FACT SHEET: UHC SOUTHEAST ASIA

	Indonesia		**Thailand**		**Vietnam**		**Philippines**	
Population	257,564,000		68,863,514		92,701,100		103,320,222	
GDP/capita (USD)	**2000:** 780.09	**2016:** 3570.29	**2000:** 2007	**2016:** 5907	**2000:** 433	**2016:** 2185	**2000:** 1038	**2016:** 2951
% of workforce informal (non-ag)	73 %		43%		68%		70%	
Infant Mortality Rate (per 1000 live births)	**2002:** 37.8	**2015:** 22.9	**2002:** 18	**2015:** 10.8	**2002:** 22	**2015:** 18	**2002:** 29	**2015:** 22.1
Maternal Mortality Rate (/100,000 live births)	126		20		54		114	
Govt. expenditure on health/capita ($)	40		167		61		41	
Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE).	47		12		37		54	

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UHC service coverage index[1] (% of population) (SDG 3.8.1)	49	75	73	58
Health Programme	Jaminan Kesehatan Nasional (National Health Insurance JKN)	UHC	Vietnam Social Security	PhilHealth
Date of launch	24 November 2011 (Law No 24/2011 merged the health insurance schemes for the poor with other schemes to créate a single health fund)	2002	2008	1995
Type of Scheme (insurance-based or not?)	Insurance based **(Mandatory)**	Both, insurance based for the formal, funded through general taxation for the informal workforce	Insurance based **(Mandatory for formal workers, voluntary for informal workers).**	Insurance based **(Voluntary)**
How is it Financed? (VAT levy's? contributions from formal social security? General taxation?)	CENTRAL GOVERMENT REVENUE (70% subsidized members)[2]	General tax revenue + 2% "sin taxes" (for the Thai Health Promotion Foundation)	SHI[3] Contributions + TAX REVENUE (to enroll those with insufficient means) Co-payments at health facilities were re-introduced in 2010, except for high ranking	Out of Pocket Payments +SHI+TAX REVENUE (to enroll those with insufficient means) Co-payments are expected.

[1] WHO 2016 data drawing on a composite index of tracer indicators for measuring UHC coverage, which include: i) reproductive, newborn, maternal and child health; ii) infectious diseases; iii) non-communicable diseases; iv) service capacity and access to essential health services.

[2] The JKN introduces a fundamental difference from the previous Jamkesmas and Jamkesda (prior health schemes) in shifting from tax-funded fee waiver schemes for poor people, to a premium-based mandatory health insurance system with high levels (70%) of subsidisation.

[3] SHI = Social Health Insurance.

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			police officers, people of merit, and children under 6.	
Who is eligible?	Individual participation is mandatory for all Indonesian residents, by January 2019. Meanwhile, employers must enroll their employees by January 2016. Premiums are on a sliding scale according to income.	All citizens	There are 5 main categories: **Cat 1**: Contribution of 4.5% is split bet employer (3%) and worker (1%). Applies to formal workers and civil servants. **Cat 2**: Contribution of 4.5% is paid by the Social Security Agency. Applies to pensioners and those on unemployment. **Cat 3:** Contribution of 4.5% is paid by Govt. Applies to war vets and people of merit. **Cat 4:** Groups with partial (30-50%) subsidy from govt. Applies to "near poor" and students. **Cat 5:** Voluntary enrolment of 4.5% of salary with no subsidy. Applies to "agricultural households, members of cooperatives, household enterprises."	There are several categories. Three main ones: **Formal workers:** Employers & workers each contribute 2.5% of income. **Informal workers:** Voluntary membership at set premium according to earnings (2400 ($48)-3600 ($72) pesos annually depending on earnings). **Indigent:** Sponsored by national govt.

