Providing additional benefits coverage

A review of country experiences to inform Viet Nam's revision of the Health Insurance Law

Final Report

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Acronyms

ASEAN	Association of Southeast Asian Nations
DRG	Diagnosis-related group
HMO	Health maintenance organization
ILO	International Labour Organization
LMIC	Low and middle-income countries
MOH	Ministry of Health
NA	National Assembly
NGO	Non-governmental organization
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-pocket (expenditure)
PPP	Public-private partnership
SHI	Social health insurance
UHC	Universal health coverage
VSS	Vietnam Social Security
WHO	World Health Organization

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Definitions

Community rated premiums: The premium amount is the same for all members of the same policy, regardless of their health risks.

Complementary coverage: Pays for some of the costs for services that are covered by the health insurance system (typically patient co-payments) and for services that are explicitly excluded from the health insurance system's benefit package.

Co-payment: The member of a health insurance scheme pays part of the fees charged by health providers. Co-payments can be either a fixed amount (or lump sum) or a percentage of the fees (also called co-insurance).

Duplicative coverage: Covers services already covered by the health insurance system, but with access to additional providers or levels of service, e.g. private health facilities. However, unlike substitutive insurance it does not exempt enrollees from contributing to social health insurance.

Individually rated premiums: Calculated based on each individual's risk of requiring health care (which is influenced by factors such as age, gender, pre-existing conditions, etc.).

Private health insurance: Health insurance offered by private for-profit or not-for-profit entities, including private insurance companies, health maintenance organizations (HMOs).

Risk rated premiums: The premium amount is set in relation to the person's health status and health risks. An individual with higher health risks will have to pay a higher premium.

Social health insurance: Mechanism with the objective of insuring the population (total population of certain groups) against the costs of health care. Sometimes referred to as National Health Insurance. In many cases, social health insurance schemes were initially developed through payroll deductions. As systems evolved, financing sources have been expanded to include both government grants (for operational costs) and subsidies (for vulnerable or specific groups) and direct contributions (self-employed, workers in atypical forms of employment). Social health insurance distinct from commercial health insurance in that the risk-pooling is based on the principle of equity and solidarity (as opposed to individually calculated risk premiums in commercial health insurance). When social health insurance is defined by a legal instrument, it is called statutory insurance.

Substitutive coverage: Covers population groups that are excluded from publicly financed coverage or allowed to "opt out" by not making their mandatory contributions to the health insurance system.

Supplementary coverage: Provides enhanced access (e.g. bypassing queues/waiting lines), more inpatient amenities, or greater user choice of providers compared to those covered by the health insurance system.

Voluntary health insurance: Prepaid pooling arrangement in which the decision to join and pay the premium is voluntary. Voluntary health insurance can be privately managed, such as employer-based for-profit schemes and non-profit schemes such as community-based health insurance, or publicly managed such as in Vietnam before the health insurance law of 2008.

Summary

The Ministry of Health (MOH) of Viet Nam is revising the Health Insurance Law 2014, with the aim of addressing several design and implementation issues. As part of the process of the Health Insurance law revision, the MOH is currently identifying the core policies to be reformed and defining alternative options. The Resolution 20 of the 6th meeting of the 12th central committee dated 25 October 2017 formulates the need to "diversify health insurance packages; strengthen linkages and cooperation between social health insurance and commercial health insurance" as one of the primary solutions to "Strongly reform health finance". In that context, the MOH is exploring the option of creating an additional or diversifying the benefit package(s) with the aim of providing a higher level of coverage to those willing and capable of contributing more.

To inform decision making, the current review documents other countries' experiences of designing and implementing models to expand and diversify the benefit package, including the benefits covered, premium setting, operational modalities, and regulatory arrangements.

Based on international experience, this review argues that there are two main options for Vietnam to consider when determining if and how to provide additional benefits coverage. In option 1, an additional benefit package could be provided through the health insurance scheme of Vietnam Social Security (VSS). In option 2, additional benefit packages would be left to private companies offering voluntary health insurance policies. Given the potential benefits and risks of each option summarized in this report, the review recommends the adoption of option 2.

The creation of an additional benefit package administrated by VSS has very limited and uncertain advantages: it might contribute to retain high income members into VSS by offering a more attractive benefit package. The possible magnitude of the latter is however questionable. On the contrary, the provision of an additional benefit package by VSS would pose serious threats to equity of the health insurance scheme among the citizens and residents of Viet Nam. First, setting up an additional benefit package may lead to a two-tier health system. Second, this option requires extra investment (human resources, update of software and standard processes, contracting etc.) to establish a new package, administer separate benefits, contract with different and more demanding health providers, and address requests from more demanding members – hence creating a diversion of internal resources towards better-off members. Altogether, the implementation of this option would signify to the population that priority is given to those who belong to higher income groups and who can generate resources for the scheme – to the detriment of the rest of the population, instead of addressing problems that impact everyone, such as ensuring quality of care.

For these reasons, very few countries in the world are providing additional benefits coverage or creating different benefit package in their main health insurance system. Accessing a higher level of financial and benefits protection is most often left to the private sector through voluntary health insurance. Indeed, based on international experience, the potential of private health insurance to contribute to universal health coverage is likely to be maximized if it takes on a complementary and supplementary role, with strong policy direction and a robust legal and regulatory framework implemented by the government.

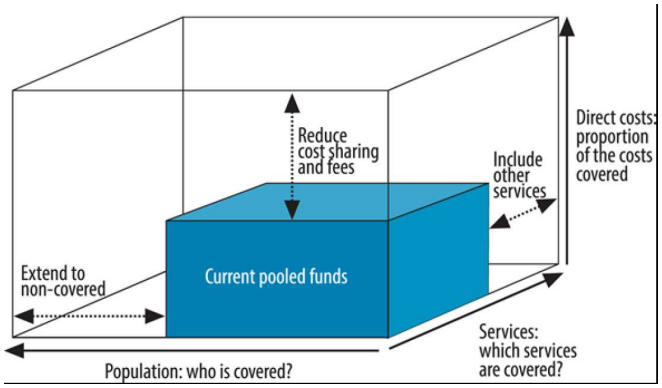
1. Introduction

1.1 Background

The Government of Viet Nam has built and strengthened its social health protection mechanisms over the past three decades. Starting from publicly financed health systems inherited from the centrally planned economy with free access to health care, Viet Nam gradually implemented reforms in line with the Doi Moi policies and made a transition from a tax-based system to a system with multiple sources of financing. Today, the major sources of financing are general government revenues, social health insurance (SHI) funding, and out-of-pocket (OOP) payments from households. Population coverage now stands at 87%, in large part thanks to policies of exemptions and subsidies of contributions for vulnerable, near poor and meritorious population groups (Government of Vietnam, 2008, 2014, 2018).

Progress towards Universal Health Coverage in Vietnam can be measured along three dimensions (Figure 1) reflected in Sustainable Development Goal (SDG) 3.8: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." (www.who.int/sdg/targets/en/)

Figure 1: Three dimensions to consider when moving towards universal health coverage



Source: WHO, 2010

In addition to financial protection and quality issues, Viet Nam faces the challenge of maintaining the level of population coverage achieved. More specifically – and along with broader reforms on the overall health systems – this means addressing three concurrent issues: (i) implementing additional strategies to close the coverage gap, (ii) maintaining coverage of households with the capacity to contribute, and (iii) retaining households who are gradually moving out of poverty and are no longer eligible for partial and/or total subsidies.

