International Labour Organization

Fostering inclusion : Advancing social health protection for persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam

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Executive summary

Social health protection is a critical measure to achieve both universal health coverage and universal social protection. Rooted in international human rights instruments and international social security standards, the concept of social health protection designates a series of public or publicly organized and mandated private measures to achieve:

- effective access to quality healthcare without hardship; and
- income security to compensate for lost earnings that can result from the need to maintain or restore health (ILO 2008a).

Countries across Asia and the Pacific have made significant progress in recent years in extending the coverage of social health protection schemes. A comprehensive regional analysis undertaken by the ILO (2021) describes a wide range of approaches used, including extending coverage of contributory schemes to the informal economy and extending tax-financed measures to different groups of the population. In many cases, this has led to significant increases in coverage and has had impacts on indicators related to financial protection, including out-of-pocket and catastrophic health expenditures. Nevertheless, significant gaps remain. Around 950 million people – a quarter of the population in Asia and the Pacific – remain excluded from legal entitlements; while 77 per cent of persons worldwide who were pushed into poverty by out-of-pocket health spending in 2019 were found in this region.[1] A critical question is the extent to which persons with disabilities are able to access the social health protection measures that are already in place across the region.

This report explores the extent to which persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam are able to access social health protection. Persons with disabilities typically have higher healthcare needs, which – without adequate social health protection mechanisms in place – can translate into poverty and worse health outcomes. While countries across Asia and the Pacific have made significant progress in extending social health protection, the extent to which these measures have benefitted persons with disabilities has been less explored. In order to better understand these issues, the report combines a review existing literature, research and data analysis with new qualitative field work, including focus group discussions with persons with disabilities and with caregivers in the three study countries.

Context

Persons with disabilities across the three study countries face considerable barriers to participation in society on an equal basis with others. All three countries are on a journey to understanding the scale, nature and impacts of disability, but, some common issues stand out. There is substantial diversity in the nature of disability in terms of the types of impairments, the degree of functional limitations and support needs. As in other countries, the prevalence of disability is higher among women, and increases significantly at more advanced ages. Persons with disabilities face significant barriers to participating in education and in the labour market, resulting in lower levels of literacy and being less likely to be in employment. These factors – alongside the healthcare costs discussed in this report – contribute to higher levels of poverty among persons with disabilities than those without disabilities.

Persons with disabilities have higher healthcare needs than those without disabilities. This includes both a higher need for general healthcare services and for more disability-related provisions, such as rehabilitation and assistive devices. This is borne out in quantitative indicators in Cambodia and Viet Nam, and emerged strongly in the focus group discussions with persons with disabilities conducted for this research. Multiple persons with disabilities reported having to make frequent visits to medical facilities, although this varied substantially depending on the nature of disability.

[1] According to data from the World Health Organization (WHO) Global Health Observatory, of the 56 million people pushed below the US$1.90 a day poverty line by household health expenditures across the globe in 2019, 44 million were in Asia (WHO, n.d.-c).

All three countries define rights to healthcare in disability-related legislation, but disability is largely absent from social health protection legislation. All three countries have dedicated laws on disability that articulate rights in relation to healthcare and rehabilitation with varying levels of specificity. By contrast, legislation guiding the social health protection systems do not make specific reference to disability in any of the three countries. While this may not necessarily preclude disability-specific components within social health protection arrangements (as in Viet Nam), it arguably limits the extent to which these systems can be actively inclusive of persons with disabilities and combat stigma, discrimination and attitudinal barriers. One consequence is that organizations of persons with disabilities do not have a formal role in social health protection policymaking, even if they may have been included in policy discussions in the three countries in an ad hoc fashion.

Population coverage

Social health protection coverage among persons with disabilities is strongly related to coverage among the population as a whole. In the Lao People's Democratic Republic and Viet Nam, population coverage has reached over 90 per cent, with similar – if not higher – coverage among persons with disabilities. A key enabling factor in both countries was the establishment of a legal framework and policy measures to achieve universal coverage. Cambodia has larger gaps, with less than half of the population covered – although evidence suggests coverage is comparatively higher among persons with disabilities. A recently-launched Roadmap Towards Universal Health Coverage in Cambodia seeks to address these wider gaps in coverage (Cambodia, Government of Cambodia 2024).

Coverage by non-contributory public health insurance is higher among persons with disabilities than among those without disabilities. In Viet Nam, this is mainly due to the fact that recipients of social allowances for persons with disabilities are automatically enrolled into the public health insurance scheme as a fully-subsidized group. Meanwhile, the poverty-targeted Health Equity Fund in Cambodia is more likely to reach persons with disabilities than those without due to the higher levels of poverty faced by persons with disabilities, as well as adaptations made to the targeting process to include them. By contrast, coverage under contributory public health insurance tends to be lower among persons with disabilities given the barriers that they face to securing employment, especially formal employment, which de facto results in lower contributory capacities and limited access to social security.

Recognition of disability status as a criterion for access to subsidized health protection coverage can play an important role in extending coverage, but requires accessible and inclusive disability assessment systems. Viet Nam provides the most established example of disability certification providing a gateway to health insurance coverage. Cambodia's newly established Disability ID Card has the potential to play a similar role, however, the understanding that this provides entitlement to free healthcare does not appear to be formal government policy. The Lao People's Democratic Republic is in the process of developing a disability card system that could also provide a channel to healthcare entitlements. In all of these cases, it is critical to build disability assessment and determination systems which are accessible, inclusive in approach and reliable, and countries must clearly define the entitlements linked to disability cards/certification. While there is room for improvement, the community-centred models of disability assessment and determination used in Cambodia and Viet Nam have positive attributes in line with international standards, including moving away from purely medical models and making assessment processes more accessible.

Benefit packages and availability of services

Persons with disabilities require both general healthcare goods and services, as well as goods and services that are specifically related to their disability – such as rehabilitation and assistive devices. The type of healthcare required varies substantially among persons with disabilities. While social health protection benefit packages in the three countries cover a relatively comprehensive set of goods and services from primary to tertiary levels, in all cases there are exclusions that may particularly affect persons with disabilities, including the costs they incur in accessing healthcare (see below on financial protection). Many persons with disabilities reported having to pay for general services that were excluded from social health protection benefit packages.

The extent to which rehabilitation services and assistive devices are included in social health protection packages varies across the three countries. Viet Nam has integrated rehabilitation within the benefit package of its health insurance scheme, and provision of such services is more integrated within the public health system than in Cambodia or the Lao People's Democratic Republic. Nevertheless, assistive devices remain largely excluded from Viet Nam's health insurance package, while provision of rehabilitation services remains uneven across different parts of the country. In Cambodia and the Lao People's Democratic Republic, social health protection packages contain minimal provision for rehabilitation and assistive devices. In both countries, rehabilitation services and assistive devices are mostly provided via rehabilitation centres, and referral pathways from the wider health system are often not in place. There is also a heavy dependence on international organizations for financing of these systems (especially in the Lao People's Democratic Republic). In general, there provision of rehabilitative services and assistive devices remains unpredictable and there are geographical inequities in access.

Across the three countries, provision of rehabilitation and assistive devices has a greater emphasis on physical impairments, although there are some moves to expand the scope. The emphasis on physical impairments partly relates to the history of conflict in the three countries, and the related issue of unexploded ordnance. An expansion of the scope of the rehabilitation services and assistive devices provided is important given the diverse nature of disability, and the epidemiological transition associated with demographic ageing.

Persons with disabilities are particularly affected by issues of service quality in the delivery of health services. Issues related to physical accessibility in healthcare facilities (such as a lack of ramps, appropriate toilet facilities and lack of seating) create major barriers for persons with physical disabilities. Healthcare staff also commonly do not have the appropriate skills, knowledge and attitudes to support persons with disabilities – such as a lack of sign language interpretation or lack of understanding of intellectual disabilities. There was a mixed picture across the three countries in terms of whether persons with disabilities are prioritized over other patients. These issues applied both to general healthcare facilities as well as those providing more specialist services, such as rehabilitation.

Financial protection

The costs of healthcare for persons with disabilities need to be understood in the context of broader gaps in financial protection when accessing healthcare in all three countries. Out-of-pocket expenditures are relatively high in all three countries, at between 42 and 64 per cent of current health expenditure. Gaps in population coverage and benefit packages mean that persons with disabilities are often even more exposed to these high costs. Available data from Cambodia also shows that levels of catastrophic health expenditure are more elevated among persons with disabilities than among those without disabilities, something that is reflected in other countries in the wider region and the world.

Qualitative data shows that both the medical and non-medical costs associated with accessing healthcare can be substantial. While many persons with disabilities describe an important level of financial protection provided by social health protection schemes, a variety of costs remain, including:

- **Medical costs:** Persons with disabilities covered by social health protection schemes often have to cover the cost of goods and services not included in benefit packages, or for which rates of co-payment are higher. Many also resort to paying for private healthcare and purchasing medicines in pharmacies due to factors such as the availability of relevant services, service quality and convenience. A tendency to pay for higher-level service providers was also observed in Viet Nam, linked to challenges in obtaining referrals.
- **Non-medical costs:** The cost of transportation can be high, particularly for those in remote areas and because most transportation options are not adapted for persons with disabilities. Many persons with disabilities also require assistance from family members or interpreters in accessing health facilities. Non-medical costs may also include loss of income resulting from taking time off of work to seek care, although this did not emerge prominently in the field research.

In the context of these costs, the main coping strategies are to forego healthcare, or to resort to family support and indebtedness to cover these costs.

Cash benefits can play an important role in covering some costs related to accessing healthcare. However, their potential is limited by gaps in adequacy and coverage. Cash benefits are most relevant in covering non-medical costs. However, while not their primary objective, they may also contribute to covering medical costs when social health protection systems offer limited protection in terms of benefits or level of financial protection. Two of the study countries have non-contributory cash benefits in place that benefit persons with disabilities. Viet Nam's non-means-tested disability allowance provides a relatively predictable source of income to those assessed as having moderate or severe disability. The landscape of cash benefits in Cambodia is evolving, but remains focused on poverty-targeted household benefits, albeit with adjustments to account for disability. The role of cash benefits in covering healthcare-related costs is more evident in Viet Nam due to the higher coverage of the disability allowance, and also its higher benefit level. Nevertheless, the benefit adequacy for both schemes is below the global average for disability benefits, with recipients generally describing them as only making a partial contribution to covering the healthcare-related costs that they face.

Long-term care

The legal framework for long-term care remains very limited across the three countries. While laws on disability make some reference to care and support services, dedicated legislation on these services is largely absent. Reflecting the legal framework, in practice there are very limited formal care and support services in place in all three countries. Existing services are primarily provided by non-government organizations, although Viet Nam has some residential care facilities and nursing homes.

Existing care and support to persons with disabilities is almost exclusively provided by family members. The requirements for accessing care and support services varied significantly among focus group discussion participants, from those with minimal requirements for care and support, to those with significant difficulties with activities of daily living that require significant care. The focus group discussions and available quantitative data indicate that care and support is mainly provided by family members, and sometimes by friends and community members. The impact of caregiving responsibilities on family members can be significant, including sometimes requiring them to exit the labour market to provide support to persons with disabilities. There is an important gender dimension to care and support, with care providers being far more likely to be women, and women are also more likely to receive care and support from adult children in later life.

Recommendations

Population coverage

- **Countries should continue broader efforts to expand universal population coverage** of social health protection schemes, by putting a comprehensive legal framework and effective policies in place to meet these goals.
- While legal provisions on the scope of coverage should ensure universality without singling-out persons with disabilities, **specific provisions should be made to facilitate coverage of persons with disabilities and ensure non-discrimination**. This includes adjusting eligibility criteria and providing contribution subsidies.
- Given the significant extra health costs and other costs faced by persons with disabilities across the income distribution, there is a strong case to **remove means-testing requirements** for persons with disabilities to be included on a non-contributory basis.
- Countries should continue efforts to **build accessible, comprehensive and reliable systems of disability assessment, determination and certification**.
- There is a need for **greater clarity and effective communication** on social health protection entitlements. This involves more clearly defining the healthcare entitlements for persons with disabilities at a legal and policy level, including those linked to disability cards. It also requires

active awareness campaigns to sensitize persons with disabilities to their entitlements, with communication approaches appropriate to their needs and circumstances.

Benefit packages

- Steps should be taken to gradually **include a greater range of rehabilitation services and assistive devices in social health protection benefit packages**.
- Attention should also be paid to removing **exclusions of (or additional co-payments for) certain general health services** that persons with disabilities may have higher usage of. Indeed, given the more frequent need for healthcare services of persons with disabilities and the extra costs they are facing, there is **rational for considering covering disability-related and additional general services and goods for persons with disabilities**. Eligibility for such services could be linked to disability assessment and determination systems.
- Extending benefits packages to address the needs of persons with disabilities requires i**nvestments in making these services available, acceptable and of sufficient quality**.
- Countries may adopt a **progressive approach** to extension of benefits, considering fiscal constraints.
- **Evidence** on the cost-efficiency and pricing of assistive devices is crucial for guiding the revision of the benefit packages.
- Revision of benefit packages should be informed through **consultations with persons with disabilities or their representatives** to ensure they cover a broad scope reflecting the diversity of disabilities and medical needs.

Financial protection

- Improving financial protection will be strongly related to **improvements in population coverage and enhancement of the adequacy of benefits covered (both the scope of benefits and the level of financial protection)**, as well as addressing questions of service availability and quality.
- One measure for consideration is the **removal of co-payments** for persons with disabilities
- Countries should also ensure that **transport allowances and inpatient allowances** are extended to persons with disabilities, ideally without resorting to means-testing.
- Countries should seek to introduce or strengthen **social protection cash benefits** as a way that helps to cover non-medical costs associated with accessing healthcare. Of particular relevance is the need to strengthen the coverage and adequacy of cash benefits targeted at persons with disabilities, including those seeking to address the costs of care. Meanwhile, persons with disabilities will also benefit from efforts to strengthen mainstream benefits as part of a comprehensive social protection system, including benefits addressing old age, sickness and employment injury.

Long-term care

- Countries should take steps to **build a concrete strategic and legal framework** for both the provision of long-term care services - with a vision to progressively expand provision of formal Countries should take steps to **build a concrete strategic and legal framework** for the provision of long-term care services – with a vision to progressively expand provision of formal services – as well as the provision of financial protection for those in need of long-term care services.
- Efforts to expand provision of long-term care services need to **consider the role of different actors in both the healthcare system and the social welfare/affairs space** and their required coordination in the financing and delivery of services.

- Expansion of provision of long-term care services means **addressing labour shortages in the sector** as well as decent work deficits, particularly in relation to labour and social security rights.
- **Extending financial protection to long-term care** implies identifying which kind of care and support services may be covered as a matter of priority, and defining the financing and institutional models to administrate these benefits.
- By adopting a life-cycle approach, social protection systems can help prevent disabilities by **addressing social determinants of health**, ensuring effective and affordable access to long-term care, and promoting decent work within the care economy. This requires that social protection systems establish strong coordination among healthcare, social care, and other social and employment policies.
- There is also a need to **connect policy discussions on care and support services for persons with disabilities with discussions on long-term care for older persons** in relation to population ageing. Separating these discussions risks fragmentation in the provision of care and support services.

Cross-cutting recommendations

Legislation

- Steps should be taken to **actively include consideration of disability within social health protection legislation and adjust design parameters accordingly**. This can help to ensure that different elements of social health protection regulation relating to population coverage, service coverage and financial protection take specific account of disability-related issues.
- One concrete step would be to formally include persons with disabilities and their representatives as stakeholders in the formulation and implementation of social health protection schemes.
- Given that the implementation of social health protection schemes involves implementation by a range of organizations, **legal provisions supporting institutional coordination** can support access among persons with disabilities.

Financing

- Increasing population coverage, extending benefits and increasing the level of financial protection as recommended above require mobilizing additional financing resources. In pursuing universal coverage, **countries should consider specific government-funded subsidies to the contributions or tax-based financing** of healthcare for persons with disabilities. This can help prioritize population coverage for persons with disabilities.

Awareness-raising

- Information on entitlements is closely related to access to benefits. Awareness-raising campaigns should intentionally seek to reach out to persons with disabilities, using adapted communication approaches and media.
- Developing partnerships with organizations of persons with disabilities could be particularly instrumental to the development of communication strategies and tools.

Disability-inclusive administration of social protection

- Disability sensitization trainings would benefit social security officials, who in turn may initiate discussions within their institutions on necessary adjustments to the administration and implementation of the scheme in order to adapt to the specific needs of persons with disabilities.

- A comprehensive assessment of the compatibility of internal processes relating to registration, contribution payment, access to benefits, grievance mechanisms and so on, with the specific needs of persons with disabilities should be initiated, with the objective of adopting disability-inclusive operational procedures.

Data and research

- Steps should be taken to **systematically include indicators on persons with disabilities within health system administrative data**. In many cases, data on disability is not collected in healthcare data systems, or not routinely reported. Indicators on disability can be included by making linkages to disability certification, or by adding standard survey questions (such as the Washington Group questions) to management information systems. This should be done in a way that also allows for data to be disaggregated by other dimensions, including age and sex.
- Relatively minor **adjustments to national survey questionnaires** could provide a rich source of quantitative data on social health protection for persons with disabilities.

Acronyms

CRPD	Convention on the Rights of Persons with Disabilities, 2006
CSES	Cambodia Socio-Economic Survey
CT-PWD	Cash Transfer for Persons with Disabilities (Cambodia)
CTP-COVID	Cash Transfer for Poor and Vulnerable Households during COVID-19 (Cambodia)
GDP	gross domestic product
HEF	Health Equity Fund (Cambodia)
IDPoor	Identification of Poor Households Program (Cambodia)
LSSO	Lao Social Security Organization
NGO	non-governmental organization
NHI	National Health Insurance (Lao People's Democratic Republic)
NHIB	National Health Insurance Bureau (Lao People's Democratic Republic)
NSSF	National Social Security Fund (Cambodia)
OOPs	out-of-pocket expenditures
OPD	organization of persons with disabilities
PwD	persons with disabilities
SHI	Social Health Insurance (Viet Nam)
SSI	social security institution
UNICEF	United Nations Children's Fund
UHC	universal health coverage
VDS	Viet Nam Disability Survey
VSS	Viet Nam Social Security

1

Introduction

1.1. Background

Social health protection is a critical measure to achieve both universal health coverage and universal social protection. Rooted in international human rights instruments and international social security standards, the concept of social health protection designates a series of public or publicly organized and mandated private measures to achieve:

1. effective access to quality healthcare without hardship; and
2. income security to compensate for lost earnings that can result from the need to maintain or restore health (ILO 2008a).

