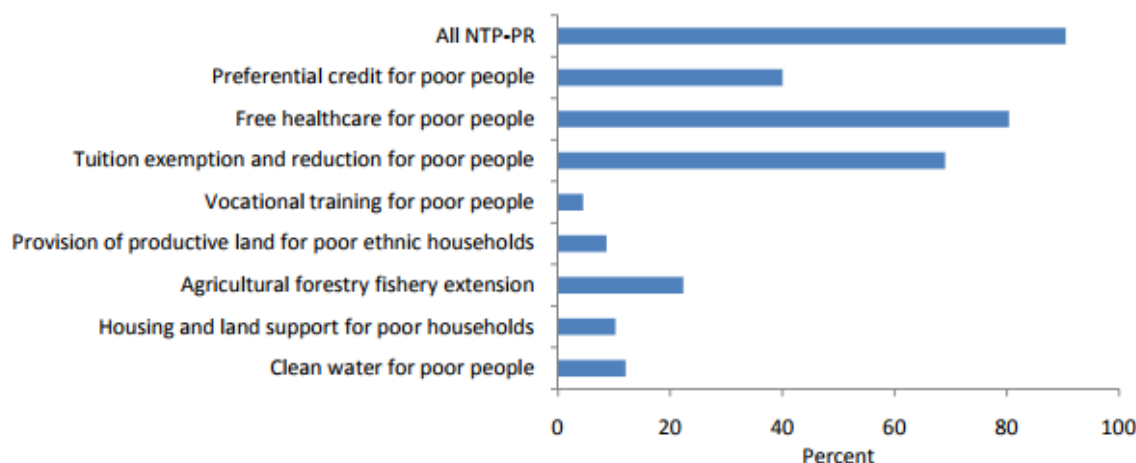
In the healthcare sector, the utilization of health services has also fallen. The outpatient consultations has fallen from an annual rate of around 2.1 visits per capita in 1987 to 0.9 per capita in 1993. The inpatient admission rate also dropped sharply during this period, falling from about 105 per 1,000 persons in 1987 to 68 per 1,000 in 1990 (World Bank, 1997). The access by poor people was much worsen both in the frequency of medical treatment and self-treatment. These developments have occurred in parallel with major changes in the provision and financing of social services. As part of Viet Nam's ambitious program of structural reform, user fees were introduced for publicly-provided education and health services and private sector provision was liberalized in both sectors in 1989. The decline in utilization rate was attributed to the deterioration in quality of government health services resulting from the compression of public expenditures in the late 1980s.

The Government of Viet Nam also promoted the enforcement of social protection through access to basic social services such as education and healthcare, particularly for the poor in this period. The social protection scheme also provided cash transfer programs for people at the lowest quintile. However, according to a report by the World Bank, the coverage of those programs was severely limited (Figure 3), which only covered 1.3% of the poorest quintile in 2006.

Figure 3: Coverage of cash transfer in Viet Nam

Source: World Bank, 2010.

Household targeted programs were enormous during this period, either under national targeted programs for poverty reduction, including preferential credit, free healthcare, exemption/reduction of tuition fee, clean water, housing and land support,... or separated programs targeted to poor and disadvantaged ethnic minority households living on agriculture and forestry to provide them with land, housing and clean water. The coverage rates of eligible households (through the selection of beneficiaries and on the poor list certified by the community) under those programs appeared to be high (Figure 4).

Figure 4: Coverage of national targeted programs

Taking into account these results with targeting to effectiveness, the Government of Viet Nam continued to pursue policies on ensuring access to basic social services for all people, and

considered it as one of most important goals in the social security system of Viet Nam. Those basic social services included education, health care, housing, clean water and access to information, which have been adjusted (in terms of enforcement) and incorporated in the consequence national targeted programs and national strategy on social protection.

Policy response

Being considered as national system and an engine for socio-economic development, a Social Protection Strategy 2011-2020 has been formulated by the Ministry of Labor, Invalids and Social Affairs. According to it, social protection in Viet Nam includes three main pillars: (1) labor market; (2) social insurance and social health insurance; and (3) social assistance. These three pillars aim to deal with various risks. For instance, the labor market policies are to prevent risks; social insurance and social health insurance policies aim to mitigate risks once they occur; while social assistance policies help people overcome their risks if they are unable to cope by themselves.

In general context, social protection embraces not only social transfers but brings into a consistent and comprehensive framework labor market policies, social insurance policies, health-care policies, social welfare/assistance, poverty reduction programs and access to public social services, which comprises of four basic policy group:

- (i) policy for ensuring minimum income and poverty reduction: participation in labor market;
- (ii) policy on social insurance;
- (iii) policy on social assistance; and
- (iv) policy on basic social services,

With regards to the focus of the paper, the following section will provide some analysis on policy response to ensuring basic social services under social protection scheme in Viet Nam.