Viet Nam started to develop health insurance mechanisms in 1989 with pilot health insurance schemes in selected provinces and on a voluntary basis. A regulatory framework was gradually developed and the first Health Insurance Law No 25/2008/QH12 came into force in 2009. In 2014,

the National Assembly (NA) enacted the Amendment of Health Insurance Law to address several provisions which were deemed inadequate[1]. However, there are remaining shortcomings with the law that prevents effective management of the health insurance system. These limitations can be grouped into two categories as follows (i) limitations in the way basic principles of health insurance are reflected in the law (ii) limitations related to the implementation in the law itself. Through the revision of the Law, the Ministry of Health (MOH) intends to address core issues such as the need to strengthen financial protection (to limit co-payment) and increase population coverage (to close the remaining gap, ensure compliance, provide incentives to membership and address fairness in financing). It also seeks to address practical implementation issues which include shortcomings such as unclear split of roles and responsibilities of Vietnam Social Security (VSS) at central and local levels, adding private health care providers, lack of regulations of medical review, and absence of provisions dealing with management of data and information. Therefore, the MOH has recently been assigned to review and propose a fundamental amendment of the health insurance law for the NA to consider and adopt.

To address the issues mentioned above the MOH is exploring the option of providing additional level of benefits coverage to address expectations of members who would like to enjoy higher level of protection and provide them with incentives to join and/or remain in the health insurance scheme. It has to be noted that demand from society for additional coverage is primarily among the better-off and some vocal meritorious members who want to use on-demand services in public hospitals or private services, for which the higher service fees are not fully covered by the health insurance fund, leading to higher out-of-pocket payment burden on this group. Transforming these out-of-pocket payments at point of service use to pre-payment schemes has some welfare benefits for this group.

The MOH has identified several areas of reform to be addressed by the new health insurance law:

- Expansion of social health insurance coverage and consideration of subsidies to premiums for dependents
- Expansion of the scope of the benefit package to incorporate more preventive and other primary care services and alternative packages with alternative premiums
- Contracting with private health facilities and all CHS
- Administrative reforms and social health insurance modernization (e.g. computerization of records)
- Reform supervision and promote the role of grassroots health facilities and family medicine to promote greater integration between primary providers and referral facilities
- Effective management of the fund (e.g. regulations, premium setting, independent claims reviews)
- More explicit regulations on payment methods, including consideration of diagnosis-related groups (DRGs) with a global budget for inpatient services and capitation for outpatient primary care

[1] Changes introduced in the revised HIL 2014 includes but are not limited to the new definition of persons eligible for health insurance, change in the basis on which health insurance premium are calculated, increase of the benefits level, addition of criteria for the allocation and use of health insurance fund etc.

1.2 A bi-dimensional approach to the progressive realization of comprehensive social health protection: The case of Vietnam

The ILO strategy on the extension of social protection is based on the two-dimensional strategy adopted by the 100th Session of the International Labour Conference in 2011 (Box 1). The aim of the two-dimensional approach is to allow a rapid implementation of national defined social protection floors (horizontal dimension), in line with the Social Protection Floors Recommendation, 2012 (No. 202). Its objective is also to allow for the progressive achievement of higher levels of protection (vertical dimension) within comprehensive social security systems according to the Social Security (Minimum Standards) Convention, 1952 (No. 102). Over the past decades, Vietnam has gradually built its social health protection system in line with this approach – expanding the groups of population covered and the benefits covered in a stepwise manner.

Box 1: Definition of ILO Social Protection Floor

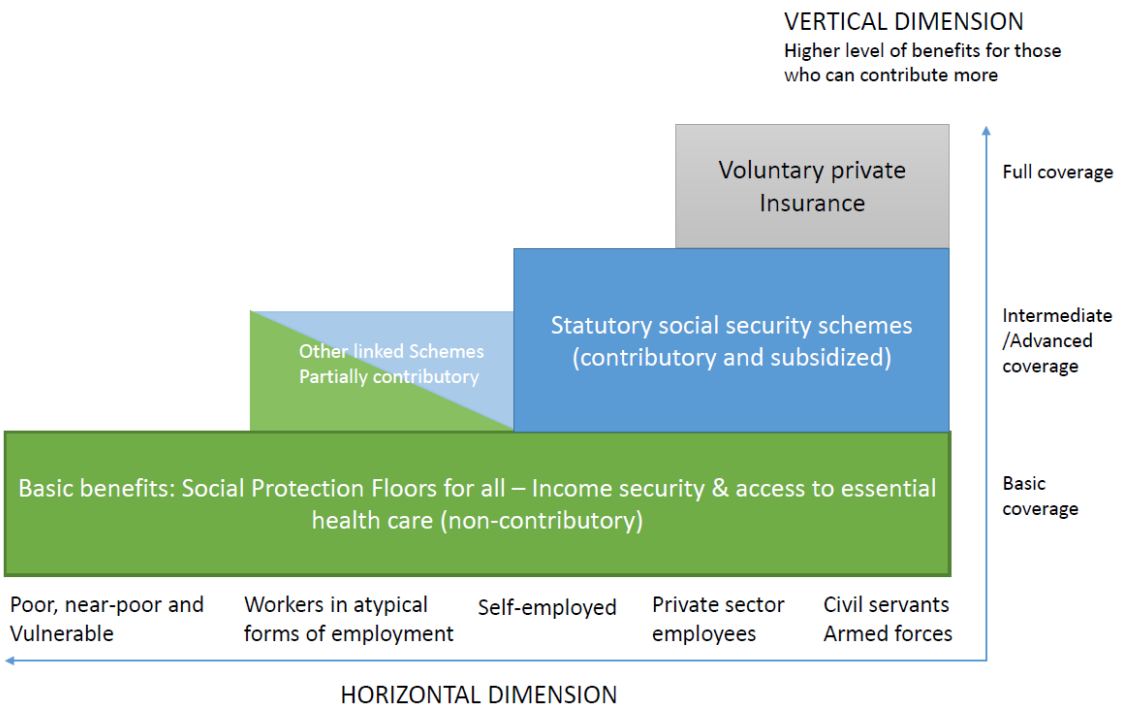
"Social protection floors are nationally-defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion. These guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and basic income security. National social protection floors should comprise at least the following four social security guarantees, as defined at the national level:
1. Access to essential health care, including maternity care;
2. Basic income security for children, providing access to nutrition, education, care and any other necessary goods and services
3. Basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability;
4. Basic income security for older persons.

Such guarantees should be provided to all residents and all children, as defined in national laws and regulations, and subject to existing international obligations."

Source: ILO, 2011

The ILO two-dimensional strategy illustrated in Figure 2 below may be applied/transcribed to Vietnam social health protection systems in the following way:

Figure 2: ILO two-dimensional strategy for social protection



Source: ILO

The floor

In Vietnam, the "health component" of the social protection floor can be deemed to be constituted by tax-financed services such as immunization. These services are accessible to all on a non-contributory basis.

The intermediate level

On top of the tax-financed services, which are limited in scope, the social security institution VSS provides a comprehensive benefit package for 86% of the population on a compulsory basis. Those who can afford to contribute pay the full premium, while more than 40% are fully subsidized and more than 20% are partially subsidized (VSS, 2019). In Viet Nam, health insurance used to be compulsory only for employees in the formal private sector and civil servants but the self-employed are required to enroll in VSS health insurance since the 2014 health insurance law amendment.

The health insurance scheme provides a unique benefit package to all members, with a few minor differences. First, levels of co-payment varies - ranging from 0 to 20% - according to the membership group a member belongs to.[2] Second, there is no cap on total reimbursements for some eligible groups.[3] Applicable co-payments are also higher for patients using a hospital different from the hospital s/he registered with.[4] The benefit package covers the costs of medical examination and treatment; rehabilitation; pregnancy follow-up and delivery; costs associated to referrals; screening and diagnosis tests and; medicine, medical supplies and equipment, the latter based on a list

[2] Article 22 of the Health Insurance Law
[3] Article 14 in Decree 146/2018 on the implementation of the Social Health Insurance Law.
[4] Article 22, Clause 3. This will be abolished from 1st January 2021 (as per clause 6 of article 22), but still applies to people bypassing to central level, only abolished when seeking care at provincial level and below.

promulgated by the MOH.[5] Exclusions include but are not limited to medical check-up, aesthetic surgery, prostheses, medical examination and treatment related to addiction and specific sight defects except for children under six years of age.[6] In addition, Circular 35/2016/TT-BYT includes limits on reimbursements above a certain threshold.