Countries across Asia and the Pacific have made significant progress in recent years in extending the coverage of social health protection schemes. A comprehensive regional analysis undertaken by the ILO (2021) describes a wide range of approaches used, including extending coverage of contributory schemes to the informal economy and extending tax-financed measures to different groups of the population. In many cases, this has led to significant increases in coverage and has had impacts on indicators related to financial protection, including out-of-pocket and catastrophic health expenditures. Nevertheless, significant gaps remain. Around 950 million people – a quarter of the population in Asia and the Pacific – remain excluded from legal entitlements; while 77 per cent of persons worldwide who were pushed into poverty by out-of-pocket health spending in 2019 were found in this region.[2]

A critical question is the extent to which persons with disabilities are able to access social health protection measures that are already in place across the region. Persons with disabilities typically have higher healthcare needs than those without disabilities meaning that – where social health protection measures are weak – they are likely to face particularly high costs. These costs can lead persons with disabilities to forego healthcare and – alongside other disability-related extra costs – contribute to higher levels of poverty in households with persons with disabilities. These dynamics also create a major barrier to the participation of persons with disabilities in society and the labour market on an equal basis with others (UNPRPD 2023; Cote, Knox-Vydmanov and Lippi 2024). The importance of extending health coverage to persons with disabilities is encapsulated in a wide variety of human rights instruments and international social security standards, as well as the 2012 Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific. The Strategy represents the first set of regional development goals on disability. Of the ten goals included in the Strategy, Goal 4 on social protection sets out specific targets and indicators to increase the access of persons with disabilities to health services (including rehabilitation) and to other social protection programmes (ESCAP 2018).

This report summarizes research assessing the effectiveness of social health protection measures for persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam. The approach taken by this research is to evaluate the extent to which social protection measures cover persons with disabilities and provide adequate benefits and financial protection, while also exploring the role of these measures in providing long-term care services without hardship. This research comes as part of a wider project of the ILO supporting the extension of social health protection in Asia financed by the Government of Luxembourg. The research is the fruit of collaboration among research organizations within the framework of the CONNECT network for Social Health Protection in Asia. The three focus countries of the research were selected due to aspects of their respective national contexts, as well as interest from research partners within the CONNECT network. All three countries are lower-middle-income countries that have undergone major initiatives in recent years to extend social protection, but available analysis on the disability dimension of these developments is relatively limited.

The report is structured as follows. Section 2 provides context for the discussion by offering a summary of the situation of persons with disabilities in the three countries. Section 3 focuses on population coverage, describing the different channels through which persons with disabilities can access social health protection in the three countries, and their experiences with these channels. Section 4 explores the extent to which social health protection benefit packages include services that are relevant for

[2] According to data from the World Health Organization (WHO) Global Health Observatory, of the 56 million people pushed below the US$1.90 a day poverty line by household health expenditures across the globe in 2019, 44 million were in Asia (WHO, n.d.-c).

persons with disabilities, with a particular emphasis on rehabilitation services and assistive devices. In addition, section 4.3 assesses the level of financial protection provided by these schemes, by describing the different costs persons with disabilities incur, their consequences and the extent to which available cash benefits contribute to financial protection. Section 6 discusses the question of long-term care, mainly focusing on the extent of need for and provision of care and support in contexts with limited formal services. Finally, Section 7 provides conclusions and recommendations for improving social protection measures for persons with disabilities.

1.2. Methodology

The research framework is mainly orientated around the three dimensions of coverage: population covered, range of benefits covered and level of financial protection provided. The full set of research questions that guided the research is listed in Appendix 1. In addition to a set of research questions seeking to understand the context of disability, three sets of research questions are dedicated to population coverage, service coverage and **financial protection**. A final set of questions relate to the question of long-term care.

In order to explore these questions, the research employed a mix of qualitative research and a review of existing literature, legislation and existing data analyses. The qualitative research was led by three national research organizations: Agile Development Group in Cambodia, the Health Strategy and Policy Institute (HSPI) in Viet Nam and the Tropical and Public Health Institute (TPHI) in the Lao People's Democratic Republic. Agile Development Group is a social enterprise focusing on persons with disabilities, while HSPI and TPHI are both government research institutions sitting under each country's Ministry of Health. An international consultant led the literature review – with support from national research organizations – and also contributed to the design and analysis of qualitative data.

In total, 30 focus group discussions (FGDs) with a total of 277 participants were conducted across the three countries. Various factors were taken into consideration when sampling focus group participants:

- Sampling for the focus groups used one of **two main approaches**. In Viet Nam, participants were sampled from lists of persons with disabilities held by commune health stations, which mostly consist of those who have been certified as having severe or extremely severe disabilities. A limitation of this approach is that it does not provide insights into persons with disabilities who have not gone through this certification process. In Cambodia and the Lao People's Democratic Republic, focus groups were primarily sampled based on lists provided by organizations of persons with disabilities, non-government organizations and rehabilitation centres. An advantage of this latter approach is that it is less limited to individuals already connected to government services and systems. A disadvantage is that individuals connected to these organizations may already be among those with stronger access to services and better social connections and may live in less remote areas. These points are discussed in the interpretation of the results throughout the report.
- The participants were divided into focus groups based on **type of impairment**, as previous experience in Viet Nam and elsewhere has shown that such discussions tend to be more successful where participants have similar types of impairments.[3] The main impairment groupings used for this purpose were physical impairment, visual impairment and hearing impairment. In addition, some of the participants were caregivers (generally of children and adults with intellectual impairments), who were placed in their own focus groups. In Cambodia and Viet Nam, discussions were also conducted with recipients of work injury benefits to provide insights on this particular group covered by contributory social insurance arrangements.

[3] See, for example, Palmer et al (2015).

- In terms of **geographical location**, the research sought to incorporate some diversity in terms of rural and urban locations, although it the aim was not to be nationally representative. Indeed, the research does not include some of the most remote locations in the three countries, where access to services is likely to be most limited. Figure 1.1 gives a visual representation of the geographical locations of the where the FGDs were held in each of the three countries. Cambodia had the broadest geographical coverage of field work, including five provinces (Battambang, Kampong, Cham, Kampong Speu, Phnom Penh and Siam Reap). In the Lao People's Democratic Republic, the field work was divided between Vientiane Capital and Champasak Province in the south of the country. In Viet Nam, the field work focused on two provinces close to the capital of Hanoi: Phu Tho (an urban area) and Hung Yen (a rural area).
- The focus groups were sampled in order to provide a **balance of men and women**. Overall, 47 per cent of participants were men, and 53 per cent were women (table 1.1).
- The sampling approach was relatively open in terms of the **age** of participants. Across the three countries, the average age of participants was 36.8 years, ranging from an average of 31.7 years in Cambodia to 47.6 years in Viet Nam.[4]

Table 1.1. Key indicators on focus group participants

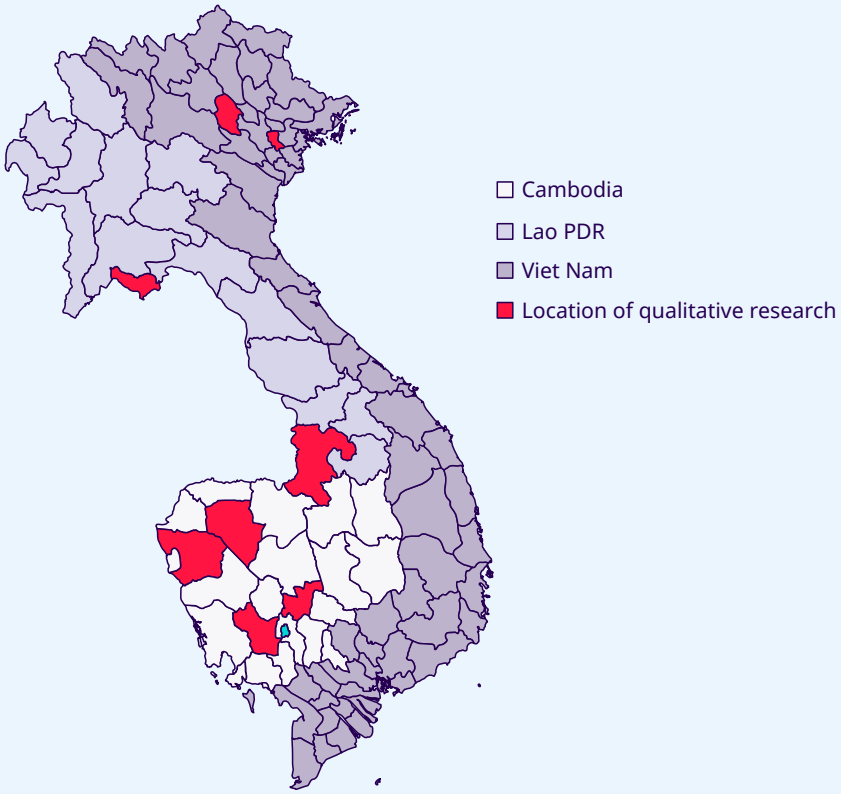
Country	Number of participants	Males	Females	Average age	Type of impairment/group				
					Physical	Hearing	Visual	Caregivers	Work injury
Cambodia	122	53	67	31.7	31	23	21	33	14
Lao PDR	84	41	43	33.6	21	18	22	23	0
Viet Nam	71	36	35	47.6	22	11	14	19	5
Total	277	130	145	36.8	74	52	57	75	19

The research tool for the FGDs was developed in collaboration between the research partners, the ILO, the international consultant and, in the case of the Lao People's Democratic Republic, representatives of organizations of persons with disabilities. The structure was similar for all three countries, but adapted according to the national context. Transcriptions were thematically analysed using Excel, based on pre-identified themes linked to specific research questions and additional/cross-cutting themes that emerged during the research. Quotes from focus group discussions are presented throughout the report. In most cases these include information on the age, sex, impairment (or focus group type) and location. In some cases, only some of this information is presented due to some omissions in data collection during the group discussions.

Key informant interviews were also conducted with a range of government and non-government actors. These included representatives of health and social welfare ministries, and their representatives at the provincial and district level. It also included health facilities, organizations of persons with disabilities, rehabilitation centres (government-run or independently managed) and other non-governmental organizations (NGOs). The geographical locations of the key informant interviews matched those of the FGDs (figure 1.1).

[4] There were some inconsistencies with the reporting of the age and sex of participants for groups including caregivers. In most cases this referred to the age and sex of the person with disability, but in some cases this referred to the age of the caregiver.

Figure 1.1. Locations of the qualitative research



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Field work was conducted between January and March 2024 in Viet Nam and between March and April 2024 in Cambodia. In the Lao People's Democratic Republic, most field work was conducted between November and December 2023, with a small number of KIIs conducted between January and March 2024.

2

Context

This section begins by describing key aspects of the situation of persons with disabilities in each of the three countries. It then describes the overarching legal and policy context for disability and social health protection, before summarizing key features of the social health protection arrangements in each country.

2.1. Situation of persons with disabilities

All three of the study countries are on a journey towards better understanding the scale and nature of disability in their respective nations. The last two decades have seen significant efforts at the national and international levels to increase understanding of the prevalence and diverse nature of disability. All three countries have followed this trend, for example, by including in national surveys question sets developed by the Washington Group on Disability Statistics, which seeks to strengthen collection of cross-country comparative data on disability. Viet Nam also implemented a national survey specifically on disability in 2016–17, which provided a comparatively rich source of information on the prevalence and situation of persons with disabilities.

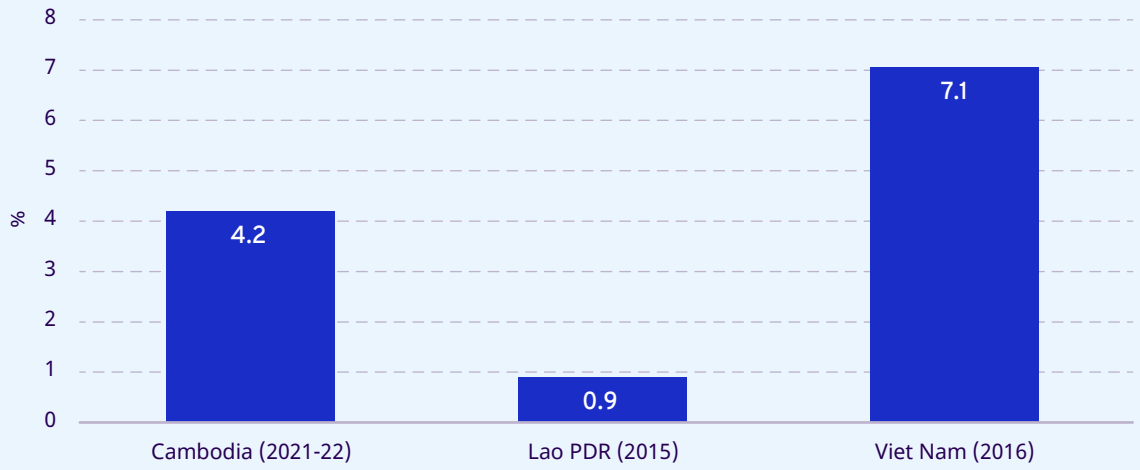
National data on prevalence of disability varies significantly among the three study countries, which is likely to be strongly influenced by methodological issues. Figure 2.1 shows the prevalence of moderate and severe disability in the three countries according to surveys using the Washington Group question sets that focus on functional limitations.[5] As can be seem, prevalence varies substantially, ranging from just 0.9 per cent of the population in the Lao People's Democratic Republic, to 7.1 per cent in Viet Nam. It is likely that methodological factors, such as the structure and wording of questionnaires and the training of enumerators, are a major contributor to these differences. Responses may also be influenced by cultural factors relating to how functional impairments and disability are understood, including issues of stigma.

One indication of these methodological challenges is that, in Cambodia, reported prevalence of moderate and severe disabilities ranged between 1.2 per cent (Census 2019) and 3.6 per cent (Cambodia Socio-Economic Survey (CSES) 2019–20) for surveys implemented in the same year (ACCESS 2022). Notably, Viet Nam, the country with the highest prevalence, used the aforementioned dedicated survey that included the extended set of Washington Group questions,[6] which is likely to identify more persons with disabilities. In this context, the relatively low figure in the Lao People's Democratic Republic is likely to be connected to this being one of the country's first attempts to measure disability prevalence at a national level, using a general survey where less dedicated attention would have been paid to issues of disability. As a comparison, the Lao Social Indicator Survey 2023, found that 2.6 per cent of children aged 2–17 were living with a functional difficulty (Lao People's Democratic Republic, Lao Statistics Bureau 2024).

Across the three countries, disability prevalence is significantly higher when including those classified as having mild disability.[7] The sum of mild, moderate and severe disability stands at 20.6 per cent in Cambodia, 2.8 per cent in the Lao People's Democratic Republic and (for the population aged 18 and over) 26 per cent in Viet Nam (Cambodia, NIS and MOH 2023; Lao People's Democratic Republic, National Statistics Office and UNICEF 2020; Viet Nam, General Statistics Office 2018).

[5] Severe disability relates to those who respond "cannot do at all" for any functioning domain. Moderate disability relates to those who respond "a lot of difficulty" for at least one functioning domain (but who do not respond "cannot do at all" for any domain).
[6] Including the Washington Group/UNICEF Child Functioning Module.
[7] Measured as individuals having "some difficulty" in at least one functional domain.

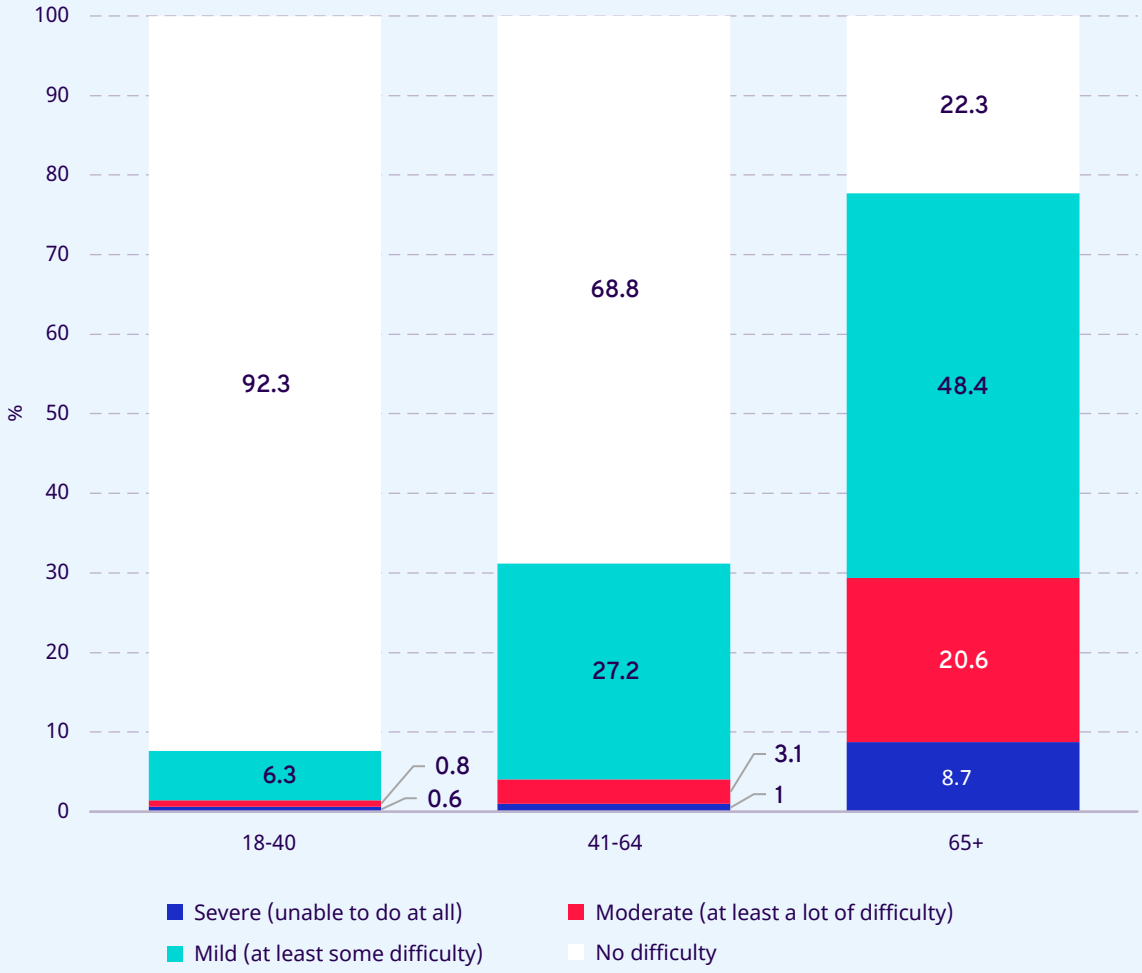
Figure 2.1. Prevalence of moderate and severe disability in the population using Washington Group question sets (percentage)



Note: Lao People's Democratic Republic and Viet Nam relate to the population aged 2+, while Cambodia relates to the population aged 5+. Sources: Cambodia, NIS and MOH 2023; Lao People's Democratic Republic, Lao Statistics Bureau 2020; Viet Nam, General Statistics Office 2018.

One consistent finding is that disability prevalence increases steadily with age, and is higher among women. This trend is illustrated in figure 2.2 for Viet Nam, which shows disability by severity and age. For example, severe disability affects less than 1 per cent of adults below the age of 65, compared to 9 per cent above this age. Indeed, nearly eight in ten older persons have some form of disability when including mild functional limitations, compared to around 30 per cent of those aged 41–64, and around 8 per cent of those 18–40. Similar trends have been found in Cambodia and the Lao People's Democratic Republic (ACCESS 2022; Lao People's Democratic Republic, Lao Statistics Bureau 2020). The relationship between disability and age is consistently found in countries across the globe (WHO 2011); nevertheless, the specific dynamics in the three study countries may also be influenced by various contextual factors – such as a history of conflict that disproportionally affected older age groups – and effectiveness in collecting disability information for different age groups, which can be more challenging for children. Meanwhile, analysis of prevalence in all countries finds it higher among women than among men, which also echoes the global trend (WHO 2011).