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Any data on coverage rates of informal workers? /Coverage rates for the whole population?	2014 10.5 million informal workers covered, 2016: 19 million/33%	99.5% of total pop	72% of total pop "The near poor and the self-employed in the informal sector/ agricultural sector are reluctant to enrol in health insurance and to contribute their share of the premium." (VSS Report).	76%[4] of total pop Self-employed members totalled 4.5 million. These comprise around a quarter of the total 34.78 million membership of PhilHealth, but represent 38-40% of the population.
Any information on what the benefits package for informal workers is?	Comprehensive basic benefit package provided based on medical indications, covering outpatient and inpatient care at primary level up to tertiary hospital level, with exclusion to a few types of care that are partially covered and fully uncovered.	Covers a comprehensive range of essential health services with a focus in primary care and prevention. Covering outpatient, inpatient and accident and emergency services; dental and other high-cost care; and diagnostics, special investigations, medicines (no fewer than are included in the National List of Essential Medicines) and medical supplies. Patients covered by UCS and SHI are unlikely to obtain expensive NEMs, owing to incentives for cost	Based on an inclusive list and covers all ambulatory and hospital basic as well as advanced diagnostic curative health services and therapeutic services – including renal replacement therapy (peritoneal dialysis, haemodialysis, and spleen transplantation), organ transplantation, invasive cardiovascular treatment, computerized tomography scan, and magnetic resonance imaging etc. In addition, transportation costs in case of referral are covered for the poor, persons entitled to	Comprehensive package of services, including inpatient care, catastrophic coverage, ambulatory surgeries, deliveries, and outpatient treatment for malaria and tuberculosis. Those identified as indigent and OFW are also entitled to outpatient primary care benefits (PCB1) or TSEKAP

[4] In 2010, it claimed to have achieved "universal" coverage at 86% of the population, although the 2008 National Demographic Health Survey showed that only 38 percent of respondents were aware of at least one household member being enrolled in PhilHealth.

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		containment. It is evident that medicines prescribed to members of CSMBS differ from, and are more expensive than, those acquired by beneficiaries covered by UCS and SHI.	social assistance allowances and those in remote areas. In contrast, rehabilitation, home care, drug addiction treatment, prostheses, teeth, glasses and hearing aids are not covered, nor are treatment of occupational diseases and accidents at the workplace. In light of a large informal sector, the latter is of particular concern, PREVENTIVE CARE Preventive health care, except for screening tests for early diagnosis of some cancers, is not covered by the health insurance fund.	

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CAMBODIA:

- Cambodia has a predominantly rural population. Government expenditure on health is significantly reliant on foreign funding.
- Fees are charged at both government and private health facilities.
- There is a lot of concern about the quality of health provision in both the public and private health systems, with those who can afford it travelling to Thailand to seek treatment.
- Several key health systems initiatives:
    - The ILO has been assisting with the development of a Social Health Insurance fund attached to the National Social Security Fund. At first this was limited to formal garment workers (with a 1.3% contribution from the worker, and a 1.3% contribution from the employer), but has now been expanded to public servants and military veterans. In 2018, the government is looking to include workers in the informal economy.
    - The World Bank is currently funding Health Equity Funds, aimed at covering health charges for the very poor (i.e. the fund covers the health fees for the very poor at state facilities).

NOTES:

- The schemes in the region which are most favourable to informal workers are the Thai Scheme and the Indonesian scheme, which is mandatory and heavily subsidised (70%) by the state. In this respect it is similar to the very successful Rwandan Health Insurance scheme which, covers over 95 percent of the population, and is mandatory with high subsidisation (over 90 percent) from the state.
- The Vietnamese and Philippine schemes are both examples of schemes which have a component based on formal payroll taxes, with employer/employee contributions, and a voluntary component for self-employed/informal workers. In Vietnam informal workers are expected to contribute the equivalent of both the employer and employee contributions. In the Phillippines the rate is set on a scale according to income.
- Oxfam argues that it is these second type of health insurance schemes which are particularly detrimental to informal workers. Voluntary schemes are administratively intensive, often have low enrolment rates amongst informal workers, and require informal workers to pay more than their formal counterparts, despite the fact that they are generally poorer (eg. The Vietnam scheme).
- Preventive health is notably absent from the benefit packages.