As a result of various adjustments to expand the benefit package, the range of benefits covered by VSS is relatively generous, with coverage of health examination and treatment, rehabilitation, regular antenatal care and delivery (including costs for medicine, chemicals, medical materials and technical services) as regulated by Article 21 of the Health Insurance Law. However, high out-of-pocket (OOP) expenditures – combined with quality concerns – remains a main concern. Although on a decreasing trend, OOP remains high at 44.6% of current health expenditures (WHO Global Health Expenditure Database).

Full coverage

The third-tier – voluntary private insurance – covers only about 10% of the population in 2016 and voluntary health insurance spending represents only 1.4% of current health expenditure (GSO, 2016; WHO Global Health Expenditure Database).

Options to access additional benefits

As stated above, all members of the VSS health insurance scheme benefit from the same package of insured health services, with variations only in the level of co-payments and that there is no cap on total reimbursements for some eligible groups. Additional coverage can be obtained on a voluntary basis by purchasing individual or group insurance policies from private insurance companies.

In this framework, there are various options to enable citizens of a country to be covered for services that are currently not included in the HI benefit package and to benefit from a higher level of protection. In this report, we are exploring two major options:

- Individuals purchasing an additional (non-substitutive) insurance policy with a private insurance company on a voluntary basis.
- Individuals accessing higher level of coverage (additional services and/or lower co-payment) by the main social security system, based on conditions defined by national laws and regulations.

1.3 Goal and objectives

The goal of the review is to analyze countries' experiences of extending health protection through either the social health insurance system itself or through private health insurance.[7] The aim of the review is to inform the MOH on the policy options available and subsequently the development of the new Health Insurance law. To achieve this goal, the review has the following specific objectives:

[5] Article 21 of the Health Insurance Law
[6] Article 23 of the Health Insurance Law
[7] In order to provide a comprehensive picture, the countries review also include countries providing substitutive private health insurance (where members are allowed to opt out of the social health insurance scheme). This is however not an option that is recommended and therefore not explored in depth.

1. Conduct a literature review to determine the roles of social health insurance and private insurance schemes in providing complementary and supplementary benefits coverage in selected countries.
2. Document countries experiences by providing additional information on their models, and more particularly on the benefits covered, contributions/premium setting, operational modalities, and regulatory arrangements.
3. Provide recommendations to the MOH on policy options for addressing the roles of mandatory social health insurance and non-substitutive voluntary private health insurance in providing additional level of health protection, in line with ILO Conventions and Recommendations.

2. Methodology

2.1 Country selection

A total of 35 countries were included in the review (Annex 1). Countries were selected purposefully to include countries with experience that would be relevant to Viet Nam. The following categories of countries were included:

- Association of Southeast Nations (ASEAN): 9 countries (all except Viet Nam)
- Other Asian countries: 1 country (China)
- Organization for Economic Co-operation and Development (OECD): 15 countries, including two countries from Asia (Japan and Republic of Korea) and two countries from Latin America (Chile and Mexico)
- Africa: 8 countries
- Latin America: 2 countries (Brazil and Colombia)

The review included 3 low-income countries, 17 middle-income countries (8 lower middle-income countries, 9 upper middle-income countries), and 15 high-income countries.

2.2 Literature review and information collection

Information available online (journal articles, grey literature and data bases) was consulted during the review. The starting date for literature in the review was originally 1 January 2015, but in some cases older materials had to be reviewed to obtain the necessary information. The reviewed documents are stored in a Dropbox folder, access to which can be provided upon request.

2.3 Matrix

To guide the review and facilitate data collection and analysis, a matrix was constructed with several indicators and areas of information (Annex 2). The matrix included high-level questions on the main social health protection system, such as population coverage, eligibility, etc. More detailed information was collected on private health insurance, such as spending, population coverage, type of health insurance, benefits covered, number of private insurance companies, unit of enrolment, premiums and method of calculation, type of providers covered, provider reimbursement

mechanisms, and regulation of private health insurance. The information in the matrix was validated by national and international experts on health financing.

2.4 Analysis and report preparation

Both quantitative and qualitative (including categorical information and narrative information) data were collected. The information was entered in the matrix, which was used for analysis of the data. The report was primarily based on the information in the matrix, complemented by other sources of information when required.

2.5 Limitations

The review has a few limitations. First, despite thorough searches, it was not possible to find recent information about private health insurance in a few countries. However, about two-thirds of the 82 documents included in the review were from 2015 or later. Second, generalizability might be constrained by different contexts, meaning that findings from one country may not be directly applied to Viet Nam. However, with some adjustments to allow for country context specific factors, the findings of the review should still be able to inform relevant parts of the new health insurance law. Third, additional specificity would have been achieved through consultations with experts in the countries in-person or through video or phone, but this was not feasible within the scope of the review. However, enough information was collected and analyzed to inform conclusions and recommendations. Fourth, the scope of the review did not allow for an in-depth assessment of the risk of any unintended, negative consequences of the provision of additional benefits through the two options, i.e. through (i) the social health insurance system and (ii) private voluntary health insurance. However, general observations could be made based on the collected information.

3. Findings

This section begins with an introduction to private voluntary health insurance, followed by a presentation of the potential benefits and risks of the two options (private insurance or social health insurance) the provision of additional benefits would entail. The section then presents a summary of the findings of the literature review at the aggregate and disaggregate level by category of countries.

3.1 Private voluntary health insurance: An introduction

Private voluntary health insurance is a prepaid pooling arrangement that receives voluntary funds and pools them separately (Mathauer & Kutzin, 2018). The decision to join the scheme is voluntary and made by individuals, households, or private companies. Private voluntary health insurance differs from a compulsory insurance mechanism (such as social health insurance) where membership and payment of contributions are mandatory as specified by the government (usually by law) for all or parts of the population. Private voluntary health insurance is usually offered by commercial or not-for-profit health insurance companies but can also be provided by companies that manage their own insurance arrangements for their employees or non-governmental organizations (NGOs).

In some cases, governments subsidize private voluntary health insurance schemes, either directly (by paying for coverage) or indirectly by granting tax deductions or tax credits for the purchase of private voluntary health insurance. In South Africa, the Medical Scheme Fees Tax Credit (MTC) is a rebate which reduces the amount of tax a person pays. The MTC applies to fees paid by a tax-payer to a registered medical scheme for that tax-payer and his or her dependents as defined in the Medical Schemes Act. The aim of the MTC is to promote greater equality in the treatment of medical expenses across all income groups. The credit is a fixed monthly amount which increases according to the number of dependents and is deducted by the employer when calculating the amount of tax to be deducted from the employee's salary.

Private voluntary health insurance as a mechanism to finance health systems plays a limited role in most countries. In 2016, only 41 countries in the world reported private voluntary health insurance expenditure above 5% of total health expenditure (Mathauer & Kutzin, 2018). Although modest, private voluntary health insurance as a share of THE is growing overall in many countries. Reasons for private voluntary health insurance growth in low- and middle-income countries (LMICs) includes the emergence of a middle class who are able and willing to pay private voluntary health insurance premiums to access what they perceive as better quality or more convenient care in the private sector and the development of government policies on the role of private voluntary health insurance and the regulatory framework, or in the case of Vietnam the lack of regulations, which allows the market to develop on its own. Increases in the share of private voluntary health insurance spending has not been consistently linked with reduced OOP spending nor increased private prepayment; various countries where private voluntary health insurance increased also faced a rise in OOP and fall in government spending on health care (Pettigrew & Mathauer, 2016).