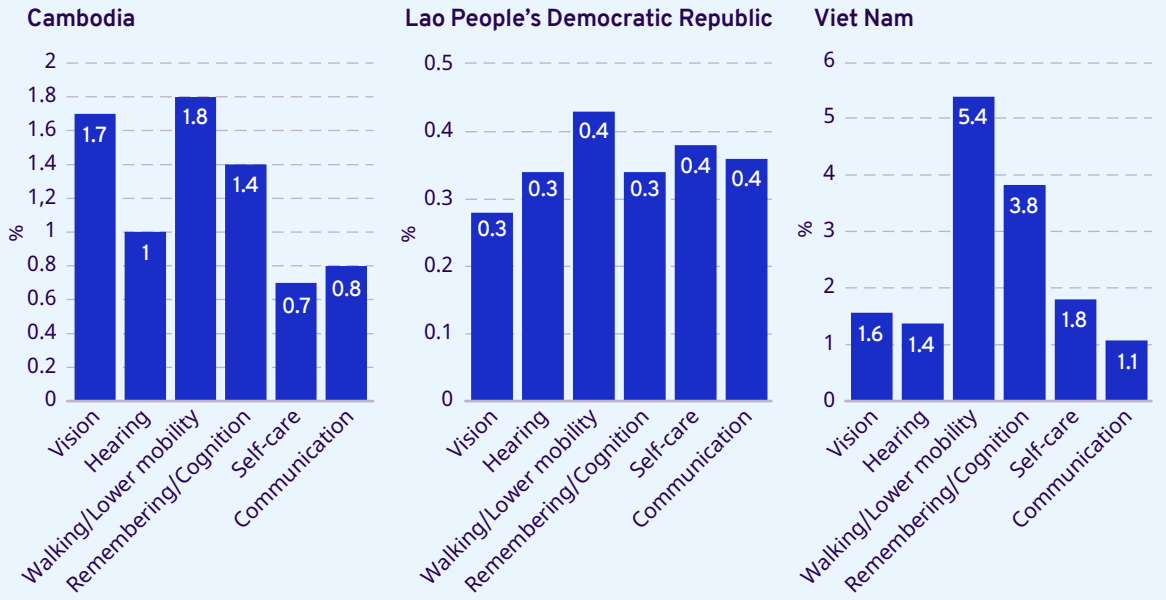
Figure 2.2. Disability prevalence among adults in Viet Nam by severity and age group, based on Washington Group questions, 2016 (percentage)



Source: Viet Nam Disability Survey (VDS) 2016.

There is significant diversity in the kinds of functional limitations that persons with disabilities experience. Figure 2.3 shows the prevalence of moderate and severe disability according to the six functional domains included in the Washington Group question sets. Prevalence is more evenly distributed across types of functional limitations in Cambodia and the Lao People's Democratic Republic, while in Viet Nam it is significantly higher in relation to walking/lower mobility and remembering/cognition. The difference seen in these distributions may partly relate to the use of the extended set of Washington Group questions in Viet Nam. One relevant factor influencing the nature of disability in Cambodia, the Lao People's Democratic Republic and Viet Nam is historical legacies of conflict and the widespread ongoing presence of unexploded ordnance (UXO). Nevertheless, analysis in the Lao People's Democratic Republic on the causes of disability show that other factors – such as illness, congenital conditions and accidents – were far more significant than war or UXO, which appear to be decreasing as a cause (Lao People's Democratic Republic, Lao Statistics Bureau 2020).

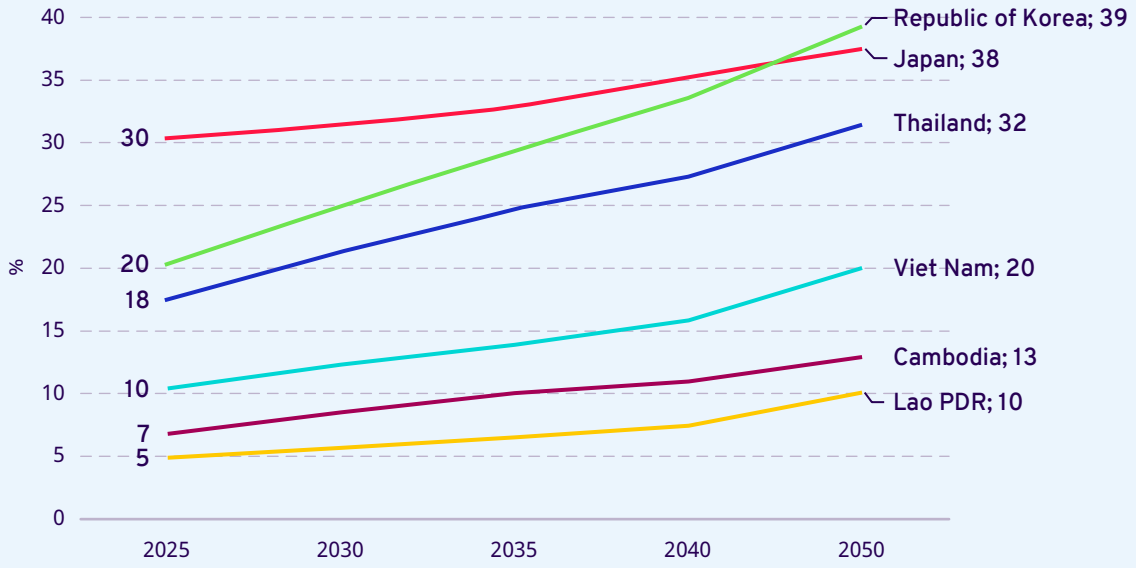
Figure 2.3. Prevalence of moderate or severe disability by type of impairment (percentage)



Note: Lao People's Democratic Republic and Viet Nam relate to the population aged 2+, while Cambodia relates to the population aged 5+. Sources: Cambodia, NIS and MOH 2023; Lao People's Democratic Republic, Lao Statistics Bureau 2020; Viet Nam, General Statistics Office 2018.

The scale and nature of disability is likely to evolve in the context of demographic change and an associated epidemiological transition. Asia and the Pacific is one of the fastest ageing regions in the world, and Cambodia, the Lao People's Democratic Republic and Viet Nam are no exception to this trend. As shown in figure 2.4, the share of the population age 65 and over is set to double over the 25 years from 2025 to 2050 in the Lao People's Democratic Republic and Viet Nam, and nearly double in Cambodia. Of the three countries, Viet Nam has the highest proportion of persons aged 65 and over (10 per cent in 2025, set to reach 20 per cent by 2050), while the Lao People's Democratic Republic has the lowest. While the size of the older population is smaller than in some higher income countries in the region (such as Japan, Republic of Korea and Thailand), the demographic changes in the three study countries are still likely to have important impacts on the scale and nature of disability over the coming years. Given the strong relationship between age and disability (discussed above), demographic ageing will result in higher prevalence of disability. The associated epidemiological transition is also set to influence the nature of disability, with more functional limitations linked to non-communicable diseases (World Bank 2016). Another consequence of population ageing – alongside greater urbanization and changing family structures – is a shift in the nature of care, with older persons with disabilities less likely to be able to depend on their adult children and extended family for care and support (Knox-Vydmanov et al. 2021; Tessier, De Wulf and Momose 2022).

Figure 2.4. Projected share of the population aged 65 and over, 2025–2050 (percentage)



Source: United Nations Population Division 2022

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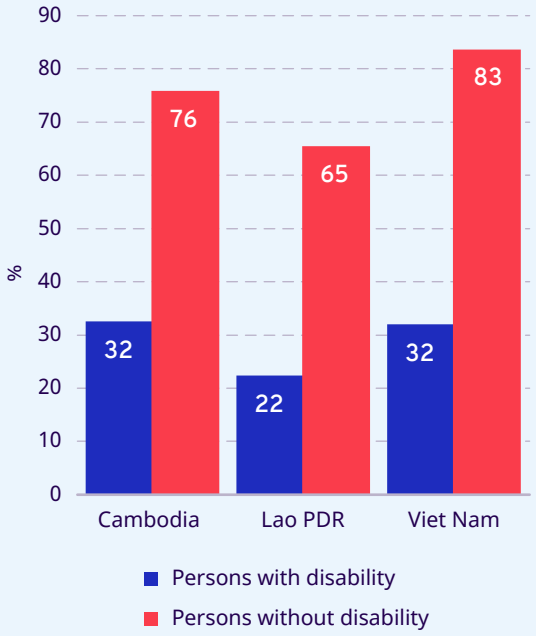
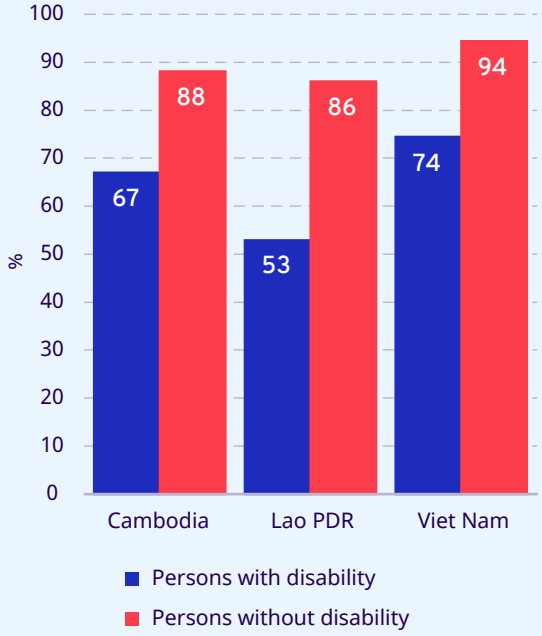
In all three countries, people with disabilities face substantial barriers to participation in the labour market and in access to education. Levels of employment are significantly lower among persons with disabilities than among persons without disabilities, with persons with disabilities being more than twice as likely to not be employed in all three countries (and very nearly three times as likely in the Lao People's Democratic Republic, see figure 2.5). Persons with disabilities who are engaged in employment are also more likely to be found in the informal economy. This has a significant influence on the likelihood of persons with disabilities being able to access contributory social protection schemes (as discussed later in this report). People with disabilities also have lower levels of literacy across the three countries (figure 2.6), which is linked to lower levels of school attendance among children with disabilities. This is one contributing factor to the lower levels of employment seen among persons with disabilities.

Figure 2.5. Level of employment among persons with and without disabilities (ages 15+), latest available year (percentage)



Source: Cambodia - LFS 2019 (ILO, n.d.); Lao People's Democratic Republic - LFS 2022 (ILO, n.d.); Viet Nam - LFS 2022 (World Bank 2024)

Figure 2.6. Proportion of the population who are literate, latest available year (percentage)

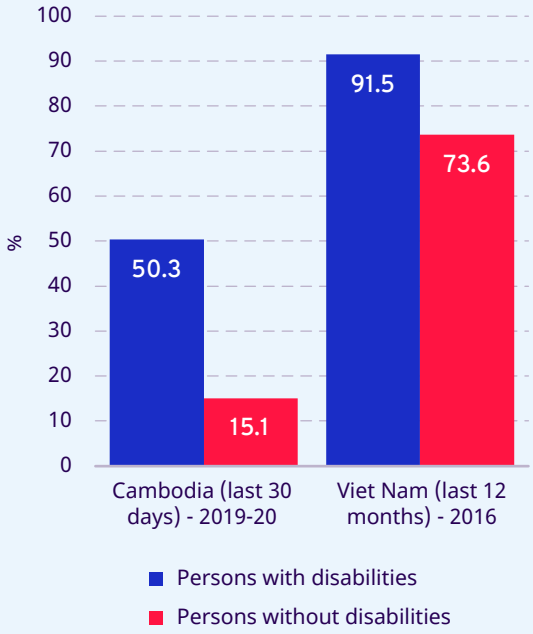


Notes: Age groups covered are – Cambodia (18–59), Lao People's Democratic Republic (6+) and Viet Nam (15+)

Sources: Cambodia – Census 2019 (ACCESS 2022); Lao People's Democratic Republic – Census 2015 (Lao People's Democratic Republic, Lao Statistics Bureau 2020); Viet Nam – National Survey on People with Disabilities 2016 (Viet Nam, General Statistics Office 2018).

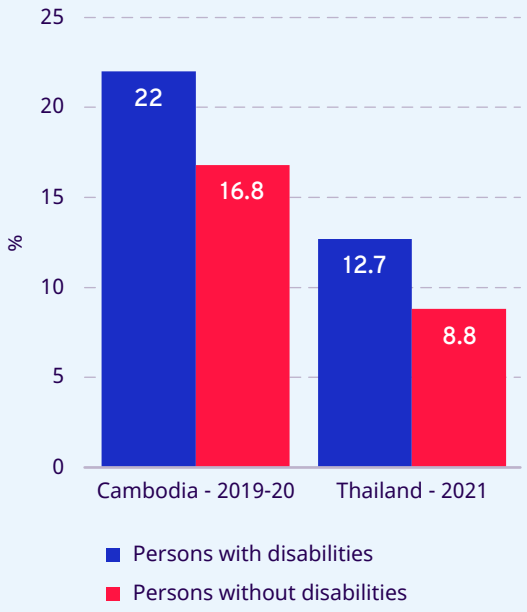
Available data shows that healthcare needs are significantly higher among persons with disabilities than among those without. Figure 2.7 shows the prevalence of illness and injury for persons with and without disabilities in Cambodia and Viet Nam. Although the data for each country relates to different time periods, in both cases the prevalence of illness and injury is significantly higher among persons with disabilities. In both countries, the prevalence of illness and injury is particularly high among women with disabilities (Viet Nam, General Statistics Office 2018; ACCESS 2022).

Figure 2.7. Prevalence of illness and injury among persons with and without disability, Cambodia and Viet Nam (percentage)



Source: Viet Nam – Viet Nam, General Statistics Office 2018; Cambodia: CSES 2019–20.

Figure 2.8. Proportion of persons with and without disability living below the national poverty line, Cambodia and Thailand (percentage)



Source: Cambodia – CSES 2019–20; Thailand – SES 2021.

Evidence from the FGDs in this research indicates a wide spectrum of healthcare needs among persons with disabilities. These vary from individuals with very minimal healthcare needs, to those who have significant ongoing need for healthcare services. The nature of an individual's impairments and functional limitations is an important factor in their need for healthcare, and those with physical and intellectual impairments generally have higher ongoing healthcare needs than those with hearing and visual impairments. However, the need for healthcare can also vary considerably among persons within any impairment grouping. Other important factors influencing the level of healthcare need are the age of persons with disabilities (with those of more advanced age having higher healthcare needs) and the presence of multiple impairments. It is also worth noting that there are likely gaps between the perceived and actual healthcare needs of many persons with disabilities.

> **"I go to the hospital quite often to get my eyes checked whenever there's debris or something in my eyes."**
>
> Male, 18, visual impairment, Battambang, Cambodia

> **"[I seek] general care because my son is usually sick with a cold or allergy. My kid also gets checked up for diabetes and Nephrotic Syndrome as well because he is overweight."**
>
> Caregiver of male, 14, with intellectual impairment (Down's Syndrome), Phnom Penh, Cambodia

> **"In general, I seek care many times per year. Last year I went to dermatology centre because I thought I have skin disease, but the doctor said I had anaemia. After that I went to hospital for treatment. I had received many oral medicines and ointments, that time I went to hospital about two to three times per month."**
>
> Male, physical impairment, Vientiane Capital, Lao People's Democratic Republic

> **"My son is unhealthy. Overall, I go to hospital every three months. He often has a fever. Three weeks ago he had a fever and was admitted in hospital."**
>
> Caregiver of male, 7, with autism, Champasak, Lao People's Democratic Republic

> **"I visit health facilities twice a month and many times a year, including going to hospital."**
>
> Male, 71, physical impairment, Hung Yen, Viet Nam

> **"My son rarely has to seek healthcare, as he is in good health. When he suffers from common diseases, I take him to health facilities for examination."**
>
> Caregiver of male, 38, with hearing impairment, Phu Tho, Viet Nam

Levels of poverty are also found to be higher among persons with disabilities. Poverty and disability are strongly interlinked, with higher levels of poverty increasing the risk of disability, and the barriers and costs associated with disability contributing to poverty. Key barriers contributing to poverty include those relating to education and employment described above, while higher healthcare needs can contribute to higher costs – as discussed throughout this report. The limited coverage and adequacy of cash benefits for persons with disabilities also limits their ability to cover the range of costs associated with disability. An analysis of data from the Cambodia Socio-Economic Survey (CSES) 2019–20 (figure 2.8 above) has found that the share of persons with disabilities living below the national poverty line (22 per cent) is significantly higher than for persons without a disability (17 per cent). This reflects international experience (Banks, Kuper and Polack 2017; Mitra, Posarac and Vick 2011), including that of neighbouring Thailand, data for which is also included in figure 2.8. Meanwhile, standard forms of poverty measurement also do not take account of the significant disability-related costs faced by persons with disabilities, and were these to be accounted for, poverty rates would undoubtedly be higher still (UNICEF, forthcoming). Persons with disabilities are also found to have higher levels of poverty when using alternative measures. For example, in Viet Nam, the rate of multidimensional poverty was found to be significantly higher among persons with disabilities (17 per cent) than persons without disabilities (12.8 per cent).

2.2. Legal and policy context of disability and social health protection

All three countries define rights to healthcare in disability-related legislation, however, the details on the nature of entitlements are relatively limited. Cambodia and Viet Nam have dedicated laws on persons with disabilities, while the Lao People's Democratic Republic has a decree on the rights of persons with disabilities. The legislations in the Lao People's Democratic Republic (2014) and Viet Nam (2010) were passed after each country ratified the Convention on the Rights of Persons with Disabilities, 2006 (CRPD), while the law in Cambodia (2009) was passed before CRPD ratification. Cambodia has been in the process of redrafting its law (Human Rights Watch 2021). In all three countries, the legislation includes specific sections on healthcare (including rehabilitation and provision of assistive devices), as summarized in box 2.1. However, these pieces of legislation are relatively ambiguous on the nature of healthcare entitlements, with the decree/law in the Lao People's Democratic Republic and Viet Nam delegating responsibility to other legislation and regulations.

Box 2.1. Healthcare within laws on disability in Cambodia, the Lao People's Democratic Republic and Viet Nam

Cambodia's Law on the Protection and the Promotion of the Rights of Persons with Disabilities (2009) includes a dedicated chapter on "Physical and Mental Rehabilitation, Health Care and Prevention" consisting of seven articles (14–20). The chapter sets out the role of the State to "develop programmes for physical and mental rehabilitation" alongside social organizations and the private sector. The chapter also sets out measures on training and prevention, but provides limited detail on healthcare entitlements for persons with disabilities.