Policy on ensuring basic education

For ensuring the access to basic education by marginalized population, this policy group targeted at (i) improving the quality of preschool education for children aged 3-5 years; (ii) universalizing primary and lower secondary education, improving the quality of general education, vocational training and university/college education; and (iii) reducing the educational disparities for the poor, ethnic minorities and disadvantaged children. Current policy response includes:

- The 2010 Education Law identified educational development as a top prioritized national policy, giving priority to the poor, ethnic minorities, and economically disadvantaged areas and universalizing preschool education for 5-years-old, primary and lower secondary level

- Decision No. 239/QD-TTg of the Prime Minister on 9 February 2010 reaffirmed the target of universalizing preschool education for 5-years-old children by 2015.
- The universalization of primary education level stipulates that children at the age of 6 must starting primary school and pupils of public elementary schools do not have to pay tuition fee.
- Exemption, reduction of tuition fee and other preferential treatment for children of poor households, ethnic minorities and marginalized children, including Decree 74/2013/ND-CP of the Government on 15 July 2013 regulating the provision of tuition fee for public kindergarten, general education, vocational training and university; Decision 12/2013/QD-TTg of the Prime Minister dated 24 January 2013 on supporting policies for pupils at upper secondary schools in disadvantaged and special difficulty areas; Decision 36/2013/QD-TTg of Prime Minister dated 18 June 2013 on supporting rice for pupils at disadvantaged schools; Decree 49/2010/ND-CP of the Government dated 14 May 2010 regulating the exemption and reduction of tuition fee for poor and nearly poor households.
- Supporting meals for students: Decision 12/2013/QD-TTg on January 2013 supporting lunch for targeted children at the age of 3-4; Decision 85/2010/QD-TTg of the Prime Minister on supporting meals and accommodation for full time and part-time boarding schools; Decision 239/QD-TTg on supporting meals and accommodation for children of poor households attending boarding schools in special difficulty communes.

Policy on ensuring primary healthcare

Aiming at (i) ensuring that all people enjoy primary health care services, especially for mothers and children; (ii) implementing universal health insurance; (iii) broadening access to and use of quality health services; and (iv) ultimately, ensuring people's living in a safe community with better development of both physical and mental aspects, reducing morbidity, improving physical fitness, increasing and improving the quality of population, the following policies have been promulgated, including:

- National Strategy on the protection, caring and promotion of people's health in 2011-2020 and vision to 2030 approved under Decision 122/QD-TTg on 10 January 2013.
- A series of national targeted programs related to health and community healthcare has been implemented, including national targeted programs on prevention of communicable and non-communicable diseases; national injection program, reproductive healthcare and improving child nutrition program; national targeted program on food hygiene and safety; national targeted program on HIV/AIDS prevention and control; and
- Some measures have been carried out for improving the quality of health treatment as well as socialization of financing and provision of healthcare services

Health Insurance Scheme

The Health Insurance Law came into force on July 1, 2009 with the initial target of implementing universal health insurance by 2014. As regulated by Law and in other consequence guiding documents, of which free medical insurance cards are being granted to persons with meritorious services to the revolution and/or their relatives, persons serving in the armed forces and/or their relatives, and children under 6 years of age, old people, poor households, and nearly poor households (Decision 705/2013/QD-TTg of the Prime Minister on increasing the level of support for health insurance premiums for nearly poor households; Decision 538/QD-TTg on 29 March 2013 of the Prime Minister approving the Roadmap of implementing universal health insurance for the period 2012-2015 and to 2020). In addition, the State contributed partly to the health insurance premiums for pupils, students in farming households with lower middle income

Policy on ensuring clean water for people

This policy group, ultimately, aims at fundamentally improving the use of clean water by people, especially in the rural areas ethnic minorities, disadvantaged and mountainous areas and minimizing adverse impacts caused by poor conditions of water on health. Therefore, the Prime Minister approved national strategy on clean water supply and sanitation in rural areas till 2020 and national targeted program on clean water supply and sanitation in rural areas during 2012-2015 with three component projects: (1) supply of water and rural environment; (2) rural sanitation, and (3) capacity building, communication, monitoring and evaluation. In addition, the Prime Minister promulgated Decision 134/2004/QD-TTg on some policies to support production land, residential land, housing and clean water for poor ethnic minority and disadvantaged households. Specific support included (i) providing common water supply for ethnic people in the hilly and rocky mountainous areas; and (ii) providing concessional credit for constructing water supply and sanitation system for rural people.