There are different kinds of private voluntary health insurance: substitutive, complementary, and supplementary (Mathauer & Kutzin, 2018). In practice, different forms of private voluntary health insurance for different groups may co-exist in a country (Pettigrew & Mathauer, 2016). **Substitutive voluntary health insurance** covers population groups that are excluded from publicly financed coverage or allowed to "opt out" by not making their mandatory contributions to the social health insurance system. **Complementary voluntary health insurance** pays for some of the costs for services that are covered by the social health insurance system (typically patient co-payments) and for services that are explicitly excluded from the social health insurance system's benefit package. **Supplementary voluntary health insurance** provides enhanced access (e.g. bypassing queues/waiting lines), more inpatient amenities, or greater user choice of providers compared to those covered by the social health insurance system. Additional definitions relevant to this review are provided before the introduction to this report.

There are advantages and disadvantages of each type of private voluntary health insurance. Private voluntary health insurance as a form of prepayment and limited pooling can be preferable to OOP expenditure, since it may provide the opportunity for people excluded from social health insurance (for example, because they are foreigners) to purchase health insurance, increase access to health care, and improve financial protection and access to additional services (WHO, 2010). Private voluntary health insurance has also been argued to bring more money into the health system (or at least shift spending from OOP to pre-payment, to cross-subsidize financing at provider level, and to enhance uptake of new technologies (Drechsler & Jutting, 2005; OECD, 2004; Siskou et al, 2009;

Thomson & Mossialos, 2009). Each type of private voluntary health insurance can also have negative effects on access, equity, and efficiency. In addition, the argument that private voluntary health insurance brings additional money into the health system has not been validated.

By its nature, voluntary health insurance suffers from adverse selection. It can significantly contribute to fragmentation and unbalanced risk pools. Private voluntary health insurance can also lead to increased use of unnecessary health care due to moral hazard and supplier-induced demand, especially for supplementary and complementary coverage. The effects of the latter are potentially stronger in private voluntary health insurance schemes, where premiums are usually costly, leading members to "make the most of the premium paid."

Private voluntary health insurance often disproportionately benefits people of higher incomes with lower health risks. Indeed, most private voluntary health insurance de facto excludes people with high health risks and low income, due to the current practice of risk-rated premiums and selection of members based on their health profiles or age. For example, in Kenya private health insurance coverage in the poorest income quintile was 3% in 2014, compared to 42% in the richest quintile (Kenya National Bureau of Statistics & ICF Macro, 2016), which poses direct equity concerns. This is especially the case in situations where governments pay the employer share of premiums for civil servants affiliated to a private voluntary health insurance system or where tax credits are granted for premium payments, in which case public spending becomes more pro-rich.

When channeling high payment to private health providers, private voluntary health insurance can also favor higher-cost private sector development (including HRH) to the detriment of the overall public health systems performance. It may be politically more difficult to introduce or expand compulsory prepayments to finance coverage extension for less affluent population groups when a private voluntary health insurance market is already in place.

Many countries have paid insufficient attention to the potential risks of private voluntary health insurance contributing to inequitable progress towards universal health coverage (UHC), including increasing fragmentation of pooling mechanisms and inequitable access to health care (Pettigrew & Mathauer, 2016). To avoid this, health financing strategies need to be clear regarding the role given to private voluntary health insurance to create complementarity between private voluntary health insurance and mandatory and subsidized publicly funded pools which are essential to progress equitably towards UHC.

3.2 Potential benefits and risks of offering a package of additional benefits through Social health insurance and voluntary private health insurance.

There are two main options for Vietnam to consider when determining if and how to provide additional benefits coverage (Figure 3). First, an additional benefit package could be provided through the social health insurance by VSS. Second, the provision of an additional benefit package could be left to private voluntary health insurance. This could be entirely disconnected from VSS or could be implemented through a public-private partnership (PPP) in liaison with VSS with scope and modalities to be defined. The potential benefits and risks are summarized in Table 1 (social health insurance system) and Table 2 (non-substitutive voluntary private health insurance).

Figure 3: Options to provide additional benefits in Vietnam

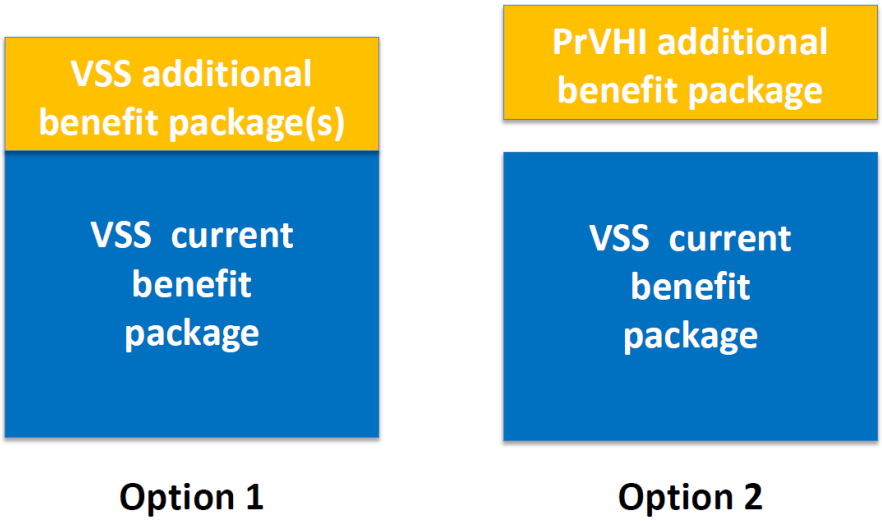


Table 1: Benefits and risks of offering additional benefits through the social health insurance system

Social health insurance system	
Benefits	**Risks**
• Retain high income members into VSS by offering a more attractive benefit package • Generate additional revenue to the scheme – provided premium is set high enough to cover medical and admin costs and reserves •	• Prioritizing those who generate resources for the scheme to the detriment of the rest of the population • Negative impact on equity in financing: may create a two-tier health system • Causing diversion of focus to benefit better-off members by addressing extra demand from the better-off instead of addressing problems that impact everyone • Creating a diversion of human resources towards better-off members • Requires extra efforts to establish a new package, deal with different (more demanding) health providers, and deal with more demanding members

Table 2: Benefits and risks of offering additional benefits through non-substitutive voluntary private health insurance

Non-substitutive Voluntary Private health insurance	
Benefits	**Risks**
• Increased consumer overall health protection • Increased consumer choice and access to private providers • Increase the public sector's influence over private insurance and private providers through regulation	• Two-tiered health system with better services to those who can afford it • Exclusions based on health risk • Adverse selection • Potential brain drain of health workers from public to private sector with higher salaries and better working conditions • Challenges to regulate private insurers *Note: The first three risks listed above are significantly lower when the mandatory social health insurance already provides comprehensive and sound health protection to the major share of the population, which is the case in Viet Nam.*

3.3 Literature review findings: An overview

Table 3 presents selected key indicators from the matrix of information and data collected through this review, including population coverage for the social health insurance system and private voluntary health insurance, voluntary health insurance spending as a share of current health expenditure, whether or not the social health insurance system provides additional benefits, and the types of private voluntary health insurance coverage.