The Lao People's Democratic Republic's Law on People with Disabilities (2018) includes dedicated articles on "Health Treatment" (article 28) and "Health Rehabilitation" (article 29). Article 28 sets out in broader terms that persons with disabilities "shall receive health treatment, such as for disease, checkups, and diagnosis" in a wide range of healthcare settings. Article 29 set out that persons with disabilities "shall receive rehabilitation, physical and psychological therapy, surgical services, the provision of equipment, and Prosthetic and Mobility Devices according to the principles of the medical profession". In both articles, fees and treatment costs are described as being exempt for "persons with disabilities who are poor or destitute and persons with disabilities who are unable to cover their own costs and have no caregiver".

Viet Nam's Law on Persons with Disabilities (2010) states the right of persons with disabilities "[t]o be provided with healthcare [and] functional rehabilitation", alongside a range of other rights. The Law has a dedicated chapter (III) on healthcare that refers to delivery of healthcare services at various levels, to rehabilitation services and to the production of assistive devices. Notably, the Law states that the entitlement of persons with disabilities to health insurance is "regulated in the health insurance legislation".

Social health protection legislation makes limited specific reference to persons with disabilities. Persons with disabilities are not singled out as a specific population group in the social health protection legislation of the three study countries, but rather they are protected just like any other population group, so long as they meet the eligibility criteria specified in each country's respective legislation. The main health insurance laws that guide the social health protection landscape in the Lao People's Democratic Republic and Viet Nam [8] do not make specific reference to persons with disabilities in the personal scope of coverage. Similarly, Ministry of Economy and Finance Prakas No. 497 (2018), which

[8] These are the Health Insurance Law of 2008 (and 2014 amendment) in Viet Nam, and the Law on Health Insurance of 2018 in the Lao People's Democratic Republic.

guides the Health Equity Fund (HEF) in Cambodia, makes no specific mention of disability.[9] The absence of reference to disability in the personal scope of coverage within these documents does not necessarily imply that disability-specific measures are absent. For example – as discussed in Section 3 – persons assessed as having severe and extremely severe disabilities are covered by health insurance in Viet Nam as recipients of social allowances in general (the disability allowance is not stated in the health insurance legislation). Meanwhile, general provision (not specific to persons with disabilities) presents the advantage of including, de facto, persons with disabilities in the scope of personal coverage. However, this should be accompanied by specific legal provisions to ensure adequate prioritization of the specific needs of persons with disabilities. Such provisions can relate to effective coverage (such as subsidies to contributions), the sensitivity of benefit packages to the needs of persons with disabilities, the inclusion of representatives of persons with disabilities in scheme governance mechanisms (such as health insurance boards), and mechanisms to make social health protection administrative processes accessible for persons with disabilities.

In all three countries, policymaking on disability, social health protection and healthcare spans between Ministries of Health, ministries focused on social affairs/welfare and ministries in charge of labour issues. While Ministries of Health are responsible for delivery of healthcare – including for persons with disabilities – the relevant ministries responsible for social affairs/welfare [10] are responsible for policy and legislation directly relating to disability. In the Lao People's Democratic Republic and Viet Nam, the social welfare/affairs function sits within the ministry covering labour-related issues – and which oversees relevant social security funds. In Cambodia the labour-related function is within a separate ministry (Ministry of Labour and Vocational Training). One notable dynamic in Cambodia (discussed in Section 4) is that rehabilitation services and assistive devices sit under the ministry in charge of social affairs (Ministry of Social Affairs, Veterans and Youth Rehabilitation). In the Lao People's Democratic Republic and Viet Nam, these services are governed by the Ministry of Health. With regard to social health protection, the responsibilities related to policy-setting and implementation are distributed across multiple ministries, as described in table 2.1 (and developed further in section 2.3.1 below).

Table 2.1. Institutions responsible for social health protection policy-setting and implementation

	Cambodia	Lao PDR	Viet Nam
Policy-setting	Ministry of Labour and Vocational Training Ministry of Health	Ministry of Health	Ministry of Health
Implementation	National Social Security Fund, Ministry of Labour and Vocational Training Ministry of Health (Health Equity Fund)	National Health Insurance Bureau, Ministry of Health	Viet Nam Social Security (VSS)

A wide range of disability-related organizations engage in policymaking on healthcare and disability, although there are few formalized channels for their participation. Across the three countries, key informant interviews with both government and non-government organizations revealed a diverse range of ways in which organizations of and for persons with disabilities have engaged in healthcare policymaking. These included being invited to consultation meetings on relevant policy developments and advocacy undertaken by organizations of persons with disabilities. Nevertheless, this participation has been relatively ad hoc – often based on the good will of policymakers – and was uneven across countries and over time. There do not appear to be any formal mechanisms for the inclusion of persons with disabilities or their representatives in policymaking. This stands in contrast to other countries, such in the case of the National Health Security Board that oversees Thailand's universal coverage scheme. Five places on the Board are allocated to representatives of non-profit private organizations working with different affected groups, including persons with disabilities (Thailand, NHSO, n.d.).

[9] A *prakas* is an official proclamation made by a government agency (usually a ministry), or jointly by multiple agencies.
[10] These are the Ministry of Social Affairs, Veterans and Youth Rehabilitation in Cambodia; the Ministry of Labour and Social Welfare in the Lao People's Democratic Republic; and the Ministry of Labour, Invalids and Social Affairs in Viet Nam.

2.3. Background and indicators on national social health protection

2.3.1. Overview of design and history of social health protection systems

Before delving into the question of access of persons with disabilities to social health protection, it is valuable to summarize key aspects of overarching systems in each country. This subsection provides a brief summary of key aspects of these systems. More detail can be found in a regional review of social protection measures published by the ILO (2021). Various indicators summarized in this subsection are referred to later in the report.

While there are some common features, the design and recent history of each country's social health protection system varies considerably. Key aspects of these systems can be summarized as follows:

- **Cambodia has two main social health protection schemes in place**. These are the Health Equity Fund (HEF) and the National Social Security Fund (NSSF). The HEF is a non-contributory scheme that dates back over two decades and provides subsidized healthcare for households assessed by the country's IDPoor targeting system as being poor and at risk. The HEF is financed by a mix of development partner resources and the government budget. The NSSF was established in 2008 as a contributory employment injury scheme for private sector workers. In 2017, it was expanded to include health insurance, alongside sickness and maternity benefits, for both private and public sector workers (ILO 2021), with a further expansion in 2023 allowing for coverage of the self-employed and dependents on a voluntary basis.
- **In the Lao People's Democratic Republic, the recent history of the social health protection system is dominated by the creation and rapid expansion of the National Health Insurance (NHI) scheme**. Up to 2012, the social health protection system consisted of a range of schemes under the Lao Social Security Organization (LSSO) (for workers in the public and private sectors and their dependents), community-based health insurance (CBHI), a Health Equity Fund for poor and vulnerable households, and a fees exemptions programme for pregnant women and children under 5. Prime Minister's Decree No. 470/PM in 2012 saw the creation of the National Health Insurance (NHI) scheme and the gradual incorporation of the country's many schemes into a single scheme. Then, from 2017, the financing of the scheme was moved to a predominantly non-contributory model, whereby all individuals not covered by the contributory LSSO are automatically covered by the NHI scheme, and must only show a family book/ID card (or equivalent) at health facilities in order to receive healthcare services. The scheme covers the whole country with the exception of Vientiane Capital, where the CBHI scheme is still in place.
- **Viet Nam's social health protection system centres on a unified national health insurance scheme**. Before 2008, various different schemes existed, including a contributory Social Health Insurance (SHI) scheme (introduced in 1992); a tax-funded Health Care Fund for the Poor (introduced in 2002); and a range of tax-funded user-fee exemptions for groups, including children aged 0–6 years and social assistance beneficiaries. The 2008 Health Insurance Law consolidated all funds and schemes into a national SHI scheme implemented by the Viet Nam Social Security (VSS) agency. In 2017, Viet Nam set the objective of progressing to universal health coverage through universal health insurance under Resolution No. 20 NQ/TW [11] (ILO 2021). In the effort to expand universal health insurance coverage, the population is divided into six groups:

    1. **Individuals whose contributions are shared between employers and employees:** Namely, those actively contributing to the compulsory contributory social insurance system, under VSS.

[11] Central Committee Resolution 20-NQ/TW on the protection, care and improvement of people's health in the new situation (2017).

2. **Individuals whose contributions are paid by VSS:** Namely, those receiving social insurance benefits from VSS, such as old-age, unemployment, disability and sickness benefits.
3. **Individuals whose contributions are fully subsidized by the government budget:** These include categories such as social assistance recipients (including persons with disabilities), children under the age of 6, members of poor households and "persons of merit" (such as revolutionaries and war invalids).
4. **Individuals whose contributions are partly subsidised by the government budget:** These include individuals living in near-poor households, school children, college students and average income agricultural households.
5. **Remaining individuals (except dependents of armed forces personnel):** These households must pay the full contribution amount.
6. **Dependents of armed forces personnel**, with contributions paid by the employer of military or police personnel.

Notably, the financing model in Viet Nam is one where contributions (regardless of their source) are paid to the VSS fund as the main purchaser of health services. This represents a shift away from the Government directly subsidizing curative healthcare facilities. Notably, local governments typically provide additional subsidies for certain groups, such as reducing the contribution paid by near-poor households or including older people of less advanced ages in the fully subsidized group.[12]

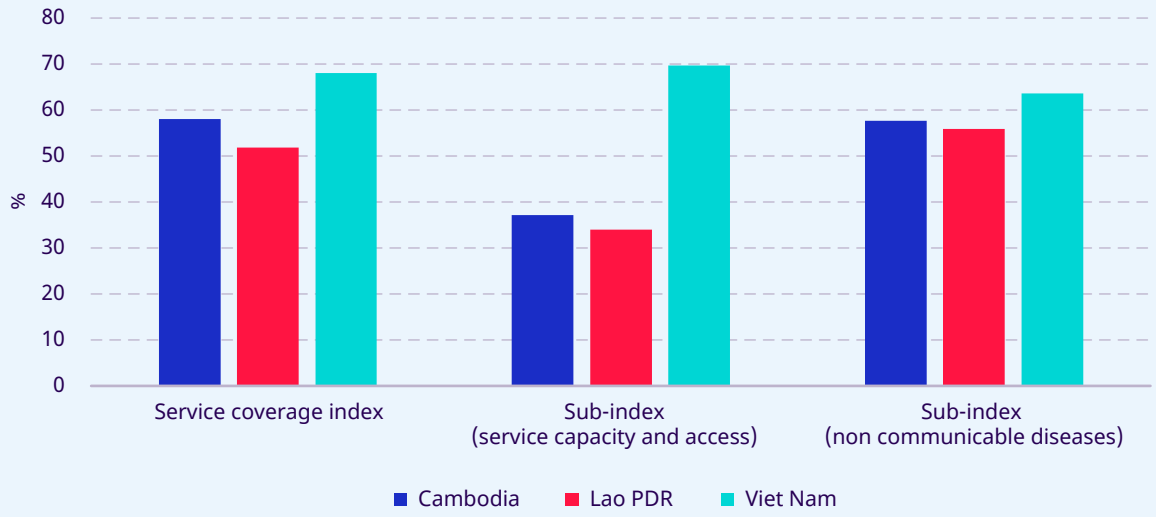
2.3.2. Key indicators

Effective coverage of social health protection arrangements stands at around 40 per cent of the population in Cambodia, while it is nearly 95 per cent in the Lao People's Democratic Republic and Viet Nam. As of 2020, individuals covered by NSSF health insurance in Cambodia represented around 13 per cent of the population (ILO 2021). Meanwhile, the poor and at risk individuals covered by the HEF/IDPoor system represent around 30 per cent of the population according to the latest data.[13] This represents a sharp increase in coverage in recent years for both schemes. For the HEF, this is the result of two developments – the first being the roll out of an "on demand" targeting mechanism since 2020, and the second being the extension of coverage to near-poor households in 2023.[14] The allocation of government funding to subsidize persons without LSSO coverage in the Lao People's Democratic Republic has resulted in a rapid increase in social health protection coverage, jumping from around 30 per cent in 2015 to 94.4 per cent in 2023 (Lao People's Democratic Republic, Ministry of Health and NHIB 2023). In Viet Nam, by 2023, 93.3 per cent of the population were covered by the health insurance scheme, and the Government has the ambition of reaching 95 per cent of the population by 2025 (Viet Nam, VSS 2024).

Levels of effective service coverage vary between countries. One relevant reference point for measuring this issue is the UHC service coverage index collated by the WHO [15] and used to measure progress against the UN Sustainable Development Goals. The index captures service availability and utilization. Figure 2.9 shows the aggregate indicator, as well as sub-index indicators for "service capacity and access" and "noncommunicable diseases". The general picture is that service coverage is greater in Viet Nam, followed by Cambodia and then the Lao People's Democratic Republic. In all three countries, and particularly Cambodia and the Lao People's Democratic Republic, service coverage presents significant gaps and reveals the lack of access to and utilization of essential health services.

[12] The law only mandates free health insurance for people over 80 years of age
[13] As of 16 August 2024, poor households and at risk households constituted 18 per cent and 12.5 per cent of the population, respectively (Cambodia, IDPoor, n.d.).
[14] The extension to at-risk families was determined by the 2023 Inter-Ministerial Prakas 603 on Expanding the Health Equity Fund to Vulnerable Families.
[15] UHC refers to universal health coverage.

Figure 2.9. UHC service coverage index indicators, 2021 (percentage)



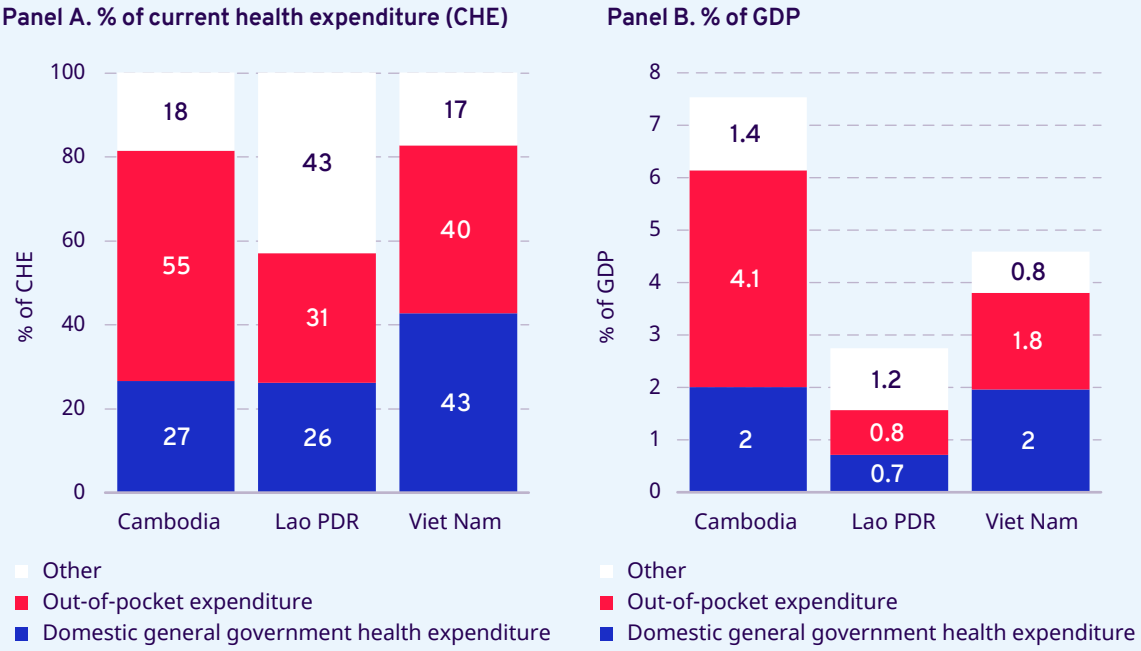
Sources: WHO, n.d.-d.

While public spending is considered the most appropriate source of funding, as it is in line with the principles of solidarity in financing and primary responsibility of the State,[16] out-of-pocket health expenditures form a major source of health expenditure in all three countries. Panel A of Figure 2.10 shows current health expenditure as of 2021 by the main financing sources – namely, domestic general government health expenditure and out-of-pocket expenditures. In all three countries, out-of-pocket expenditures (OOPs) are a significant source of current health expenditure. This situation is particularly notable in Cambodia, where out-of-pocket expenditures were equal to 55 per cent of current health expenditure as of 2019. This is one of the highest levels of OOPs in the region. The high OOPs in Cambodia mean it has by far the highest level of current health expenditure as a share of GDP (nearly 7 per cent) compared to the Lao People's Democratic Republic (2.5 per cent) and Viet Nam (5 per cent). Such a high level of OOPs can lead to significant financial burdens being placed on households. Indeed, the share of the population facing catastrophic health expenditures in each country is high, standing at a 18 per cent in Cambodia, 7 per cent in the Lao People's Democratic Republic and 9 per cent in Viet Nam (WHO and World Bank 2023). These figures also appear to be influenced by the increase in health expenditure from general government and external sources during the height of the COVID-19 pandemic, which means that OOPs constituted a comparatively smaller share overall health expenditure in 2021 than they did in the pre-pandemic period.[17] Now that the COVID crisis has abated, it is possible that the share of OOPs in total health expenditure has crept back up to higher levels.

[16] As stated in the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102).

[17] In all three countries, OOPs as a share of current health expenditure was higher in the period prior to the start of the COVID-19 pandemic. For example, OOPs as a share of current health expenditure in 2019 were: 64 per cent in Cambodia, 42 per cent in the Lao People's Democratic Republic and 45 per cent in Viet Nam.

Figure 2.10. Current health expenditure by financing source, 2021



Source: WHO, n.d.-a.

Meanwhile, the level of total health expenditure varies considerably between the three countries. Panel B of Figure 2.10 shows the scale of current health expenditure (and different sources) relative to the size of each country's economy. General government health expenditure as a share of gross domestic product (GDP) reflects, to some extent, the degree to which a country prioritizes health. The governments of all three countries spend much less than 5 per cent of GDP. General government health expenditure is around 2 per cent of GDP in Cambodia and Viet Nam, but significantly lower at 1 per cent of GDP in the Lao People's Democratic Republic.

3

Population coverage

Key messages

- Social health protection coverage among persons with disabilities largely mirrors coverage among the population as a whole in the three study countries. The two countries with highest overall population coverage by social health protection schemes (Lao People's Democratic Republic and Viet Nam) are also those with the highest coverage of persons with disabilities. A key enabling factor in both countries was the establishment of a legal framework and policy measures to achieve universal coverage.
- Non-contributory components of social health protection schemes are particularly relevant for persons with disabilities. Non-contributory affiliation in Cambodia and Viet Nam is higher among persons with disabilities than among those without disabilities. Meanwhile, contributory affiliation tends to be lower among persons with disabilities, given the barriers that they face to employment, and especially formal employment.
- Disability-specific measures have been important for extending social health protection in Viet Nam, with those receiving the disability social allowance automatically covered by health insurance. Cambodia's newly established disability card has the potential to play a similar role, however, the understanding that this provides entitlement to free healthcare does not appear to be formal government policy.
- In countries where disability status is used as a criteria to access subsidized health protection coverage, the design of disability assessment systems is a critical factor. While there is room for improvement, the community-based models of disability assessment and determination used in Cambodia and Viet Nam have positive features by international standards, including in moving away from purely medical models and making assessment processes more accessible.