Ensuring information access for poor people and poor communities

With an aim of improving information access to and shortening the gap of information for people living in rural, mountainous, remote and island areas, the Government has promulgated some following regulations:

- Decision 119/QD-TTg on 18 January 2011 of the Prime Minister approving the project on development of rural communication and information in 2011-2020, aiming at developing the telecommunication system, post office, information center, television channel and internet for improving production and business in rural areas, contributing to poverty reduction and improving intellectual level of rural people.
- On 5 September 2012, the Prime Minister issued Decision No. 1212/QD-TTg approving the national targeted program of providing information to remote, mountainous, border and island areas during 2012-2015 in order to shorten the information gap between

regions, to improve the cultural life and spirit of people. The program comprised of three components: (i) Secondment of information and communication officers to these areas; (ii) Improving facilities for information and communication systems for these areas; and (iii) Enhancing the contents of information and communication provided.

3. Impact

With regards to ensuring basic access to education, the nationwide education network has been strengthened. By the end of 2015, there were 14,513 kindergartens, 15,254 primary schools; 10,909 junior high schools and 2,788 high schools in the economy. There are also 305 full-time boarding schools and 569 part-time boarding schools for ethnic minorities.

Viet Nam has completed the universalization of primary education in 2000 and of secondary education in 2010. By 2015, the rate of children attending kindergarten at the age of 5 years reached 99.2%, primary schools of 97.8%, junior high schools of 85.5% and high schools of 54.4%. The percentage of children with disabilities attending school was 60.4%. The ratio of students per ten thousand people reached 56.1 and the literacy ratio of people aged 15 and over was 98.25%.

Social equality in education has improved, in particular in increasing the educational opportunities for girls, ethnic minority children, children of poor families and children with disabilities. Education in ethnic minority areas, remote areas has made remarkable progress.

In terms of primary healthcare, a report by Ministry of Health showed that some remarkable achievements have been made in some recent years. By 2015, the ratio of fully injected infants (<1 year of age) were over 90%, mortality rate for less than one year was below 14.3% and for under 5-years-old was 22.1%; malnutrition rate among under 5-years-old children 14.3%, the prevalence of tuberculosis was reduced to 215 people per 100,000 people. At the same time, 97% of pregnant women received tetanus vaccination; 85.4% of pregnant women received 3 or more antenatal care; some gastrointestinal diseases (typhoid, bubonic plague), meningitis, infectious diseases, especially vaccinated preventive diseases (diphtheria, pertussis, encephalitis) were significantly reduced; the average life expectancy increased up to 73.3; the number of HIV infections gradually decreased and more than 60% of HIV/AIDS patients receiving ARV treatment.

Through the implementation of Health Insurance Law and its guiding documents, by 2015, the coverage health insurance scheme increased to 77% of total population (while that figure for 2001 was 13.4%), and the State supported health insurance for 78% of participants, particularly, the support ratio for ethnic minorities attained 83% (MoH, 2016).

The objectives of the national targeted program on clean water supply and sanitation in rural areas for 2011-2015 have been met. By 2015, the number of rural people using clean water was 86%; 65% households having access to hygienic toilets; 93% of schools and 96% of communal

health stations having clean water and sanitation facilities. The communication activities have contributed significantly to raising awareness of rural people on the use of clean water, hygienic latrines, hygiene practices and environmental protection. Sanitary practices and behaviors of rural people have improved.

For the information access policy, there were investment in the infrastructure and facilities for information and communication. A total of 529 communal radio stations, 64 broadcasting stations, 56 sets of operational equipment have been set up and upgraded. Another 370 sets of signal receivers, audio-visual equipment and auxiliary equipment have been procured and provided to community of remote and disadvantaged areas. Information gap has been shortened between regions through the broadcasting of 4,195 radio and television programs; providing thematic books; distribution and dissemination of various publications to commune.

4. Challenges and Way forward

Viet Nam is facing new challenges. The pace of economic growth and the reallocation of jobs away from agriculture have slowed in the wake of structural problems in the enterprise and banking sectors and macroeconomic turmoil in recent years. Capital investments, and not productivity, have become the main source of economic growth. This is not a sustainable model for ensuring continued rapid economic growth. While the size of its workforce is still expanding, its youth population is shrinking. This means that Viet Nam cannot continue to rely on the size of its workforce for continued success; it needs to focus on making its workforce more productive and alleviating skills barriers to labor mobility. Looking ahead to the context by 2020, challenges arisen:

- Viet Nam will soon become a middle-income economy by 2020
- Entering a period of demographic bonus but also aging population
- Reducing the financial sustainability of current Social Security Fund
- More dynamic labor market development: moving from rural to urban, agriculture to non-agriculture and labor export
- International economic integration will speed up the development of a dynamic social protection system

Initiative on Social Protection Floor for all

Modernizing the social protection system in Viet Nam is fundamental to fostering more inclusive development, which then ensures more jobs are created and higher productivity, and all people are capable of taking advantage of these opportunities. Social protection is, therefore, playing an important role in enhancing resilience to risks and eradicating poverty.