Table 3: Selected matrix findings

Country	Population coverage social health insurance system	Population coverage private health insurance	Voluntary health insurance share of current health expenditure	Is the social HI system providing additional benefit package (possibility to opt for higher level of benefits within the social health insurance) ? (yes/no)	Type of private voluntary health insurance coverage
Australia	100%	55%	9.5%	No	Complementary, duplicative, supplementary
Brazil	25%	25%	21.9%	Yes	Supplementary
Brunei Darussalam	100%	n/a	n/a	No	Supplementary
Cambodia	20%	<1%	0.6%	No	Supplementary
Canada	100%	67%	9.9%	No	Supplementary
Chile	82%	18%	6.5%	Yes	Complementary, substitutive
China	95%	5%	4.3%	No	Supplementary
Colombia	96%	8%	11.5%	No	Complementary, supplementary
France	100%	96%	6.7%	Yes (for vulnerable groups)	Complementary, supplementary

Country	Population coverage social health insurance system	Population coverage private health insurance	Voluntary health insurance share of current health expenditure	Is the social HI system providing additional benefit package (possibility to opt for higher level of benefits within the social health insurance) ? (yes/no)	Type of private voluntary health insurance coverage
Germany	100%	34%	1.4%	No	Complementary, substitutive, supplementary
Ghana	38%	n/a	1.7%	No	Complementary, duplicative, supplementary
Indonesia	74%	2%	3.5%	No	Duplicative
Ireland	100%	45%	12.3%	No	Complementary, duplicative, supplementary
Japan	100%	2%	2.2%	No	Complementary, supplementary
Kenya	10%	3%	10.8%	No	Complementary, supplementary
Korea (Republic of)	100%	77%	6.8%	No	Complementary
Lao PDR	23%	1%	0.1%	No	Complementary, duplicative, supplementary
Malaysia	100%	7%	10.1%	No	Supplementary
Mexico	92%	8%	5.8%	No	Duplicative, supplementary
Myanmar	1%	2%	0.0%	No	Supplementary
Namibia	18%	13%	16.1%	No	Complementary, supplementary
Netherlands	100%	84%	6.1%	No	Complementary, supplementary
Nigeria	3%	5%	0.6%	No	Complementary, supplementary
Philippines	92%	2%	10.6%	No	Complementary, supplementary
Rwanda	87%	1%	2.4%	No	Complementary
Senegal	47%	2%	4.9%	No	Supplementary
Singapore	100%	n/a	2.1%	No	Supplementary
South Africa	20%	17%	35.9%	No	Substitutive
Spain	100%	17%	4.6%	No	Complementary, substitutive, supplementary
Switzerland	100%	28%	6.7%	No	Complementary, supplementary
Tanzania	16%	1%	0.8%	No	Complementary, supplementary
Thailand	100%	7%	6.6%	No	Supplementary
Turkey	98%	5%	n/a	No	Complementary, supplementary
United Kingdom	100%	11%	3.3%	No	Complementary, duplicative, supplementary
United States	36%	63%	2.7%	No	Complementary, supplementary
Average	**74.2%**	**22.9%**	**6.9%**		

3.4 Literature review findings: Social health insurance system

Mandatory social health insurance is the main vehicle for the provision of social health protection in most of the countries reviewed. The average population coverage of the 35 countries included in the review was 74.2%. The average was 75.6% (range 1-100%) in ASEAN countries, 93.8% (range 35.6-100%) in OECD countries, and 31.3% (range 3-87%) in African countries. 18 countries achieved a population coverage of 95% or higher through the social health insurance system.

Most countries (62.9%), especially high-income countries, base eligibility for the social health insurance system on citizenship or residency. Many countries include foreign nationals, either all foreigners residing in the country (such as in Brazil and Switzerland), foreigners who are employed in the country (such as in Chile and the Netherlands), or foreigners from countries with reciprocal agreements (such as in Australia). In other countries (37.1%), especially low-income and lower-middle-income countries, social health insurance eligibility is based on membership in certain population groups such as workers in the formal private sector and civil servants (such as in Thailand), individuals and households with incomes below a certain level (such as in Cambodia), and by age group (such as in the United States' Medicare program for people older than 65 years).

Only two out of 35 countries (Chile and France) provide the possibility to access a higher level of benefits within the social health insurance system. In France this system has been designed to help the poorest to be financially protected. How this works in practice is described in Box 2. In Chile, members can choose among four different income-based plans, with benefit variations occurring in the level of co-payment and use of private providers.

Box 2: Providing additional benefits through the social health insurance system: The case of France

In France, "Securite Sociale" provides health protection for all. The benefit package is relatively comprehensive, but co-payments remain high (e.g. 35% on medicine, 30% of consultation with GP), leading a majority of the population (96%) to sign up for complementary and/or supplementary coverage through health mutuelles to access a higher level of financial protection. For those who cannot afford complementary coverage, "Securite Sociale" provides additional coverage (full subsidies through the CMU-C scheme, based on income thresholds) or subsidizes the purchase of voluntary complementary private health insurance by offering a "cheque" to low-income members.

	CMU-C (fully paid by Social Security)	ACS (Partially subsidized)
Eligible population	Very low income – no capacity to purchase complementary coverage	Low income but with some contributory capacity
Conditions for access	income threshold, stable and regular residency in France	Same but with different income threshold
Benefits	100% coverage of benefits included in BP (waiver of all co-payment); Additional advantage (e.g free public transport) Provision by statutory social security	Benefits: waiver on co-payments, 3 different packages Subsidized premium to purchase complementary coverage with selected mutuelles (cheque)
Modalities to access benefits	Show Health Insurance card + CMU-C (or ASC) certificate. Third-party payment applies.	

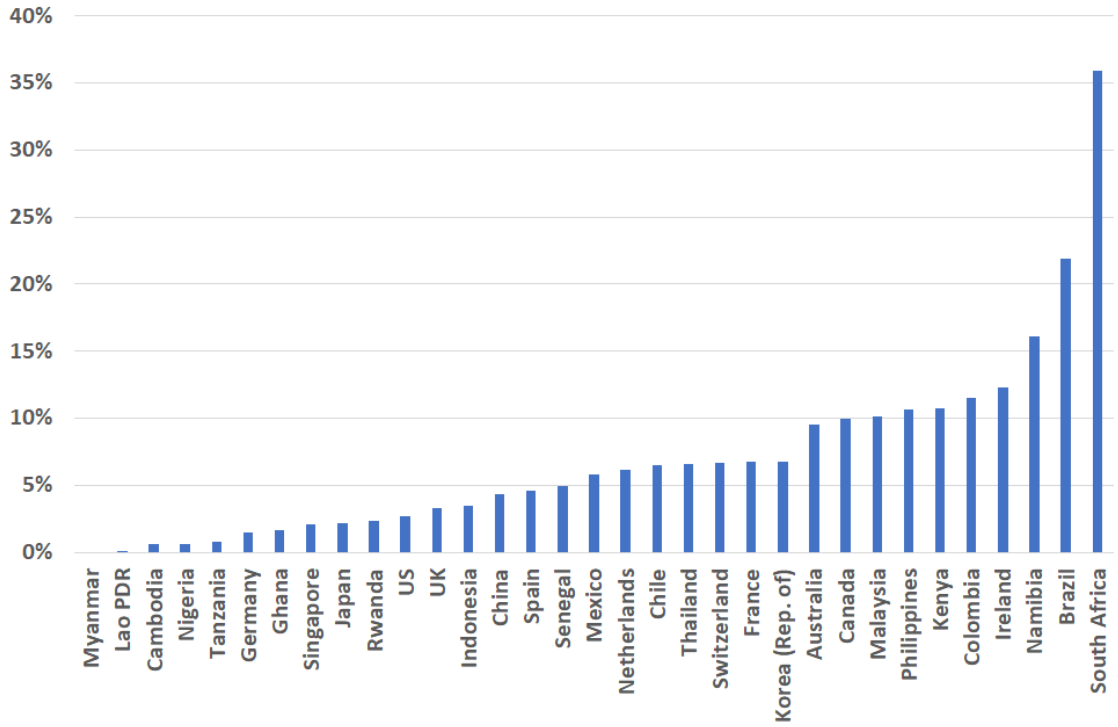
Four of 35 countries (11.4%) allow opting out of the social health insurance system to be covered by private voluntary health insurance only, under strict conditions (Chile, Colombia, Germany, and the United States). In Chile, members can select insurance plans from different private companies with varying plans and levels of coverage. However, in addition to the private insurance premium, they will still have to contribute 7% of their wages to the social health insurance system. In Germany, opting-out is only possible for those with yearly income higher than EUR 60,750. Re-entering into the social health insurance is possible under strict conditions. Premium are then based on health status. For these reasons, 92% of the population opted for coverage under *Gesetzliche Krankenversicherung* the main social health insurance scheme. As explained above, there are considerable risks and challenges to moving towards UHC if coverage by private voluntary health insurance only is allowed.