This section explores the channels to access social health protection in each country and experiences of persons with disabilities in navigating these access channels.

3.1. Cambodia

Three main channels exist in Cambodia for persons with disabilities to access social health protection. These are summarized in figure 3.1.

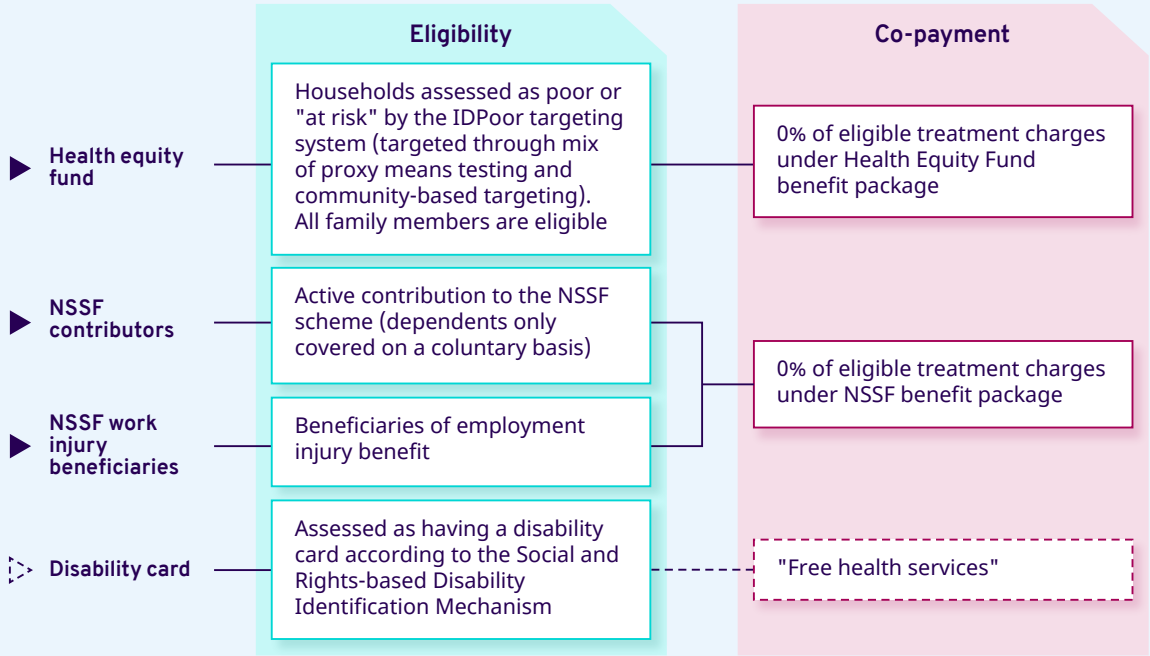
- The **Health Equity Fund (HEF)** provides families holding an IDPoor card with access to a benefit package without co-payment. To receive the IDPoor card, families need to undergo an assessment process that includes proxy means testing and community-based targeting. Those who are assessed are classified into one of three categories: (i) Poor Level 1 (very poor); (ii) Poor Level 2 (poor); or (iii) at risk (Cambodia, Department of Identification of Poor Households, n.d.). All three categories are now eligible to access healthcare via the HEF, although only those classified as Poor Level 1 or 2 are eligible for a 5,000 Cambodian riel (US$1.22) per day cash payment for inpatients.[18] The legal foundation for the HEF entitlement for at risk families is Inter-ministerial Prakas No. 603 of 2023. To be assessed as "at risk" a household must live near the poverty line (below 1.5x the poverty line) and have one of a defined set of family characteristics. One of these characteristics is the presence of a household member with moderate or severe disabilities,[19] as assessed by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (Cambodia, Ministry of Planning 2022).

[18] Ministry of Economy and Finance Prakas No. 497 of 2018, article 7.
[19] The other characteristics are the presence of: at least one family member aged 60 or over; at least one family member below the age of 2 years; a family where all members are below the age of 18; and a female-headed household (either single or widowed).

- The **National Social Security Fund (NSSF)** covers both active contributors and recipients of employment injury benefits, on the basis of the provisions of the Law on Social Security Schemes, 2019 (Chapter 5). Dependents can also now be covered on a voluntary basis.
- A potential channel is having a **Disability Identification (ID) Card**, which is obtained by going through the recently established Social and Rights-Based Disability Identification Mechanism. As of October 2023, 288,690 persons with disabilities had been identified, and 222,148 had been issued Disability ID Cards (Cambodia, MOSVY 2023). This card is used as proof of disability status within the process of identifying at risk households via the IDPoor card system. However, as discussed below, there is a lack of clarity on the extent to which the card provides entitlements to free healthcare services.

As noted in section 2.2, the legislation guiding the HEF or health insurance under the NSSF largely does not specifically mention disability.[20] The lone exception is the 2023 prakas that extended HEF coverage to at-risk households, wherein disability is a subcomponent of the eligibility criteria.

Figure 3.1. Channels to access social health protection schemes for persons with disabilities in Cambodia



One notable feature of the social health protection landscape in Cambodia is the lack of linkage between these three different channels to social health protection. All three are currently governed by separate legal frameworks, and implementation is via different government bodies. This may create some challenges if a person with disabilities moves from eligibility under one scheme to eligibility under another scheme. This marks a contrast with the Lao People's Democratic Republic and Viet Nam, where the different social health protection channels are governed by a single legal framework.

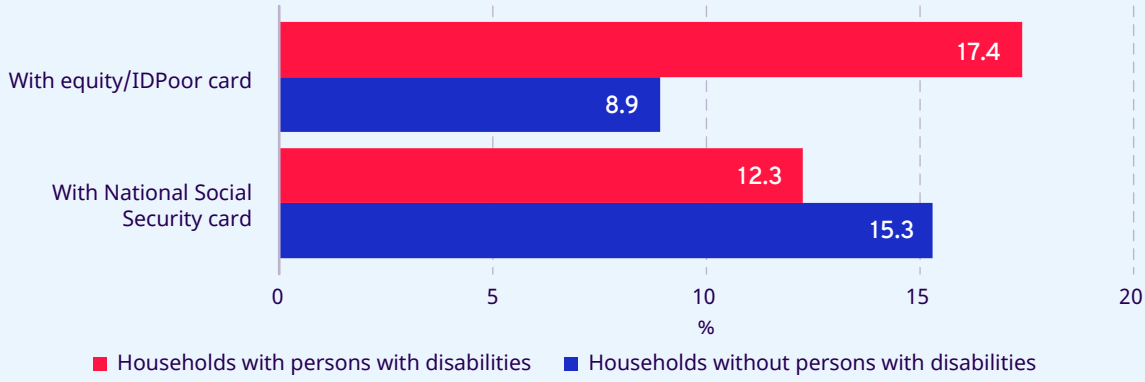
[20] The only specific reference to disability within the Health Equity Fund's offerings can be found in two benefit packages relating to disability screening for newborns and young children.

3.1.1. Health equity fund

Until recently, the Health Equity Fund (HEF) has been the most relevant social health protection scheme for persons with disabilities in Cambodia. Latest data suggests that the IDPoor card – which provides access to the HEF – now covers around 30 per cent of the population (including Poor Level 1, Poor Level 2 and at risk households), and there are indications that HEF coverage is more common among persons with disabilities than those without disabilities (Cambodia, IDPoor, n.d.). Data from 2019–20 – when the system had lower overall coverage [21] – indicates that the IDPoor card had higher coverage among households with disabilities (17 per cent) than among households without persons with disabilities (9 per cent) (figure 3.2).

The HEF also stood out as an important social health protection scheme in the FGDs in this study, although the proportion of participants holding the card varied. In some FGDs more than half of the participants had an IDPoor card, although in others the numbers were very small. This distribution was likely strongly influenced by the geographical locations of the FGDs.

Figure 3.2. Share of Cambodian households with and without persons with disabilities in possession of relevant health insurance cards, by card type, 2019–20 (percentage)



Source: CSES 2019-20

Nevertheless, various features of the IDPoor system's design limit its capacity to provide social health protection to persons with disabilities. By design, a poverty-targeted system of this nature only seeks to cover a subset of households (with disability or not) that are assessed as meeting the scheme's poverty criteria. Another challenge associated with proxy means test approaches is that the assessment criteria are based on analysis of household survey data that does not take account of disability-related extra costs, as appears to be the case in Cambodia.[22] A notable modification since 2019 has been the inclusion of a question on disability in the IDPoor questionnaire,[23] with the score being weighted in favour of households with a person with disability. Disability is also included within a list of "special circumstances" within the IDPoor questionnaire, which allows the Commune Council to overrule the proxy means testing scoring and grant an IDPoor card. As noted above, the presence of a person with moderate or severe disabilities is also a component of the eligibility criteria for at risk households. Despite these modifications, there was a perception among many FGD participants that the IDPoor targeting methodology does not adequately account for particular vulnerabilities related to disability,

[21] That is, prior to "at risk" households being granted coverage, which occurred in 2023.
[22] This can be achieved, for example, by applying equivalence scales to households with persons with disabilities to account for estimated higher costs.
[23] This question is now linked to possession of a disability card, which has a QR code that needs to be scanned to validate the cardholder's level of disability.

and that the selection at times appeared arbitrary. There also appear to be gaps in awareness about the scheme, as a number of FGD participants without an IDPoor card said they had not applied for one because they were not aware of the programme.

> **"It's difficult because mostly people with disabilities don't pass for the Poor ID cards, and there are cases where people with no disabilities have passed for the Poor ID cards instead."**
>
> Female, 42, visual impairment, Battambang

> **"I used to have Poor Level 2. Once that was expired, I requested a new one but was not given [one]."**
>
> Female, 60, physical impairment, Kampong Cham

> **"I was told by the assistant of the village chief, 'As a pregnant woman, you are considered as a member of a vulnerable family, and the fact that you struggle economically and that you also have a disability, you should go and ask for the poor ID card.' [Following the assessment] I was not told about my failing the assessment. I found out about it when I went and asked them myself [half a year later]. And then a lady who is my neighbour went and told the village staff who did my assessment that I was pregnant, I was struggling, and I had a disability. ... She told all that to the village staff, and I was invited for another round of interviews, and I passed for the vulnerable family card."**
>
> Female, 29, visual impairment, Battambang

Accessing free healthcare using the ID Poor card appears to be relatively straightforward. Only one FGD participant mentioned any issues with accessing healthcare using the card. One positive aspect mentioned by some participants was the provision of 5,000 riel per day for inpatients in the Poor Level 1 and Poor Level 2 categories.[24]

3.1.2. Disability ID Card

The new disability assessment system appears to have reached many persons with disabilities, but it remains in the process of roll out. Across the FGDs, many persons with disabilities had undergone the disability assessment process (described in box 3.1), and awareness of the disability card was generally widespread. Most of those who had undergone the disability assessment had done so some time previously as part of the mass registration process, with participants mentioning they had been registered a year ago or more (with some claiming they were registered as far back as 2020). Only some participants had actually received the disability card. It appears that disability cards have only started to be issued very recently in some locations, with some groups mentioning the distribution of cards having initiated in February 2024. This means that not all of those who have been assessed as eligible have received their cards. Key informant interviews indicated that the roll out of the card is happening in a step-by-step fashion by geographical location.

[24] This provision is described in the *Health Equity Fund Operation Manual* (Cambodia, Ministry of Health 2016).

Box 3.1. The Social and Rights-based Disability Identification Mechanism in Cambodia

Since 2020, the Cambodian Government (under the leadership of the Ministry of Social Affairs, Veterans, and Youth Rehabilitation) has been in the process of rolling out a Disability Identification Card. The aim of the initiative is "to develop and manage a consistent Disability Identification Database, serving as a foundation for implementing programs and fund assistance within the social protection system" (Cambodia, MOSVY 2023). Eligibility for the card is assessed using a Social and Rights-based Disability Identification Mechanism. The process involves local workers carrying out the assessment using a digital assessment tool. Data verification is made at the provincial level and a preliminary list is published on a community board. Once validated, the application and recommendations for determination are sent to the national level for the issuing of the Disability Identification Card. There is the possibility of referral for confirmation assessment with medical professionals. The mechanism combines assessment of medical and functional limitations with a set of social indicators drawing on a social model of disability (such as, living conditions, level of assistance and support needed, need for assistive devices and medication, and need for personal assistance). The mechanism also has a separate questionnaire for children under the age of eight. The mechanism uses a digitalized system, with a dedicated Disability Management Information System (DMIS) being linked to other relevant social protection registries (UNICEF, forthcoming). The process is governed by 'Sub-Decree No. 202 on Identification of Disabilities by Social Model and Basic Rights (2023).

Apart from the delayed issuing of the cards, the experience of the registration process appears to have generally been positive. The disability assessment system in Cambodia has various features that align well with a CRPD-compliant approach to disability assessment and determination (see box 3.2). The community-based approach is conducive to greater accessibility, compared to medical models of disability assessment that can require individuals to travel long distances to medical facilities. Participants described how they were either visited at home or called in for registration at the commune level, with information being taken on their disabilities and photos being taken. Another positive feature of the system is that the assessment extends beyond assessment of impairments to consider functional limitations and support needs. The FGDs revealed no negative perceptions of the process itself, and those visited at home seem to have appreciated this. An important caveat is that the final picture of who has and has not been provided a Disability ID Card is not yet clear, and the ultimate results may colour perspectives towards the assessment process.Exclusion from the registration process to date has mainly been due to a lack of awareness or circumstances meaning individuals missed the mass registration process.

Box 3.2. Key features of CRPD-compliant disability assessment and determination mechanisms

Designing and implementing disability assessment and determination is complex and needs to be adapted to national contexts. Nevertheless, there are three main elements which underpin a CRPD-compliant approach:

- **Accessibility:** This implies the mechanism must be made available and be accessible to the diversity of people with disabilities. It should be free of charge and available everywhere in the country. Assessment should preferably be carried out as close as possible to the homes and communities of persons with disabilities, and the process should be kept as simple as possible. The information about the process and possible benefits should be easily available and understandable. The process should be designed to impose the minimum burden possible on applicants, in terms of documentation required and the number of appointments.
- **Comprehensiveness:** The mechanism should go beyond medical assessment of impairments to include an assessment of individuals' functional limitations, support needs, barriers and participation. It should also consider the diversity of persons with disabilities, including being age-appropriate and gender-sensitive. It should also respect people's dignity and privacy.
- **Reliability:** Evaluation procedures should be transparent and applied consistently to build trust and minimize confusion among those assessed. This requires standardized and regulated processes and sufficiently trained staff. A grievance mechanism must also be in place, and the system must respond to complaints in a timely fashion. Reliability also means that steps must be taken to minimize fraud and promote trust among public entities and persons with disabilities and their families to accept all evaluation results. This also implies transparency and the participation of organizations of persons with disabilities in its design and monitoring.

In many contexts, there is a tension between these requirements, and design of disability assessment and determination systems should seek to carefully balance these tensions.

Another notable recommendation of the CRPD Committee is that countries should avoid using multiple disability assessment and determination systems for different benefits.

Source: Adapted from Cote, Knox-Vydmanov and Lippi 2024.

To date, exclusion from the registration process has mainly been due to a lack of awareness or circumstances that led individuals to miss the mass registration window. Some participants shared that they had not been aware of the registration process, and a subset of these participants had been totally unaware of the assessment process and the card until they were brought up in the FGD. Others explained that they had not been present at home or in their localities during the mass registration period. The FGDs gave a mixed picture in terms of whether ongoing registration was open, with some participants stating it was still possible to register, and others that they had been told by commune staff to wait until the next registration window.

> **"Some people with disabilities still do not know about the information since they live in a far-away area."**
>
> Focus group participant, hearing impairment, Phnom Penh

> **"I was not in the village at the time [of registration]; I was somewhere else. [I went to register] but was told, 'Not yet.'"**
>
> Female, 37, physical impairment, Kampong Cham

> **"I did go to them and ask about the registration for a disabilities ID card, but my commune staff did not know anything about it; even the commune chief said he did not know. And I said, if you did not know anything about it, at least you can bring this inquiry to the upper authorities, but all he said was, "I don't know!"**
>
> Female, 30, work injury benefit recipient, Phnom Penh

> **"[I registered] last week. … Actually, I had to go to [the village authority], and they had to call to the district level. After that, the district called me to go get registered."**
>
> Caregiver of individual with autism, Phnom Penh

There is a significant lack of clarity on the benefits that are provided by the Disability ID Card. Many FGD participants stated that they did not know, or were unclear on, the use of and benefits linked to the card. The most common entitlement shared by participants was access to free healthcare, although the information on this was not consistent. The review of legal documents as part of this research did not identify any specific legal entitlement to free healthcare linked to the card, although possession of the card is a component of the definition of an "at risk" household using the IDPoor targeting system.[25] Other potential benefits mentioned included being given priority in public services, access to cash benefits, free transportation, employment in the context of the quota law and care for children with disabilities. Some participants who were carers of children with less obviously visible disabilities (such as autism) highlighted the value of a disability card in being able to prove the child's disability status.

> **"I'd also like to share on this part; from my personal experience, even the person who came to get me registered didn't even know about the use and the benefits of [the disability card]."**
>
> Male, 35, physical impairment, Kampong Speu

> **"I was told to take care of the card well, that I can use it to access to free health services, and that there would be monthly allowance in the future."**
>
> Male, 42, physical impairment, Kampong Cham

> **"Some people said you can use it at the hospitals; some people said you can't."**
>
> Male, 18, visual impairment, Phnom Penh

[25] For example, this entitlement is not defined in the 2023 Sub-Decree No. 202 on Identification of Disabilities by Social Model and Basic Rights, or in any legislation relating to the Health Equity Fund.

There were multiple cases of persons with disabilities successfully using the Disability ID Card to access free healthcare. While only some of those who registered had received their card, a number of those who had used the card to access free healthcare had done so successfully. It should be highlighted that it does not appear these cases were linked to any entitlement to the Health Equity Fund for being part of an "at risk" household. Cases were mentioned where health staff questioned the validity of the card and were not aware of the benefits. However, in two of the three cases mentioned, managerial staff had eventually approved the user fees exemptions, hence granting access to free healthcare. In the absence of a clear legal entitlement of persons with disabilities to free healthcare, it appears that this is being offered in health facilities at the discretion of health staff.