According recent World Bank's report, there has been 40% of Vietnamese people living in or being vulnerable to poverty and a further 40% having inadequate and insecure incomes. Those people are struggling with crisis and shocks, that could, at any time, bring them back to poverty.

The report also reaffirm a large share of Vietnamese people do not enjoy social protection coverage, in spite of being guaranteed by the National Constitution on the right of accessing to social protection system.

Viet Nam has a basic system of social protection covering many stages of the human life cycle. But currently, the scheme still showed large gaps, which significantly divided between relatively generous social insurance for those working in the formal sector and very limited social assistance for the poorest. A ‘missing middle’ encompasses the near-poor, those with insufficient incomes and the lower-middle-income group who are employed in the informal sector. They are not eligible for social assistance and cannot access to social insurance scheme, leaving them highly vulnerable to reversals of well-being. Furthermore, social assistance coverage is still low for people living in poverty, working-age people with disabilities and elderly people.

The social protection in Viet Nam lacks a well-defined and evidence-base strategy for which goals and targets are set. The Resolution 15/NQ-TW on some issues of social policies for 2012-2020 (passed by June 2012) had set out wide ranges of social protection and basic social services agenda. However, its coverage was quite broad and in shortage of specific vision for social protection in linkage with national strategy on social protection.

Viet Nam’s key challenge, as in many other middle-income economies, is to build on past lessons and move towards more inclusive social protection. The overall way forward for the system to focus on assisting the poorest to sustain minimum living conditions and to aim at preventing vulnerable middle-income groups from falling into poverty and helping them to stay at the lower middle level and move up. In other words, a fundamental shift for social protection system is urgently needed. This should aim at greater levels of coverage and adequacy to eradicate poverty and build resilience among the many people who remain vulnerable to poverty. Some policy direction can be listed as follows:

Universal health insurance

The expansion of health insurance should continue focus on the poor and poorest, however, as mentioned earlier; it should also focus on the “missing middle” – especially the most vulnerable such as the near poor, the elderly and groups affected by diseases that are public health priorities (HIV and tuberculosis). The expansion is also challenge to reaching uncovered middle-income people who are working in the informal sector. To this extent, the more expansion of the scheme is the more investment from state budget it requires. The World Bank has estimated that if the coverage rate was 60% in 2010, it would require an additional of 0.8-1.7 percent of GDP for reaching full coverage. Given the current budget constraints, it should be more feasible to expand the health insurance to the near poor, middle-income people working in the informal sector and to give attention to vulnerable groups.

In addition, incentives should boost participation in health insurance and careful policy measures facilitate expansion of social insurance, while a basic package of social assistance should cover the human life cycle, particularly birth and childhood, disability and old age. Greater coherence of the key pillars of social protection system would increase coverage and efficiency. While these measures will require additional resources and/or a reallocation of funds, financing should be viewed in terms of social protection as an effective public investment with high economic and social returns.

Towards a fully-funded social insurance

VSS is facing a challenge of financial imbalance, affecting long-term sustainability and fiscal status of the State Budget (being guarantor of the Fund). Currently, VSS's pension scheme is evaluated as generous compared to contributions, and retirement ages remain low in the context of an aging population and increasing life expectancy. Projections suggest that a pension-tested elderly social pension at the level of the poverty line for 6+ years of age would cost about 0.7% of GDP for the remainder of the decade, rising over 2020-2035 as the number of elderly rises sharply (Giang 2014). Policy directions towards a fully-funded social insurance and to ensure balanced management of the VSS Fund in the next decade include (i) gradually increasing official retirement age, as being identified in the 2016-2020 Socio-Economic Development Plan; (ii) equalizing the retirement age for men and women; and (iii) accelerating the matching of pension benefits with contributions. These actions, aimed at setting a self-sufficient financial status for VSS, will lay a solid foundation for financial viability and sustainable expansion over a longer term.

Expansion of social assistance schemes

Social assistance transfers are generally too low and spread over many small and fragmented schemes, especially those targeting the poor and poverty reduction programmes, to make much of a difference. While Viet Nam's public expenditure on social protection overall accounted for 2.8% of GDP in 2013, social assistance only accounted for around 0.4% of GDP in the same year. Recently, the Prime Minister has approved Master Plan for Social Assistance Reform, creating a foundation for comprehensive social assistance programs which integrating to a more inclusive social protection scheme. The Master Plan has specified the consolidation of social assistance transfer schemes, addressing the fragmentation and defining a coherent framework for the implementation. Furthermore, there should be more consideration on the selection of beneficiaries on a vigorous assessment, gradual shift in resource allocation for National Targeted Programs.

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