3.5 Literature review findings: Private voluntary health insurance

Private voluntary health insurance spending

All countries allow the purchase of additional coverage through voluntary private health insurance. Its contribution to current health expenditure shown in Figure 4 highlights significant variation across the sample from 0% to more than 35%. Private voluntary health insurance spending accounts for on average 6.9% of current health expenditure (WHO Global Health Expenditure Database). Africa accounts for the largest share (9.1%), followed by OECD (6.0%) and ASEAN (4.2%).

Figure 4: Voluntary health insurance spending as a share of current health expenditure, 2016



Source: WHO Global Health Expenditure Database

Population coverage

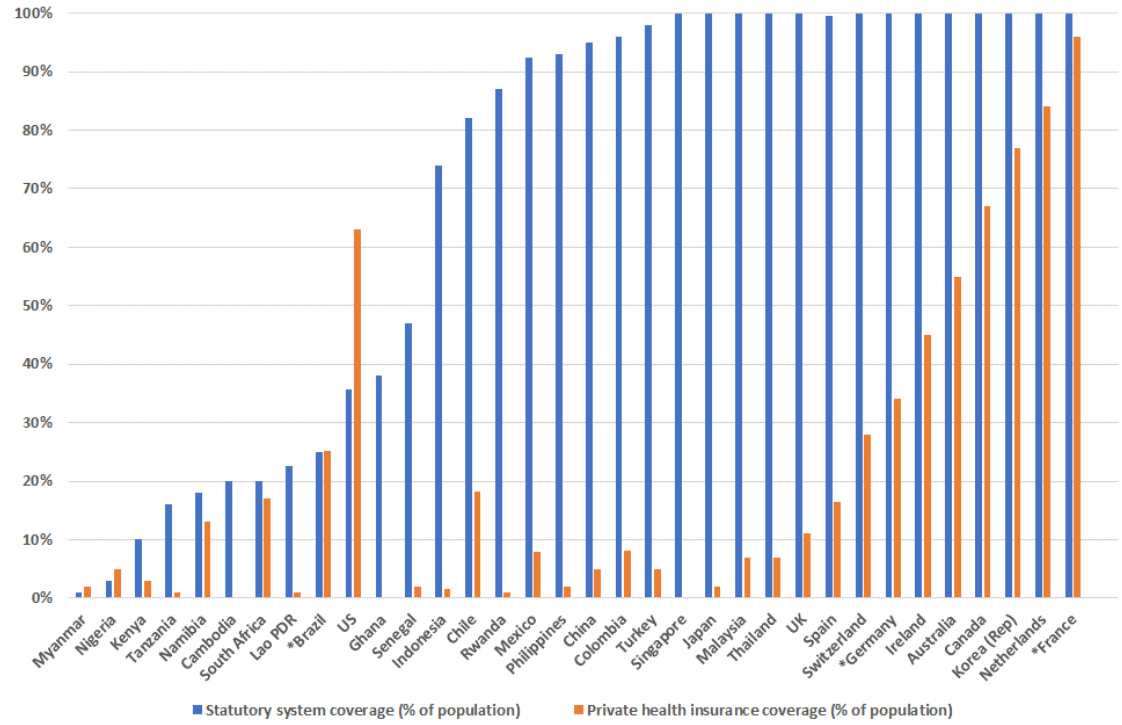
The average population coverage of private voluntary health insurance for the 35 countries is 22.9%, as illustrated in Figure 4. However, there are large differences between categories of countries. Coverage is 40.6% in OECD countries, 6.0% in Africa, and 3.4% in ASEAN.

The Netherlands (84%), the Republic of Korea (77%), the United States (63%), and Germany (34%) reach more than 30% of the population through private voluntary health insurance. Average coverage of private voluntary health insurance varies by income group: low-income 14.8%, lower-middle income 2.4%, upper-middle income 10.6%, and high-income countries 45.9%. Eight lower-middle and low-income countries in this sample have private health insurance population coverage rates of 5% or lower.

Type of coverage

The United States is the only country to have **principal** private voluntary health insurance coverage, which is reflected in Figure 5 as the only country where private insurance exceeds social health insurance system coverage (35%). In six countries (17.1%), private voluntary health insurance coverage was duplicative (Australia, Ghana, Indonesia, Ireland, Mexico, United Kingdom). In four countries (11.4%), coverage was substitutive (Chile, Germany, Spain, South Africa). Substitutive and principal coverage include inpatient care, outpatient care and medicines, but sometimes does not cover certain medical devices and mental health care.

Figure 5: Coverage of social health insurance system and private health insurance (% of population)



Source: Review matrix

In the other countries, private voluntary health insurance plays a secondary role in providing social health protection to citizens.

- In many countries, private voluntary health insurance coverage was both supplementary and complementary (such as in Colombia, France, and Japan).
- Coverage was supplementary in 28 countries (80.0%). In some countries, supplementary coverage offers faster access to a provider (such as in Ireland, Spain, and the United Kingdom), choice of provider, access to both public and private providers, and/or private or semi-private rooms in public hospitals (such as in Canada and Colombia).
- Coverage was complementary in 21 countries (60.0%). Complementary private health insurance covered all or part of the cost of benefits not covered by the social health insurance system and covered co-payments in many instances (such as in the Republic of Korea and the Netherlands). Complementary coverage included reimbursement for hospitalization, consultations, exams, pharmaceuticals, long-term care, rehabilitative care, dental care, optical care and devices, and alternative medicine (such as in Mexico).

Box 3 provides a description of the type of benefit coverage provided by private health insurance in France.

Box 3: Types of coverage by private voluntary health insurance – The case of France and Japan

France is one of the largest markets for private voluntary health insurance, which provide coverage in addition to what the mandatory social security covers. Private health insurance covers 96% of the population. Private voluntary health insurance accounted for 6.7% of current health expenditure in 2016. The publicly financed health insurance scheme provides almost universal coverage. The social health insurance benefits package is considered generous in terms of the scope, but user fees are applied to most services in the form of co-insurance (the member has to pay a percentage of the charges, as opposed to co-payments, which are set at fixed amounts) for inpatient services, extra-billing, and deductibles for outpatient services. Co-insurance rates can be as high as 30-40% for services and 35-70% for drugs.

Private voluntary health insurance offered by mutual benefit associations (mutuelles de santé) has existed in France since the 19th century and by 2010 90% of the population was covered. All private voluntary health insurance plans offer complementary cover of user charges; many cover supplementary amenities (hospital accommodation in a single room) and a few cover services not covered by the social health insurance scheme. People mainly buy private health insurance for protection against user charges for publicly financed health services. Many private health insurance plans also cover supplementary amenities, such as private hospital rooms. With the saturation of the market, some insurers now offer benefits not covered by the social health insurance scheme. Most plans fully cover co-insurance (based on statutory rates), but there are variations in coverage of the costs of some medicines, medical devices, and extra-billing varies. As for any private voluntary health insurance system, there is a risk of patient moral hazard.

In Japan, private voluntary health insurance covers co-payments (such as for hospitalization and surgery) or non-covered costs and has a fixed payment per days in hospital or per surgery performed, rather than per actual expenditure. Private voluntary health insurance also covers transportation, food and loss of income due to absence from work not covered by the national health insurance system. Some schemes also payout a lump sum for long-term illness.

In Australia, private insurance companies offer a wider range of health care options and more comprehensive cover, such as choosing provider, dental examinations and treatment; most physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology services; acupuncture (unless part of a doctor's consultation); glasses and contact lenses; hearing aids and other appliances; and home nursing. Private voluntary health insurance provides access to both private and public hospitals.