> **"When I first handed the health staff the card, they didn't know what it was, and they asked me what it was, and I said, "Disabilities ID card," and they asked who it was issued by, and I said the commune hall. They still didn't know what it was, so they had to bring it to the head doctor, and they finally understood what it was. [The next time we went, they no longer had to ask us about it.] They even gave us the priority to be served first. Doesn't matter how long the line is, we are given the priority to go in. They told us next time we come, we don't have to wait in line, we can just go in first."**
>
> Female, 53, physical impairment, Kampong Cham

> **"One of the health staff said to me, "What kind of powerful connection/nepotism must you have to have this disabilities ID card?" And I said, it was issued by the commune; it had been three years after registration before I received it. And another staff [member] finally told that staff that everything is covered by that card, so he finally let go."**
>
> Male, 44, physical impairment, Kampong Cham

> **"[The disability card] has just been announced, but we can't use this card at the hospitals, yet. The health staff do not acknowledge them still."**
>
> Focus group participant, visual impairment, Phnom Penh

3.1.3. National Social Security Fund

Coverage of NSSF cards among persons with disabilities is lower than what is seen for the Health Equity Fund and Disability ID Card. As shown in figure 3.2 above, only around 12 per cent of households with a person with disability had an NSSF card as of 2019–20, compared to 15 per cent of households without a person with disability. It is also worth underscoring that NSSF coverage applies to the insured individual and does not automatically extend to all family members – unlike the case of IDPoor cards, which cover the entire household. Instead, the dependents of NSSF members are only covered on a voluntary basis. This lower level of coverage among persons with disabilities is linked to their lower overall level of labour market participation and their greater likelihood of working in the informal economy (discussed in Section 2). This picture was reflected in the FGDs,[26] with few persons with disabilities having an NSSF card. Among those that did have an NSSF card, almost all had acquired it due to their employer registering them with the NSSF and paying contributions to the Fund. Accessing services with the NSSF card was described as being straightforward, including access to both public and approved private hospitals.

[26] With the exception of the FGD held with work injury benefit recipients, all of whom were NSSF members.

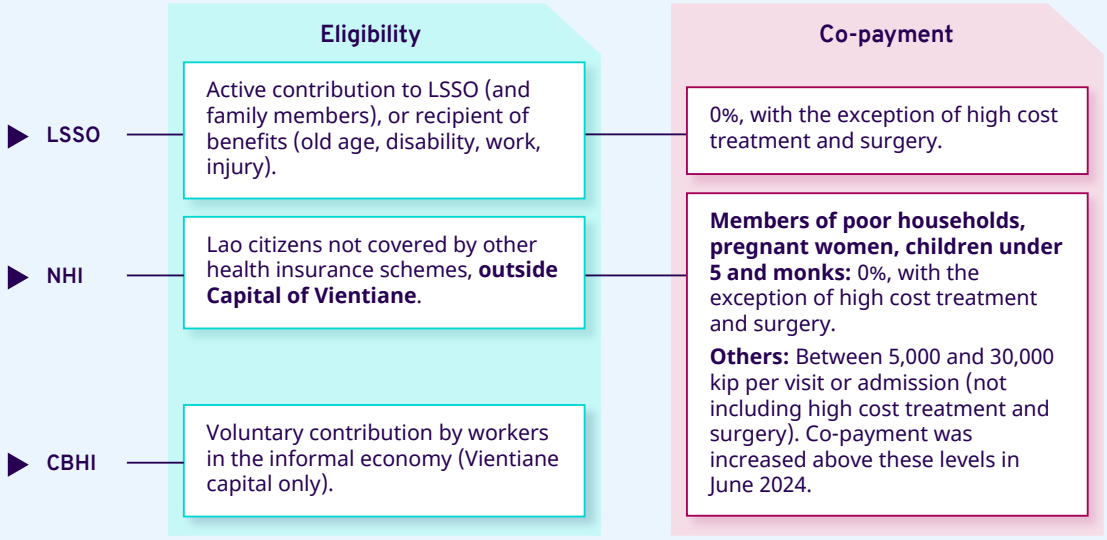
3.2. Lao People's Democratic Republic

There is no disability-specific channel for accessing social health protection in the Lao People's Democratic Republic. As noted in section 2.2, the Law on Health Insurance (2018) does not make specific reference to persons with disabilities in the scope of personal coverage. However, there are two main channels through which persons with disabilities can be covered by a social health protection scheme in the Lao People's Democratic Republic (summarized in figure 3.1):

- The **LSSO offers a contributory scheme that covers employees in formal employment in the public and private sectors, the self-employed** and the family members of insured persons, as well as current recipients of benefits being paid by the scheme (for example, elderly persons receiving an old-age pension). Qualifying conditions are defined under the Law on Social Security (2018) (articles 20 and 43).
- The **National Health Insurance (NHI)** legally covers all citizens who are not registered with the LSSO (except in Vientiane Capital) on a non-contributory basis. These entitlements are defined in the Law on Health Insurance 2018 (article 13).
- The voluntary **Community-Based Health Insurance (CBHI)** is designed for workers in the informal economy who live in Vientiane Capital. Coverage under this scheme is very low.

Since 2019, the National Health Insurance Bureau (NHIB) under the Ministry of Health has also been administering the health insurance branch of the LSSO as a step towards a single-payer system. The revenues collected by the schemes are pooled under the NHIB to finance the overall healthcare costs of the health insurance schemes in the Lao People's Democratic Republic.

Figure 3.3. Channels to access social health protection schemes for persons with disabilities in the Lao People's Democratic Republic



LSSO members and certain categories of those covered by NHI (members of poor households, pregnant women, children under 5 and monks) do not need to make any co-payment when accessing health services, with the exception of high-cost treatments and surgery (see Section 4). All others covered by NHI had previously been required to make relatively small co-payments of between 5,000 and 30,000 Lao kip [27] (US$0.23–US$1.35) depending on the level of service, but these co-payment rates were increased to between 10,000 and 400,000 kip (US$0.45–US$18.04) in June 2024.[28] It is notable that – unlike Viet Nam, discussed below – there is no exception made for persons with disabilities, which likely links to the lack of an existing system of disability assessment and certification in the Lao People's Democratic Republic. The Government is, however, currently in the process of piloting a disability management information system as a step in the development of a system to identify people with disabilities, assess their unmet needs and issue a disability ID card.

Field work conducted outside Vientiane Capital revealed a mixed level of knowledge and understanding of NHI. Some FGD participants in Champasak had heard of the NHI scheme and understood it allowed members to access low-cost services, by simply proving their identity. However, some that knew about this entitlement did not know the name of the scheme, and some FGD participants confused the NHI with the LSSO. This confusion can be seen as a consequence of the recent merging of the two schemes' administration, or perhaps the fact that those entitled to the NHI have not gone through any official enrolment process or been given any material indication of their entitlement, such a health insurance card. Key informants at various levels of government and from non-government organizations shared the perception that persons with disabilities were not generally aware of the NHI entitlement. Most people seem to learn about NHI when they try to access a health facility (for example, from health staff or visual communications) or through word of mouth. Knowledge of the NHI was – unsurprisingly – much lower in Vientiane Capital, where the scheme does not apply; although some Vientiane FGD participants had heard of the scheme from relatives living in other parts of the country or through the media. One had even used NHI services while outside Vientiane.

> **"I have heard about the LSSO, I think it is the same as NHI. I heard about the CBHI. I heard about visiting hospital at a lower cost from a doctor in the provincial hospital."**
>
> Male, 29, hearing impairment, Champasak

> **"I know about NHI from providers at the provincial hospital. When we go to hospital, we need to bring our family book and present it to the nurse at the counter, and we will pay only 15,000 to 30,000 kip [US$0.67–US$1.35] for the services."**
>
> Female, 48, physical impairment, Champasak

> **"I do not know the details, I heard from my friend in Bolikhamxay Province that there are these services in the province, but they only get paracetamol, and the procedure is complicated. My friend is a disabled person, she said that she gave birth to her child without any payment, just presented her family book. I do not know if that is just policy for this province or a support from a development project."**
>
> Female, 33, physical impairment, Vientiane Capital

[27] Co-payments during the period of study were 5,000 kip for health centre services, 10,000–15,000 kip for district hospital services and 15,000–30,000 kip for provincial hospital services.

[28] In June 2024, the Ministry of Health revised, upwards, the level of the co-payment through Note No. 824/MOH on the Adjustment of the reimbursement rate and co-payment policy for people who can afford to pay when using health services at all health facility levels. The new co-payment rates are 10,000 kip for health centre services; 30,000–50,000 kip for outpatient services and 100,000 kip for general inpatient services at district hospitals; and 60,000–80,000 kip for outpatient services and 400,000 kip for general inpatient services at provincial hospitals.

Many FGD participants outside Vientiane Capital had been able to access health services using NHI, although some had been unable to due to lack of relevant documentation. Various FGD participants in Champasak noted positively that they only had to pay between 15,000 and 30,000 kip (US$0.67–US$1.35) for accessing health services, including inpatient services. FGD participants generally framed this co-payment as being minimal. There do not appear to have been any FGD participants who were able to access services without the co-payment; although one participant mentioned the entitlement for pregnant women under the co-payment exemption policy. Some participants did note that they had not been able to access healthcare using the NHI entitlement, due to not having a family book or ID card. This lack of documentation appeared to relate to having forgotten to bring it when accessing healthcare, or to not having such documents. For example, participants mentioned their family book being in another location, or not having applied for the ID card.

> **"When my son was sick last year, we went to the provincial hospital. I just paid 15,000 kip [US$0.67]. I have heart disease; I have to go to see the doctor every month. I also just pay 15,000 kip. Sometimes, I have to buy medicines outside the hospital, because they do not have it in the hospital. Staff at the hospital gave me a card,29 so every time I go to hospital I do not need to show my family book."**
>
> Female, 50, hearing impairment, Champasak

> **"Last year I was admitted to the provincial hospital for three weeks, and I paid only 30,000 kip. Health staff in the hospital just asked me about family book, then I was admitted. They did not explain that the service is named NHI."**
>
> Male, 32, physical impairment, Champasak

> **"I went to the provincial hospital, but I forgot to bring my family book to present [to them]. At that time I did not have an ID card yet; I paid for everything."**
>
> Male, 27, visual impairment, Champasak

> **"I always pay for healthcare by myself. I do not have family book here."**
>
> Male, 39, physical impairment, Champasak

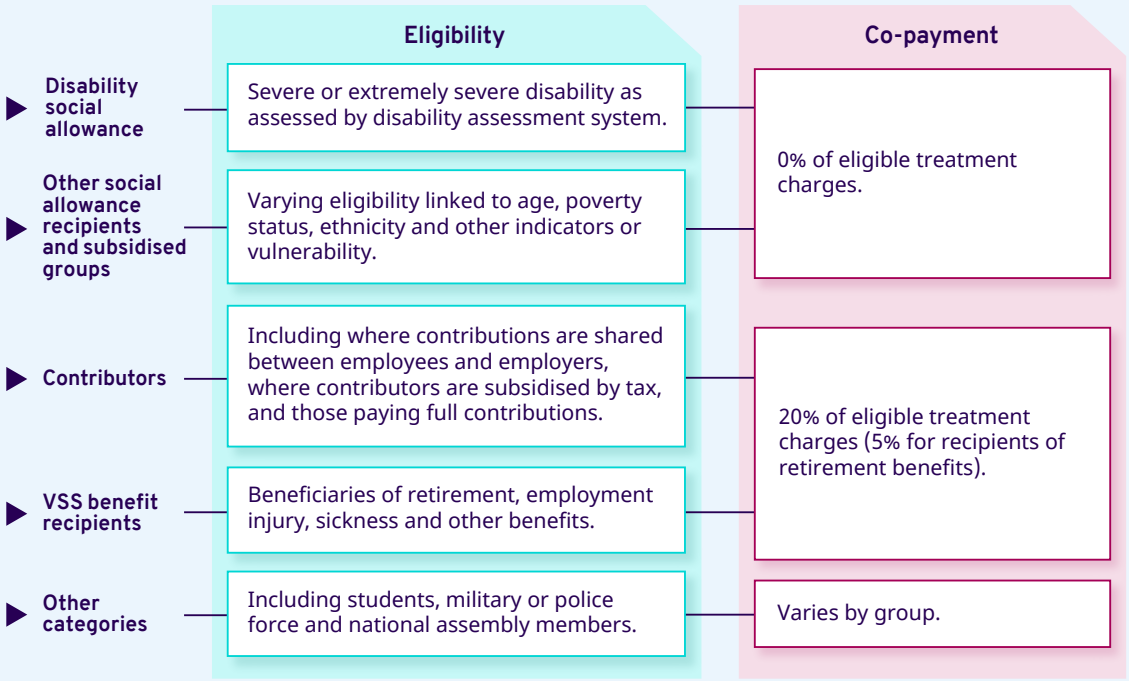
Coverage by other health insurance schemes was relatively limited among the FGD participants. While many participants were aware of the LSSO scheme (and those for civil servants and military staff) few were covered by this scheme, which is largely limited to formal sector employees. These included a small number who were covered by the LSSO through their employment, as well as those covered as family members of insured workers. In some cases, parents of children with disabilities were covered by health insurance – via the LSSO or private insurance – through their employment. Some participants had also been LSSO members in the past. The small number of participants covered by schemes other than the NHI reflects their limited levels of coverage in general, and particularly among persons with disabilities, who (as noted above) are less likely to be found in formal employment. Indeed, the sampling of the focus groups – with one of two locations being Vientiane Capital where levels of formal employment are higher – may overstate the coverage of such schemes across the population as a whole.

[29] This appears to relate to a card (piece of paper) provided by the provincial hospital to those who have already used a service with the correct documentation so that they can access services with greater ease in the future.

3.3. Viet Nam

Various channels exist through which persons with disabilities can enter the government health insurance scheme in Viet Nam. The Law on Health Insurance of 2008 (amended in 2014) defines eligible groups (article 12) and associated co-payment levels (article 22). The configuration is relatively complex. Figure 3.4 provides a simplified illustration of the main channels of particular relevance for persons with disabilities.[30] The main disability-specific channel for support is as a recipient of the social allowance for persons assessed as having severe or extremely severe disabilities, who are automatically enrolled in the health insurance scheme, with the contribution fully paid by the State. Persons with disabilities may also be entitled to health insurance as recipients of other social allowances, or by belonging to subsidized age groups such as children aged 0–6 years. For each of these groups, the cost of eligible healthcare services is fully covered, so there is no co-payment. Other notable groups include: employees, whose contributions are shared between the employer and employee; those that contribute to the health insurance scheme as "households" (that is, when not belonging to any other groups); and those covered as beneficiaries of social insurance benefits. These groups must pay a co-payment of 20 per cent, with the exception of individuals receiving retirement benefits.

Figure 3.4. Channels to access social health protection scheme for persons with disabilities in Viet Nam



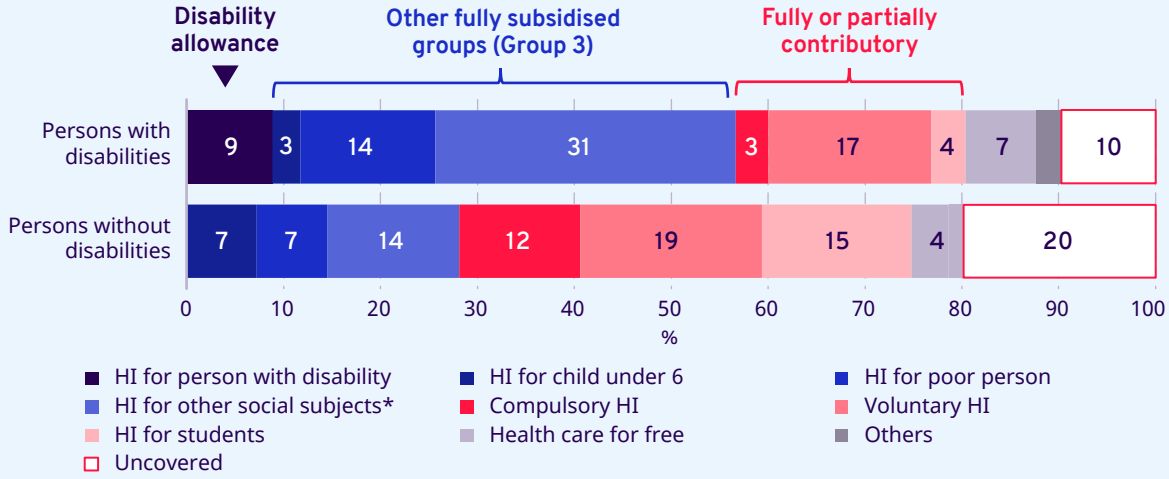
Source: Adapted from ILO 2021 and the Amendments to the Law on Health Insurance. No: 46/2014/QH13 (2014).

Existing data indicates that persons with disabilities are effectively covered by social health insurance, and that their coverage is higher than those without disabilities. The law provides for total contributions subsidies – and no co-payments – for all persons assessed as having severe or extremely severe disabilities. However, those assessed as having "mild" disabilities will not benefit from

[30] For further information, see section 2.3 above and ILO (2021).

those subsidies and waiver on co-payments. Nevertheless, available data suggests effective coverage is very high. Data from the Viet Nam Disability Survey (VDS) 2016 (figure 3.5) found that 90 per cent of persons with disabilities were covered by health insurance, compared to around 80 per cent of those without disabilities. But given that health insurance coverage among the total population has risen since 2016 – to 93 per cent in 2020 (ILO 2021) – it is likely that coverage of persons with disabilities is even higher. The VDS 2016 data also shows that persons with disabilities were more than twice as likely to be covered by fully subsidized health insurance (57 per cent) compared to those without disability (28 per cent).

Figure 3.5. Share of persons in Viet Nam with and without disabilities that have health insurance, by type of insurance, 2016 (percentage)



HI = health insurance.

Note: "Other social subjects" refers to those receiving other social allowances, or who are in other subsidized groups. Source: Viet Nam, General Statistics Office 2018.

Nevertheless, only a minority of persons with disabilities appear to be covered by disability-specific health insurance measures. VDS data (figure 3.5) indicates that 9 per cent were covered by health insurance as recipients of the disability social allowance. A substantial portion were covered as recipients of other social allowances (31 per cent) or due to living in poor households (14 per cent). Meanwhile nearly a quarter (24 per cent) were covered on a fully or partially contributory basis. This data needs to be interpreted with care, keeping in mind the definition of disability in the VDS 2016, which relates to a much larger population (around 7 per cent of the total population) than those receiving disability social allowances (1.7 per cent). Also, the overlap between these two groups in the survey is not total, with only around two thirds of those with a disability certificate being captured in the VDS 2016 definition of disability. One important factor is the strong relationship between disability and age, with many older persons with disabilities who do not have a disability certificate likely to be covered by old-age social allowances (although coverage of old-age allowances and pensions is not universal). A final factor to consider is that the number of persons receiving an allowance for severe or extremely severe disability has increased substantially in recent years, from 1 million in 2018 to 1.65 million in 2023.[31]

The sampling approach used for the FGDs meant that most participants were covered by health insurance under the disability allowance. Focus groups were sampled via lists of registered persons with disabilities provided by local authorities. By definition, this meant that participants were those who had successfully gone through the disability assessment process, and were receiving social allowance and health insurance coverage as a consequence.

[31] Based on Ministry of Labour, Invalids and Social Affairs administrative data.

Nevertheless, some participants had other types of health insurance entitlement. This was most obvious in the case of beneficiaries of work injury benefits (one FGD in Phu Tho province). There was also a small number of individuals who fell into other groups, such as older persons, students and individuals living in poor households. In various cases, individuals had more than one form of health insurance card at the same time, which is not supposed to happen. According to Decree No. 146 of 2018 relating to implementation of the health insurance, "If a person is classified into different groups of policyholders, he/she shall be entitled to the health insurance benefit which is offered to the policyholder entitled to the highest health insurance benefit in accordance with clause 1 of this Article" (article 14). The fact that some FGD participants were enrolled in multiple groups appears to relate to implementation issues, such as gaps in the integration of different management systems that provide access to the health insurance.

> **"I can tell you that for years I have been in a poor household. However, when I visit hospital, I only use health insurance for persons with disabilities. Health insurance for the poor does not work as well as health insurance for the persons with disabilities, which is permanently valuable. That is the reason why I use this kind of health insurance."**
>
> Focus group participant, physical impairment, Hung Yen

Another notable factor identified in the research are local level adaptations to health insurance eligibility criteria. It is common across Viet Nam for local authorities to provide higher levels of health insurance subsidy than what is prescribed under the national law. This was the case in the two focus provinces for field work. Hung Yen Province provides fully subsidized health insurance to older persons aged 60–79 years [32]and to near-poor households, as well as a regime with lower co-payments for workers in certain sectors. Phu Tho Province has increased the government subsidy on health insurance premiums from 70 to 85 per cent. All of these measures have the potential to support persons with mild disabilities to access health insurance; nevertheless, they may be problematic in terms of equity, given they are likely to reflect the level of resources available to each specific provincial government.

While perceptions towards the disability assessment process were generally positive, there are some factors that can create obstacles to access. The disability assessment process is summarized in box 3.3. Across the Viet Nam focus groups, those who had gone through the process described it as being straightforward, and noted having been supported through the various steps of the process by medical staff and commune level officials. As in Cambodia, the disability assessment process in Viet Nam has various features that align with a CRPD-compliant approach. These include a community-based model that supports accessibility and an assessment that assesses functional limitations and support needs in addition to impairments. Nevertheless, there are also some indications of challenges within the system. While the FGD participant responses were positive, it is important to note that these experiences represent those of people who successfully passed the assessment and who also live in relatively more urbanized areas of Viet Nam. Taking this context in mind, some notable issues include:

- **Exclusion of potentially eligible applicants:** The method of sampling for this study focused on persons who had passed the disability assessment, which means we have limited insight into the experiences of those who applied and were not successful, and those that have not applied but who are eligible. Some key informant interview respondents perceived the assessment process as not 100 per cent accurate. Other research has indicated that medical staff and other officials often play a gatekeeping or screening role by only directing persons with disabilities to the assessment when they are fully confident they meet the criteria, which may leave some potentially successful applicants being excluded (Banks, Walsham, Minh et al. 2018). This picture was echoed in this research, with FGD participants describing how they were directed to apply by medical staff or officials, and that information on the assessment is not widely available.
- **Limited account of intellectual disabilities:** Until recently, certain intellectual disabilities required referral to a Medical Assessment Council (as indicated in the third testimony below); however, more recent regulations (Circular No. 01/2019/TT-BLDTBXH) have included certain

[32] At the national level, this is only provided universally from age 80.

intellectual impairments such as autism in the community-level assessment. Nevertheless, there is a perception that certain intellectual disabilities are still not accounted for in the disability assessment.

- **Documentation requirements for application:** In order to apply for the disability assessment, applicants (or their legal representatives) need to collect various documents such as medical records and examination and treatment documents. FGD participants described this first stage of the process, which typically required visiting medical facilities, as being straightforward with support provided by medical staff and other officials. However, it is possible that in more remote areas, this process might be significantly more costly and time consuming for applicants.
- **Timeliness:** The time it takes to complete the disability assessment process can vary considerably, with FGD participants sharing that it can take up to a year. One key informant at the commune level shared that the disability assessment council only convenes once or twice per year to assess applications.

> **"I have been disabled since I was a child, but it wasn't until about ten years ago that I got the disability certificate. I went to hospital for a health check-up, and then they took pictures of me and created a file for me. Then I went to the labour department of the district and submitted the file. After that they came to my house for an inspection and decided to give me the certificate. They came to my house to observe my actual living conditions and realized that I was unable to work, and then they issued the certificate to me. In my case, they assessed that I was unable to work in the fields because my leg was deformed and I can't walk for a long time. I received the certificate a few months later. The process was quick and easy. I didn't need any help."**
>
> Female, 65, physical impairment, Hung Yen

> **"Registering and enrolling in the scheme is not difficult at all. The commune staff did all the things for me, and I just needed to ask for a referral."**
>
> Female, 58, physical impairment, Phu Tho

> **"I used to take him to hospitals in Hanoi for examination and treatment. However, when I submitted the papers and documents to the Commune Department of Labour, Invalids and Social Affairs, they were not accepted. I then had to take him to the provincial hospital for examination. After that, he was accepted as a registered person with disability."**
>
> Caregiver of male, 15, with intellectual disability, Phu Tho

Box 3.3. The disability assessment process in Viet Nam

The disability assessment process in Viet Nam is currently guided by Circular No. 01/2019/TT-BLDTBXH, and includes the following steps:

1. The applicant (or their legal representative) **submits an application** to the Commune People's Committee where they reside. Documents to be provided include those providing evidence of an impairment (such as medical records, examination and treatment documents) and identity documents (ID card and household registration book).
2. On receipt of the application, the Chairman of the **Commune People's Committee** is responsible for establishing a **Disability Assessment Council** to assess the applicant's level of disability. Members of the Disability Assessment Council include the Chairman of the Commune People's Committee; commune officers in charge of labour, invalids and social affairs; and representatives of the commune health station, the Fatherland Front Committee, Women's Union, Youth Union, Commune Veterans Association and the commune association of persons with disabilities.
3. The **Disability Assessment Council** conducts the assessment of the nature of the impairment and level of impairment of persons with disabilities through directly observing these persons performing simple daily activities, through the use of a set of questions based on medical and social criteria specified in the disability level assessment form, and through other simple methods to determine nature of the impairment and level of impairment of each person with disabilities. Assessment of disability level is carried out at the Commune People's Committee or the commune health station, or in the residential area of the applicant.
4. In case the Disability Assessment Council cannot reach a conclusion on the level of disability or the registered person with disabilities or their legal representative disagrees with the council's conclusion, the Council will submit the papers and documents to the **Provincial Medical Assessment Council**.
5. Within five working days from the date the conclusion of the Disability Assessment Council is reached, the Chairman of the Commune People's Committee posts and publicly announces the conclusion of the Disability Assessment Council and issues the disability certificate.

It should be noted that the disability assessment process for VSS benefits is separate from that for the disability social allowance. The VSS assessment process is used to determine eligibility for work injury benefits and early retirement benefits based on loss of work capacity. The VSS assessment process is strongly focused on loss of capacity to work, and is undertaken by a Ministry of Health medical board. Participants in the FGD for work injury benefit recipients described how this assessment was undertaken at provincial and central hospitals. The assessment ascribes a degree of loss of work capacity, which determines the kind of benefits available. It is notable that various participants in the work injury group with lower levels of assessed loss of work capacity were still in employment, sometimes in the same situation where they had obtained their work injury. The same assessment system is applied to provision of early retirement benefits based on a loss of work capacity.

4

Benefits package and availability of services

Key messages

- Persons with disabilities require both general healthcare goods and services, as well as healthcare goods and services that are specifically related to their disability – such as rehabilitation and assistive devices. The range of healthcare goods and services needed varies substantially among persons with disabilities.
- In the three study countries, social health protection schemes vary in regard to the scope of the benefit package that they cover. Overall, benefit packages appear relatively comprehensive, covering care from primary to tertiary levels. However, various services are part of the exclusion list, while others require a higher level of co-payment than the standard level of co-payment for included services.
- Many persons with disabilities reported having to pay for general services that were excluded from social health protection benefit packages.
- Rehabilitation services and assistive devices are particularly relevant to persons with disabilities, and can make a major contribution to supporting their inclusion.
- **Viet Nam** has integrated rehabilitation within the benefit package of its health insurance scheme. However, assistive devices remain largely excluded. The provision of rehabilitation services is integrated within the public health system, and steps have been taken to increase the kind of rehabilitation services on offer. However, service provision remains uneven across different locations.
- In **Cambodia** and the **Lao People's Democratic Republic,** social health protection packages contain minimal provision for rehabilitation and assistive devices, and formal referral pathways are not in place. In both countries, rehabilitation services and assistive devices are mostly provided via rehabilitation centres. In the Lao People's Democratic Republic, these centres sit under the Ministry of Health, but with limited continuum of care with the wider health system. In Cambodia, rehabilitation centres exist in parallel with the public health system, although the Government is moving towards greater integration. There is also a heavy dependence on international organizations for financing these systems (especially in the Lao People's Democratic Republic). In general, the provision of rehabilitative services and assistive devices remains unpredictable in both countries, and there are geographical inequities in access.
- Across the three countries, provision of rehabilitation and assistive devices has a greater emphasis on physical impairments, although there are some moves to expand the scope. The emphasis on physical impairments partly relates to the history of conflict in the three countries and the related issue of unexploded ordnance. An expansion of the scope of rehabilitation and assistive devices is important given the diverse nature of disability, and the epidemiological transition associated with demographic ageing.

Persons with disabilities require both general and specialized healthcare goods and services. General health services include the broader range of services available to the wider population (including consultation, treatment, immunization, screening, and sexual and reproductive health). While these services may not directly relate to a person's disability, they respond to the fact that persons with disabilities may have greater need for these general services. Meanwhile, many persons with disabilities will require additional services more directly related to their disability (UNPRPD 2023). Two kinds of healthcare goods and services that are strongly related to disability (if not necessarily disability-specific) are rehabilitation and assistive devices. After briefly reviewing the shape of the overall social health protection benefit packages, this section mainly focuses on benefit package coverage and the provision of rehabilitation and assistive devices. The section then summarizes issues related to service quality and accessibility for persons with disabilities that emerged during the field work.

4.1. Overview of social health protection benefit packages

Social health protection schemes across the three countries vary in terms of the kinds of services and goods they cover. A comprehensive analysis of the overall benefit packages of the various health protection schemes goes beyond the scope of this report; however, table 4.1 provides a summary of services and goods included and excluded based on a prior ILO analysis of the Asia region (ILO 2021). Benefit packages in the three countries' schemes tend to define both a "positive" list of services and goods that are included, and a "negative" list of services and goods that are excluded. The specific scope of these packages varies from country to country, but many seek to exclude: (i) more expensive treatments and tests that are not considered medically required (such as aesthetic surgery); and (ii) services covered by other specific disease control programmes. One notable observation is the schemes in all three countries exclude various kinds of assistive devices. This reflects the general exclusion of assistive devices from social health protection benefit packages, as discussed below in section 4.2.

Table 4.1. Summary of inclusions and exclusions within social health protection packages

Scheme	Included	Excluded
Cambodia - HEF	The HEF benefit package defines 39 medical services covering inpatient admission, outpatient consultations, diagnostic tests, emergency care, preventive services and medicines on the essential drugs list. The 39 services listed include those that are general (for example, general consultations, in-patient admission and minor surgery) and those that are specific (for example, screening for a variety of communicable and non-communicable diseases). A transportation allowance is offered for referred cases, delivery/attempted delivery and postabortion care. A funeral grant is also provided for referred cases.	Oncology, organ transplants, cosmetic surgery and infertility treatments.
Cambodia - NSSF	Outpatient and inpatient care, maternity-related care, child general medicine, family planning, medium surgical intervention and transport (referral and corpse). Rehabilitation, a daily allowance and a room with air conditioning are also included. Reimbursement of drug costs is limited to pharmaceuticals included on the essential drug list published by the Ministry of Health. Cash benefits provided to replace income in cases of illness and maternity.	Dental care, sex change operations and care, organ transplants, artificial insemination, self-treatment, plastic surgery, **artificial vision devices and laser vision surgery**, treatments for drug abuse, infertility treatment, **eye implant surgery**, coronary and heart surgery, haemodialysis and general health check-ups.
Lao PDR - NHI	A relatively comprehensive benefits package covering most health services in the public sector and at each level of care.	Healthcare covered by vertical programmes, VIP rooms, repair surgery, cosmetic surgery, artificial teeth, sterilization, **glasses and contact lenses**.
Viet Nam - SHI	A broad set of benefits including diagnosis and treatment, rehabilitation, antenatal care, delivery care and, in some situations and for certain groups, medical transport. Includes medicines, radioactive substances, technical medical services, medical devices and consumables, which includes traditional and modern medicine methods.	Items that are covered by other funding sources (preventive services, contraception, forensic medicine, clinical trials, medical interventions in times of natural disasters, and prosthetic devices for war victims and people with disabilities), elective services (health check-ups, fertility treatments, foetal screening not related to treatment, abortion, elective aesthetic medicine services and nursing homes) and other services (**optometry, hearing aids, mobility devices**, medical care and rehabilitation for substance abuse).

Source: ILO 2021; Cambodia, Ministry of Health 2018.

As a consequence of these exclusions, it is clear that the cost of general health services sought by persons with disabilities are often not fully covered by social health protection schemes. Participants in the FGDs described how, even when covered by one of the listed schemes, they needed to pay at least part of the cost for certain treatments, tests and medicines. This issue was most evident in Viet Nam, which partly reflects that all participants were covered by health insurance (compared to Cambodia and the Lao People's Democratic Republic where a bigger issue raised in the FGDs was lack of coverage). In general, participants had limited understanding of which general services were and were not included in various benefit packages, and therefore simply followed the instructions of medical staff.

> **"My daughter was hospitalized one month ago and I had to buy medicine out of pocket. The health insurance only paid for her hospital bed, ultrasound and X-ray. There were still many things I had to pay out of pocket. That's all I know."**
>
> Female, 59, physical impairment, Hung Yen, Viet Nam

> **"I am told that I am covered 100 per cent by health insurance. When I am admitted to hospital, I just pay extra if the health workers ask me to do that."**
>
> Male, 68, physical impairment, Phu Tho, Viet Nam

> **"I would like more services covered by the health insurance so that I don't have to pay anything when I seek medical examination and treatment."**
>
> Female, 58, physical impairment, Phu Tho, Viet Nam

> **"In general, it is like this. As in the case when I was hospitalized, I was told that CT scans and MRIs would be charged. I had to buy some medicines for my heart and liver when I received treatment at the provincial hospital. The doctor gave me the prescription for medicines to be bought out of pocket, and then I brought the medicines back to the doctor's office. After that, I would be injected along with the medicines covered by health insurance. Briefly, when I visited health facilities and needed more advanced medicines, which I don't really understand, so I just guess – which are not covered by health insurance. The items that are not covered by health insurance, I had to pay for them out of pocket. The doctor would prescribe them directly and I would buy them. All the medicines that are not covered by health insurance have to be purchased out of pocket."**
>
> Male, 65, physical impairment, Hung Yen, Viet Nam

> **"My son often uses rehabilitation services. However, the health insurance only pays for a few services. I have to pay many other services out of pocket."**
>
> Caregiver of male, 15, with intellectual impairment, Phu Tho, Viet Nam

4.2. Rehabilitation and assistive technology

The provision of rehabilitation and assistive technology is particularly important to persons with disabilities. These two areas (defined in box 4.1) are strongly connected, as assistive devices are commonly provided alongside rehabilitation services. The provision of rehabilitation and assistive devices can make a significant contribution to supporting the inclusion of persons with disabilities in social and economic life. For example, recent research in Cambodia found that the provision of prostheses and orthoses could increase recipients' sense of self-worth and empowerment, while also improving functional performance and social interactions (Ramstrand et al. 2021).

Recent years have seen growing attention globally paid to how rehabilitation and assistive devices should fit within health systems. One dimension of this has been a shift away from considering rehabilitation as a standalone service for persons with disabilities and physical impairments, and towards considering it as an integral part of universal health coverage – along with health promotion, prevention, treatment and palliation – that benefits those with and without disabilities. International labour standards have long articulated rehabilitation and assistive devices as core components of healthcare benefits.[33] More recently, various global and national initiatives have been put in place to strengthen rehabilitation in health systems (WHO 2022). One notable recommendation has been the need to include rehabilitation within health insurance packages (WHO 2017). Meanwhile, growing attention is being paid to the provision of assistive devices, which has commonly been limited in low- and middle-income countries, which tend to have a strong reliance on international actors for support. The provision of assistive devices should include delivery via public health systems and should gradually be covered by social health protection mechanisms. For example, the WHO recommends that all countries should have "an integrated or standalone assistive technology policy and plan of actions with adequate budgetary support to improve access to assistive technology for everyone, everywhere without any financial hardship" (WHO and UNICEF 2022, xiii).

The following subsections consider the way in which rehabilitation and assistive devices are delivered in the three study countries, including the extent to which they are a component of social health protection benefit packages. Box 4.2 also provides a summary of the situation in Thailand, a country that has made progress on the extension of rehabilitation services and also has included the provision of assistive devices within the benefit package of its universal coverage scheme.

Box 4.1. Overview of rehabilitation and assistive devices

Rehabilitation refers to "interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment" (WHO 2017, 1) "The scope of rehabilitation is wide and includes psychological, assistive technological, environmental, cardiopulmonary, geriatric, neurological, orthopaedic and paediatric rehabilitation, among others" (OECD, Eurostat, and WHO 2011, 87).

Assistive devices are products that can "enhance performance in all key functional domains such as cognition, communication, hearing, mobility, self-care and vision". This can include: "physical products such as wheelchairs, spectacles, hearing aids, prostheses, orthoses, walking devices or continence pads; or they may be digital and come in the form of software and apps that support communication, time management, monitoring, etc. They may also be adaptations to the physical environment, for example portable ramps or grab-rails" (WHO and UNICEF 2022).

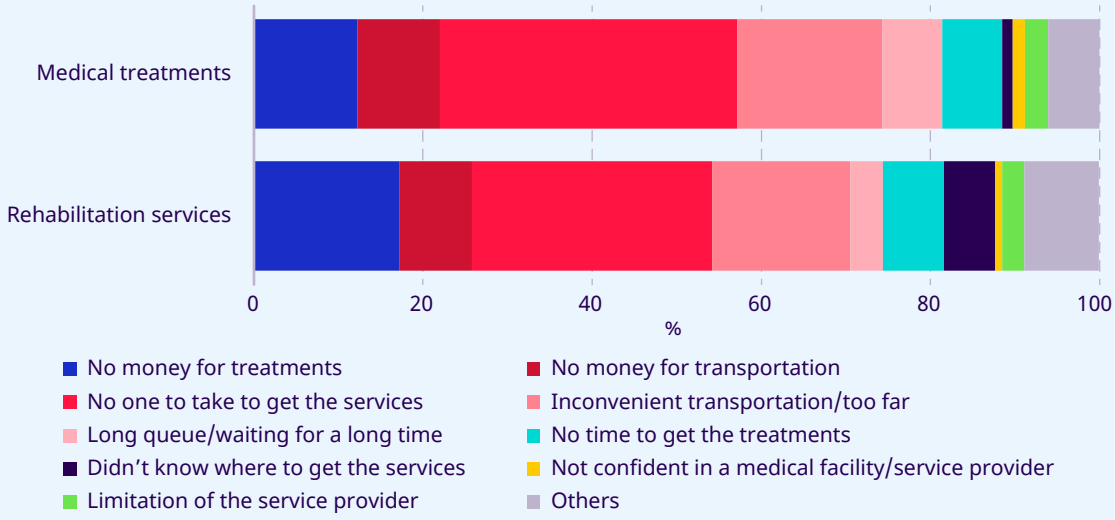
[33] For example, Article 13 of the ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130), defines a minimum provision of medical care as including "medical rehabilitation, including the supply, maintenance and renewal of prosthetic and orthopaedic appliances, as prescribed".