Sources: European Observatory on Health Systems and Policies (2015), Sagan & Thomson (2016), WHO Global Health Expenditure Database

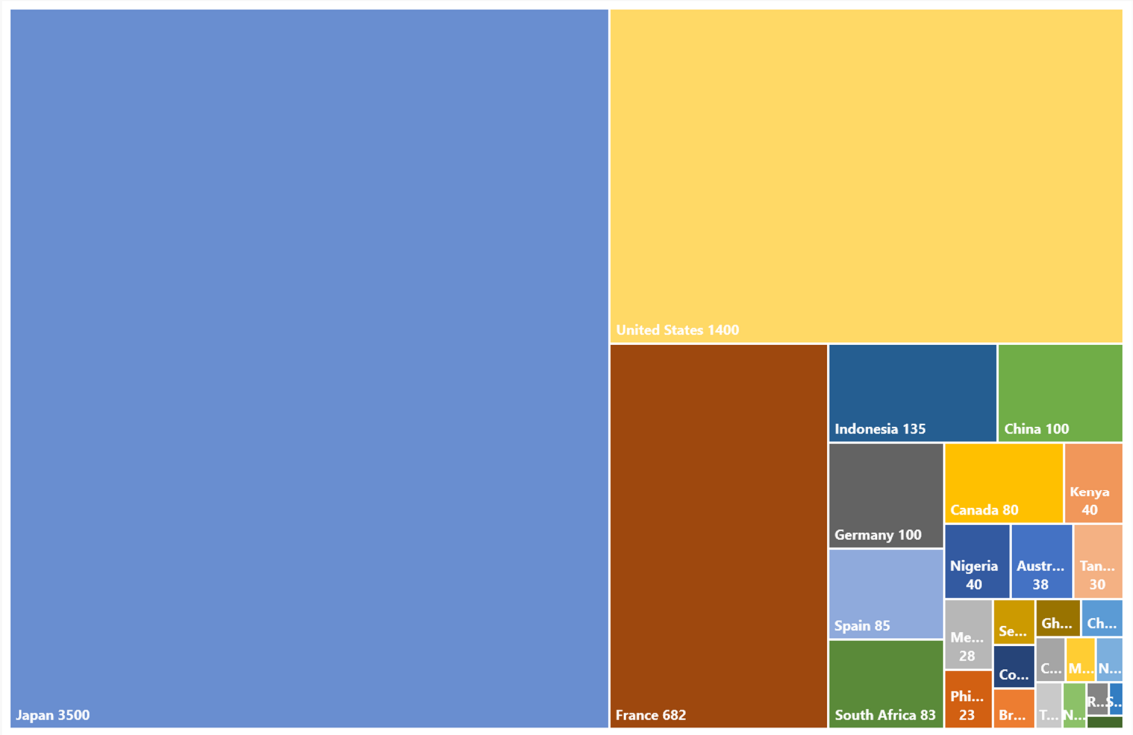
Other benefit coverage

A few countries covered specific diseases. For example, in Namibia private health insurance covers HIV/AIDS benefits. In some countries (such as in Japan, the Philippines, and Switzerland), private health insurance covers loss of income due to illness.

Number of private insurance companies

The average number of private health insurance companies in the 35 countries was 232 (range from less than 10 to 3,500). The mean is higher than the median (14) because of a high concentration of private health insurance companies in Japan (3,500 companies), the United States (1,400), and France (682) (Figure 6). In 32 countries (91.4%), the companies were commercial, for-profit in nature. In six countries (17.1%), not-for-profit entities offered private health insurance. Three countries (8.6%) had HMOs and three countries had mutual associations.

Figure 6: Number of private voluntary health insurance companies by country



Source: Review matrix

Unit of enrolment

The most common unit of enrolment is the individual (20 countries, 57.1%), such as in the Republic of Korea and Malaysia. Some countries also enrolled by group (9 countries, 25.7%), such as in Spain and Tanzania, and by household (7 countries, 20.0%), such as in Nigeria.

Premiums

Health insurance premiums can be either individually rated or community rated. In 32 countries (91.4%), premiums are individually risk-rated (such as in Namibia and the Netherlands). Individually rated premiums are calculated based on each's individual risk of requiring health care (which is influenced by factors such as age, gender, pre-existing conditions, etc.). In three countries (8.6%), community-rated premiums are applied (Australia, Ireland, and South Africa). Community rated premiums means that the premium amount is the same for all members of the same policy, regardless of their health risks. The rationale for community rated premiums is to ensure that no

one is excluded from health insurance based on their health status. Box 4 describes premium setting in private voluntary health insurance in Mexico, Rwanda, and Switzerland.

Box 4: Setting premiums in private voluntary health insurance – The example of Rwanda, and Switzerland

In Rwanda, the maximum amount of the premiums to be charged is determined by the authority regulating insurance business (National Health Insurance Council and Rwandan Social Security Board. Law No 48, which governs the organization, functioning, and management of health insurance schemes in Rwanda, prohibits insurance companies from denying a person or a group of persons access to health insurance based on discrimination of any kind.

In Switzerland, for supplemental coverage, private insurance companies can set premiums based on individual risks, and they can refuse enrolment to applicants based on medical history including preexisting diseases are often excluded from coverage. For primary coverage, no variation by health status is permitted with exceptions allowed for some variation for children and students, and for geographic area.

Sources: Machado (2018), USAID (2016)

Providers and reimbursement mechanisms

In 34 countries (97.1%), private health insurance covered private providers. In 22 countries (62.9%), private health insurance also covered public providers. Most countries use a combination of mechanisms to reimburse providers for services covered by private health insurance. Fee-for-service was used in 24 countries (68.6%), but in most countries private insurance companies apply mechanisms such as pre-approvals and caps to control costs. Other reimbursement mechanisms included capitation (9 countries, 25.7%), DRGs (5 countries, 14.3%), and per diem (4 countries). A mechanism whereby the patient pays the provider and gets reimbursed by the insurance company after they submit the bills was used in four countries. Table 4 describes the main advantages and disadvantages of different provider payment mechanism. Box 5 illustrates how provider payment mechanisms are applied by private insurance companies in Indonesia, South Africa, and the United States.

Table 4: Potential benefits and risks of different provider payment mechanisms

Payment mechanism	Definition	Potential benefits	Potential risks
Fee-for service	Providers are paid per service	Incentive to provide services	Providers have incentive to overprovide services, which increases costs
Capitation	Providers are paid lump sum to treat a certain number of people for a certain period of time	Administratively simple, incentives to control costs by prioritizing preventive care	Incentive to underprovide services to increase profit
DRGs	Providers are paid a certain amount for a certain group of diagnoses	Incentive to provide services, more nuanced than fee-for-service	Providers can game system, heavy administrative and information burden
Per diem	Providers are paid a daily amount per admitted patient	Administratively simple	Incentive to retain patients longer than medically necessary

Box 5: Provider payment mechanisms in private voluntary health insurance – The example of Indonesia, South Africa, and the United States

In Indonesia, private insurance companies use a mix of provider payment mechanisms, including fee-for-service, capitation, and per diem. Capitation is used for primary care and a negotiated fee schedule is applied to reimbursement of secondary and tertiary care. When patients pay providers and then get reimbursed by the insurance company, fee-for-service or per diem is used.

Private insurance companies in South Africa use a mix of fee-for-service, capitation (for general practitioners to service lower income groups, DRG payments and per diem are used by a few schemes to reimburse private hospitals.

In the United States, providers are reimbursed by insurance companies through fee-for-service, capitation, and per diem. Primary care physicians and specialists are reimbursed through fee-for-service or capitation, while hospital services are primarily paid through per diem negotiated between each hospital and insurer on an annual basis

Sources: Asia-Pacific Observatory on Health Systems and Policies (2017), McIntyre et al (2018), Sagan & Thomson (2016)

Legal and regulatory framework

Regulation of private voluntary health insurance has three main goals. First, ensuring market stability by setting financial and non-financial standards for insurer entry and operation; conditions for insurer exit; and requirements for financial reporting, scrutiny and oversight. Second, protecting consumers by governing insurers' marketing practices and their relations with health service providers. Third, ensuring affordable access to VHI through a wide range of rules, including: open enrolment (guaranteed issue); lifetime cover (guaranteed renewal); community rating (delinking premiums from individual risk of ill-health); premium review, approval or caps; mandated (usually minimum) benefits; prohibition of exclusion of pre-existing conditions from cover; caps on user charges for VHI-covered services; prohibition of benefit ceilings.

Regulation of private health insurance market is necessary to ensure that insurers' practice to minimize their risk to avoid losses, including denial of coverage for applicants who have preexisting health conditions is not detrimental to access and equity. It is necessary to ensure overall consumer protection by ensuring that insurers are financially solvent, capable of prompt payment of claims and to employ fair claims handling practices. Regulations implemented by the Ministry of Finance (MOF) in Vietnam are meant to ensure that private health insurance have adequate reserves of funds to pay claims.

Thirty-one countries (88.6%) had a specific law covering private health insurance. In most countries, private health insurance was regulated by authorities regulating all insurance products (such as the China Insurance Regulatory Commission and the Namibia Financial Institutions Supervisory Authority). In a few countries, private health insurance is regulated by the Ministry of Health or similar in five countries (such as the Health Insurance Bureau, Ministry of Health, Labor and Welfare

in Japan and the Ministry of Health in Singapore) and by the Ministry of Finance or similar in three countries (such as the Ministry of Economy and Finance in Cambodia). Box 6 provides examples of regulation of private health insurance in China, Japan, and Malaysia.

Box 6: Regulating private voluntary health insurance – The example of Europe and Asia

In Europe, private voluntary health insurance is regulated exclusively as a financial service in most countries and regulatory bodies are typically financial supervisory authorities, central banks or insurance regulators under the jurisdiction of the Ministry of Finance. In recent years, health regulators have been replaced by financial regulators in France (2010) and Ireland (2015). National regulation that goes beyond general insurance requirements mainly aims to improve affordable access to private voluntary health insurance. It is concentrated in markets with a strong mutual or non-profit-making insurer presence (e.g. France, Ireland) and where the market plays a substitutive role (Germany) or a complementary role covering user charges (France). The intensity of regulation has increased in all these countries in the last 10 years, especially in France, Germany, and Ireland.

In China, private health insurance is regulated by the China Insurance Regulatory Commission (CIRC), which regulates all types of insurance. Commercial health insurance emerged in the 1980s. With increasing demand for health insurance, various kinds of health insurance plans by different insurance companies have appeared. In August 2006, the CIRC issued the Health Insurance Regulation to set up a uniform regulatory standard for operation of property insurance, life insurance, and health insurance companies. The regulatory framework governs the definition of benefit packages and the reimbursement level of health insurance schemes. Benefit packages of social health security programs are defined by local governments based on principles set by the central government and program implementation is overseen by the local authorities.

In Japan, the health sector through the Health Insurance Bureau, Ministry of Health, Labor and Welfare, regulates private health insurance. The central government sets the nationally uniform fee schedule for insurance reimbursement and supervises local governments, insurers and health-care providers.

In Malaysia, private health insurance is regulated by the Central Bank. The Private Health Care Facilities and Services Act 1998 requires insurance companies to register and furnish information to the MOH, and they may be liable to legal action if it engages in unethical conduct.

In Rwanda, specific clauses have been added to the regulatory framework to ensure consumer protection against discriminatory practices.

Sources: Asia-Pacific Observatory on Health Systems and Policies (2009, 2013), Choi et al (2018), Sagan & Thomson (2016)

4. Conclusions and recommendations

The Social health insurance basic package that is currently provided by VSS is a core element of Vietnam's social protection system and is enshrined in Article 58 of the Constitution (2013): "The state shall provide health insurance for the entire population." Diversified packages are therefore considered as packages in addition to the basic package already covered under the Constitution. It is important that the SHI Law protect this constitutional right by enforcing compulsory SHI insurance for a basic package and restricting additional packages to cover items (or providers) not already covered in this basic package. Allowing people to obtain substitutive coverage would undermine the strong financial protection and risk pooling of Vietnam's current SHI scheme. Additionally, the basic SHI fund should not be put at risk of paying out for additional benefits, which requires that any additional package fund should be administered independently of the basic SHI fund.

Very few countries are providing additional benefits coverage through the social health insurance system. Accessing a higher level of financial and benefits protection is most often left to the private sector through voluntary health insurance.

This review has argued that there are two main options for Vietnam to consider when determining if and how to provide additional benefits coverage. In option 1, an additional benefit package could be provided through VSS health insurance. In option 2, additional benefit packages would be left to private companies offering voluntary health insurance policies. Given the potential benefits and risks of each option summarized in Table 1, and based on international experience, this review recommends the adoption of option 2. The provision of an additional benefit package through social health insurance would pose serious threats to equity in health financing among the citizens and residents of Viet Nam.

#1. It is recommended to preserve the current design of the health Insurance scheme, which is compliant with principles of equity and solidarity in financing and access to benefits, on the basis of a single risk pooling. **It is recommended not to create additional and/or different benefit packages within the current social health insurance system.**

#2. It is recommended to let citizens and residents purchase private health insurance policies on a voluntary basis to access a higher level of protection – as a complement to mandatory statutory coverage, and **without giving the possibility to opt-out of VSS**.

Certain policy and regulatory components need to be in place to effectively harness the potential benefits of private health insurance.

#3. The country's health financing policy framework should provide clarity on what will be publicly funded so that the space for the private health insurance market to provide additional coverage is identified, with the aim of voluntary funds being complementary to public funds and contributing to an explicit public goal of sustainable and equitable financing for UHC.

#4. Voluntary funds should be complementary to public funds to contribute to UHC goal and the government should carefully consider if it wants to provide any subsidies to private health insurance premiums to prevent public funding being captured by the better off.

#5. A robust regulatory framework is needed to address or minimize the potential negative effects of private health insurance (adverse selection, cost-escalation, brain drain from the public to private sector within the country, the creation of a two-tier health system, etc.). This should include consideration of how public and private sectors can cooperate to support greater access to skills and competencies needed by an expanding health care industry, with a specific focus on youth, women and migrant workers.

#6. Policy objectives around private health insurance should be aligned with UHC policy objectives across different sectors and ministries.

#7. Systematic engagement between the public sector and private health insurance companies in the design and implementation of policy and regulatory frameworks should be encouraged. This engagement should include issues such as design policies and regulatory frameworks for benefit package definitions, premium-setting, and provider payment. Finally, coordination and information-sharing between different government institutions with a stake in managing and regulating private health insurance should be enhanced, for example by strengthening intra-governmental platforms and focus on UHC.

As next steps, it is proposed to carry out further in-depth case studies in key areas such as regulation of private voluntary health insurance for consumer protection and potential modalities for integration and coordination between VSS and private insurance companies, and to conduct focused consultations with key stakeholders.

Finally, given the challenges in finding information for some countries, especially low and middle-income countries, in combination with some information not being completely up-to-date suggests that there is a need for additional, systematic, and regular collection and analysis of data and information on private voluntary health insurance. Even among high-income European countries only five countries (France, Germany, Ireland, the Netherlands, and Switzerland) have central sources of comparative information about voluntary health insurance products from 2012 or later.

5. References

Note: References that informed the matrix are presented in an annex to the matrix.

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Annex 1: Country list

Country	Category
Australia	OECD
Brazil	Latin America
Brunei Darussalam	ASEAN
Cambodia	ASEAN
Canada	OECD
Chile	OECD
China	Other Asian
Colombia	Latin America
France	OECD
Germany	OECD
Ghana	Africa
Indonesia	ASEAN
Ireland	OECD
Japan	OECD
Kenya	Africa
Korea (Republic of)	OECD
Lao PDR	ASEAN
Malaysia	ASEAN
Mexico	OECD
Myanmar	ASEAN
Namibia	Africa
Netherlands	OECD
Nigeria	Africa
Philippines	ASEAN
Rwanda	Africa
Senegal	Africa
Singapore	ASEAN
South Africa	Africa
Spain	OECD
Switzerland	OECD
Tanzania	Africa
Thailand	ASEAN
Turkey	OECD
United Kingdom	OECD
United States	OECD

Annex 2: Matrix

See separate Excel-file.