Box 4.2. Rehabilitation and assistive devices in Thailand

Thailand is a country that has taken active steps to extend rehabilitation to persons with disabilities. Rehabilitation services are stated as a health service within the 2002 National Health Security Act and are included as a service under Thailand's Universal Coverage Scheme (UCS) benefit package. The UCS is the largest social health protection scheme in Thailand, and coverage is higher among persons with disabilities than those without. Moreover, the scheme includes a specific benefit package which includes the provision of assistive devices for persons who hold a disability card.

Rehabilitation services seem to have relatively wide availability and accessibility, although gaps exist. Data from the National Survey on People with Disabilities 2016 found that only 4.2 per cent of persons with disabilities lack medical treatment or rehabilitation when needed, although it should be noted that this data may underplay the lack of awareness among people with disabilities about the potential role of rehabilitation. When exploring reasons for not accessing services, physical accessibility (such as limited/unaffordable transportation, or a lack of support to access services) seems to be an important factor (figure 4.1).

Figure 4.1. Share of persons with disabilities in Thailand lacking medical treatment and rehabilitation services when needed, by reason, 2017 (percentage)



Source: Lao People's Democratic Republic, National Statistics Office and UNICEF 2020.

There appear to be even greater gaps in the availability and accessibility of assistive devices. Of the 34 per cent of people with disabilities claiming they need assistive devices in the National Survey on People with Disabilities 2016, 41 per cent reported not having them. Around a third (32 per cent) had received their devices from government sources, and a further 27 per cent from other sources. This highlights the still limited provision of assistive devices in Thailand. One issue may be the fact that, under the UCS, assistive devices are limited to those with a disability card, which may exclude those with less severe forms of disability who require assistive technology.

4.2.1. Cambodia

In Cambodia, rehabilitation services and assistive devices are primarily provided through physical rehabilitation centres that run in parallel to the public health system. There are 11 physical rehabilitation centres in the country, five of which are financed by the Cambodian Government, and six of which are supported by funds from international NGOs (Exceed Worldwide, Humanity and Inclusion, and the International Committee of the Red Cross). All physical rehabilitation centres are overseen by the Persons with Disabilities Foundation, which is a department within the Ministry of Social Affairs, Veterans, and Youth Rehabilitation. The activities of these physical rehabilitation centres vary from location to location, but as the name suggests, these centres focus on physical impairments. The main focus of the centres is the provision of prosthetic and orthotic devices, with some centres also providing physical therapy, production of assistive devices, remote rehabilitation activities in communities and information dissemination. One recent initiative has been the development of a Minimum Package of Services for physical rehabilitation centres (UNPRPD 2022).

Rehabilitation services and assistive devices are not included in the Health Equity Fund (HEF) benefit package, but are included as part of the health insurance scheme and work injury benefit package under the NSSF. The HEF benefit package does not make any specific reference to functional rehabilitation, which is associated with the limited provision of rehabilitation services and assistive devices through the public health system. In the context of the ambiguous health entitlements linked to the Disability ID Card discussed in section 3.1.3, there is also no clear entitlement to rehabilitation or assistive devices under this channel. By contrast, rehabilitation services are a component of the health insurance benefit package and the work injury benefit package under the NSSF (see table 4.1 above). Participants in the FGD with work injury benefit recipients shared their experiences of accessing rehabilitation through both public and NGO-managed rehabilitation centres and public hospitals, the costs of which were paid for or reimbursed by the NSSF. It should, however, be noted that the absolute number of people using rehabilitation services via the NSSF remains very low. For example, in 2022, just 90 people received rehabilitation services under the employment injury scheme, and 29 under the health insurance scheme [34] (Cambodia, NSSF 2023).

Physical rehabilitation centres often provide their services and assistive devices for free, although this is not always the case and often changes over time. In key informant interviews for this study, rehabilitation centres generally described the goods and services they provided as being free, and many FGD participants shared that they had accessed these goods and services for free. However, this was not consistent, with some FGD participants describing how they were obliged to pay for assistive devices or were asked to make voluntary contributions to the cost. The extent to which the physical rehabilitation centres request payment appears to be strongly influenced by the availability of funding. FGD participants revealed cases of both public and NGO-supported physical rehabilitation centres that had changed their policies on payment for goods and services over time. Key funding issues described by key informants from the rehabilitation centres included fluctuations in levels of support from the Government and donors and inflation in the cost of assistive devices. There is a general perception that government-run physical rehabilitation centres have lower levels of funding than those managed by NGOs.

In addition to covering the costs of services and devices, physical rehabilitation centres are also meant to provide patients with payments to cover their food and transportation costs. These payments are made within the context that patients are often required to spend a period of days, weeks or months at the rehabilitation centre, and often have to travel long distances to reach one of the 11 centres. Current government policy is that each patient should be provided with 3,000 riel per day for food and 10,000 riel for transport – with a payment also being made to the caregiver of a child receiving rehabilitation services. There was a general perception among FGD participants that the value of these payments is inadequate, especially where patients need to travel long distances to the rehabilitation centre, and the Government is considering an increase in the payment level. NGO-managed rehabilitation centres sometimes provide higher levels of payments, with some reimbursing the actual cost of transportation, rather than providing a flat amount. In some cases, the provision of the transportation allowance is only provided to patients facing greater socio-economic difficulties. In

[34] Including both private sector (14) and public sector (15).

one rehabilitation centre (Kampong Cham), eligibility for the transportation allowance was based on possession of an IDPoor card, although this was often followed by further validation of socio-economic status given the perceived inaccuracies in the IDPoor system.

> **"I decided to stay there for one whole week because they provided three meals a day as well as a daily allowance, but that was a period when there was so much support because it was funded by NGOs. Recently, though, I just took someone there, and they got much less than before. There were some equipment that could not be provided."**
>
> Male, 22, physical disability, Kampong Speu

> **"I accessed [a non-government rehabilitation centre] when I came to Phnom Penh from the beginning – they didn't charge any fee in 2014. That's not the problem – they provided free services. And in 2020–2021, I heard that they didn't have any funds anymore, but on their registration list they asked us a lot like: "Do you have a poor ID card or NSSF card or disability ID card or relevant card." ... Because at that time, they needed to charge. Like I mentioned, because they didn't have any funds for support, that's why they asked for some contribution – as much as the client can pay."**
>
> Focus group participant, physical impairment, Phnom Penh

Existing rehabilitation services mainly focus on physical impairments. As noted above, the focus of rehabilitation centres in Cambodia is on prosthesis and orthosis, and there are limited services and assistive device provision relating to areas such as hearing, vision, cognition, communication and self-care. FGDs with persons with hearing impairments found that those who had hearing aids had received them from a French medical organization, and not through the service of rehabilitation centres. Persons with visual impairments shared that they accessed medicine and treatment (such as replacement of lenses) via public and private hospitals, although there was a general preference towards private hospitals (see section 5.1).

Quantifying unmet needs when it comes to rehabilitation services and assistive devices is challenging. Access to rehabilitation services among FGD participants was relatively high – particularly for those with physical disabilities – however, this was likely influenced by the way in which the focus groups were sampled. Because they were selected via organizations of persons with disabilities, which are involved in both awareness-raising and facilitating access to rehabilitation, FGD participants likely had higher levels of awareness and access than is the norm. Data on number of people served by physical rehabilitation centres is patchy, and is hard to interpret without a broader national assessment of need.

Nevertheless, it is clear that issues of information, availability and affordability create significant barriers to access, particularly for those in remote areas. Physical rehabilitation centre staff noted that persons living in remote areas face particular barriers to accessing the centres due to the cost of travel, opportunity costs related to leaving livelihood and caring activities, and lack of information and understanding about rehabilitation. The issue of lack of information reflects other research recently conducted in Cambodia, which noted that there are often significant delays in accessing prostheses and orthoses due to gaps in information, although these delays were lower for landmine victims (Ramstrand et al. 2021). Remote rehabilitation activities – involving visits to communities – seek to address this, but only allow for a limited amount of time with persons with disabilities, and they are not widespread due to budget constraints. More generally, rehabilitation centres shared that they often need to turn away some patients due to a limit in the number that can be served.

> **"We have a network for people with disabilities here that often spreads awareness in terms of the rehabilitation services for people with disabilities. So people who have wheelchairs or crutches often got from the centre, and the centre does not charge for the services, and they even provide a transportation allowance. … The local authority at the Commune Hall also knows about the services, so when people with disabilities come and ask, they are usually directed to the centre. I never seek for rehabilitation services, but I know about the services as well. Here, the NGOs and the local Authority work together to help spread awareness and information about the rehabilitation services. The organization of persons with disabilities would usually fill in the gaps in terms of awareness."**
>
> Male, 22, physical impairment, Kampong Speu

> **"People with disabilities often have busy schedules caring for their families, crops and animals. Another challenge we encounter is that some people with disabilities may not fully understand the concept of rehabilitation services."**
>
> Key informant, rehabilitation centre, Kampong Speu

> **"[An important] challenge is the financial issue. They live in rural areas. The transportation is difficult and their financial status, as they earn for a day and eat for a day; so they don't have money to come. Also, even if there is support to take them here, they themselves expect to be cured fast."**
>
> Key informant, rehabilitation centre, Kampong Cham

4.2.2. Lao People's Democratic Republic

In the Lao People's Democratic Republic, rehabilitation services are provided either via dedicated rehabilitation centres or via healthcare facilities. The most clearly established channel for rehabilitation services are dedicated Medical Rehabilitation Centres, which include a national centre in Vientiane Capital (the Centre for Medical Rehabilitation (CMR)), plus five provincial rehabilitation centres in Xieng Khouang, Oudomxay (not yet operational), Luang Prabang, Savannaket and Champasak. One notable contrast to Cambodia is that these centres fall under the management of the Ministry of Health. While the rehabilitation services and specialized assistive devices, such as the prosthetics, orthotics and postural support wheelchairs provided by these centres, have tended to focus on physical impairments, there have been efforts to expand the scope of these activities. For example, the CMR in Vientiane Capital has developed forms of training and care services for children with autism, while the rehabilitation centre in Champasak provides intellectual rehabilitation among its services. Rehabilitation services are also envisioned to be provided by rehabilitation departments in three central hospitals, in all provincial hospitals and in some district hospitals, although the scope and availability of these services was less clear in the qualitative field work. The provision of routine assistive products integrated in the Supply Chain Management System of the Ministry of Health and available in 11 health facilities was piloted in 2023–24 by the Department of Healthcare and Rehabilitation with the support of the USAID Okard project.

There have been notable initiatives in recent years to strengthen the provision of rehabilitation via the health system. Since 2013, the Ministry of Health, the CMR and various international organizations (including WHO and the USAID Okard project of World Education and Humanity and Inclusion) have been involved in the process of improving rehabilitation provision in the country. A key landmark in this process was the development of the National Rehabilitation Strategy 2018–2025 and its accompanying action plan. The Strategy sets out a variety of objectives on governance, financing, integration of rehabilitation within the health system, workforce development, expanding the network of services and improving data and research (Lao People's Democratic Republic, Ministry of Health 2018). One accompanying development has been the renaming of the Ministry of Health's Department of Healthcare, to the Department of Healthcare and Rehabilitation.

The extent to which rehabilitation and assistive devices are covered under health insurance schemes in law and in practice is not completely clear. The 2018 Law on Health Insurance – which provides the legal underpinning for the NHI – includes provision of "physical rehabilitation". In practice, the picture from key informants across the health and rehabilitation sector on what is covered is unclear. There is some indication that rehabilitation services provided within hospitals are covered by the NHI (outside Vientiane Capital) or other schemes (LSSO, SASS), but there is contradictory information among different stakeholders. There is also some suggestion that rehabilitation services in the provincial rehabilitation centre in Champasak are covered by NHI, LSSO and SASS. Services provided by the CMR in Vientiane Capital appear not to be covered by any health insurance scheme. A fairly consistent message is that the costs of assistive devices are generally not covered under any form of health insurance, but rather are provided for free or at lower costs via rehabilitation centres.

FGD participants accessed rehabilitation services and assistive devices through a range of sources. The network of physical rehabilitation centres appears to be particularly key for the provision of specialized assistive devices across the country, particularly those relating to physical and visual impairments. Some participants also reported accessing rehabilitation services and routine assistive products within provincial and central hospitals. For persons with visual impairments, the National Ophthalmology Centre in Vientiane was cited as an important source of support, but mainly for treatment.

> **"The item that we need is a walking aid stick. I got it from the provincial disabled people's association, which got them from the centre in Vientiane Capital, but there was not enough for all of the blind [people] in this province."**
>
> Female, 38, visual impairment, Champasak

> **"I got this wheelchair from a project, from a rehabilitation centre. I paid only 100,000 kip"**
>
> Female, 35, physical impairment, Vientiane

> **"In the past I was often sick, I went to hospital every week or two weeks, because I had eye problems. I was often visiting the Mahosot Hospital and Ophthalmology Centre."**[35]
>
> Male, 31, visual impairment, Vientiane

> **"I went to hospital for acupuncture about three–four days per week for two months. After that I went once per week. And now I still got to hospital for acupuncture and rehabilitation every two–three weeks."**
>
> Female, 52, physical impairment, Champasak

As in Cambodia, issues of information, availability and affordability/funding are key drivers of the gaps in effective access to rehabilitation and assistive devices. A common observation in Vientiane Capital was that individuals only became aware of the CMR through word of mouth. There are also strong indications that the services provided in the CMR are significantly more developed than those provided by rehabilitation centres in other parts of the country. Persons with disabilities in Champasak reported receiving assistive devices from the CMR in Vientiane Capital, or being advised to visit that centre for specific services. While the quality of services in the CMR were generally perceived to be high, some participants also mentioned gaps in capabilities and technology. The financing of assistive device provision by international organizations also results in unpredictability concerning their availability. Various participants and key informants described how certain devices were only provided intermittently,

[35] Both of the health facilities mentioned are public.

and that this supply typically was not sufficient to meet demand. Nevertheless, key informants gave the impression that the provision of both rehabilitation services and assistive devices has been increasing.

> **"Many people do not know about this [rehabiliation] centre yet. While many families face this problem, they do not know where to go. Some people have gone to Thailand or other countries. For my case, I also went to Thailand and the doctor suggested this centre in our country."**
>
> Father of boy, 4, with intellectual impairment, Vientiane Capital

> **"First, I think this centre [MRC in Vientiane] is for people with physical disabilities only. A friend of my grandmother and her daughter who works with COPE suggested that I come to this centre; it is close my house."**
>
> Mother of girl, 7, with intellectual impairment, Vientiane Capital

> **"My child is not using hearing aid devices at this time. Because she has many difficulties in hearing, the Korea project ordered new ones that are appropriate for her. They will arrive about next month."**
>
> Mother of girl, 12, with hearing impairment, Vientiane Capital

> **"When I went to provincial hospital, it was suggested I go to the medical rehabilitation centre in Vientiane to check the hearing of my son."**
>
> Caregiver of male, 6, with autism, Champasak

> **"I got an armpit crutch from the rehabilitation centre in Vientiane, and I paid only the transportation, it was about 50,000 to 100,000 kip."**
>
> Male, 39, physical impairment, Champasak

4.2.3. Viet Nam

Viet Nam has a relatively elaborate legal framework relating to rehabilitation and assistive devices, with various concrete initiatives underway to extend services. The Law on Persons with Disabilities No. 51/2010/QH12 states that provision of rehabilitation is a right of persons with disabilities (article 4) and that that state policies should create the conditions for persons with disabilities to have access to functional rehabilitation services. Various legislative instruments exist on rehabilitation services, which continue to be refined; these include an update of guiding principles for implementing rehabilitation services under the recently-passed Law on Medical Examination and Treatment No. 15/2023/QH15. The Government of Viet Nam has also launched a programme to strengthening the rehabilitation system for the period 2023–30.[36]

Reflecting the legal framework, rehabilitation services appear to be more readily available through the public health system in Viet Nam than in Cambodia or the Lao People's Democratic Republic. Key informant interviews and FGDs describe rehabilitation services being delivered through commune health stations and hospitals. Dedicated staff are in place in some cases, such as rehabilitation nurses in some commune health stations and dedicated rehabilitation departments in some provincial hospitals. Dedicated hospitals also exist for some kinds of impairments, such as the Provincial Eye Hospital in Hung

[36] Prime Minister's Decision No. 569/QD-TTg on Approving the Program for Rehabilitation System Development during 2023–2030, with a Vision towards 2050.

Yen Province. In Hung Yen, there was one commune health station that appeared to be particularly developed, providing acupuncture and massage for many FGD participants with physical disabilities. These aspects of the provision of rehabilitation in Viet Nam – when compared to the situations in Cambodia and the Lao People's Democratic Republic – are likely to be more conducive to a continuum of care, with referral to relevant services within the health system.

The coverage of rehabilitation services and assistive devices under the social health insurance scheme has been progressively increasing over the last decade, although gaps remain. While "functional rehabilitation" is included within the scope of health insurance under the Law on Health Insurance 2008 (and the 2014 amendment to the law), the law specifically excluded the "use of prostheses including artificial limbs, eyes, teeth, glasses, hearing aids or movement aids in medical examination, treatment and function rehabilitation". Previous analysis found that health insurance only covered 33 of the 248 technical categories of functional rehabilitation approved by the Ministry of Health, and no assistive devices were covered (Banks, Walsham, Neupane et al. 2018). Circular No. 18/2016/TT-BYT on "Regulations for rehabilitation techniques and items and reimbursement of daytime rehabilitation cost under coverage of health insurance fund" expanded the package of devices covered under health insurance, mainly relating to orthopaedic and rehabilitation devices. However, a number of devices, such as orthotics, wheelchairs and prostheses remain excluded (ACDC 2018).[37]

> **"The area where the vertebra was operated on is painful, so I often go for acupuncture. I go once every few months or once a month. Sometimes I go twice a month."**
>
> Female, 59, physical impairment, Hung Yen

> **"My left leg has been atrophied since I was 10 years old. ... I cannot walk or work. On average, every three months, I go to this commune health station to get medicine. The health workers in here massage the disabled area of my leg."**
>
> Male, 75, physical impairment, Hung Yen

The provision of rehabilitation is also uneven, and depends on a range of factors, including funding. Data from the VDS 2016 found that only a very small share of persons with disabilities (2.3 per cent) had received functional rehabilitation services within the previous year. The same survey also showed that only 57 per cent of communal health stations provided rehabilitation services, with lower rates in rural areas than in urban areas (Viet Nam, General Statistics Office 2018). The availability of funding appears to be a key factor in the provision of services. For example, in the case of the commune health station in Hung Yen referenced above, the provision of services was dependent on support from philanthropists and charities. Another commune health station in the same province reported no implementation of rehabilitation activities due to lack of funds. Where they exist, rehabilitation services are mainly focused on physical disabilities, and are much more limited for services such as speech and psychological therapies. Meanwhile, some rehabilitation services and assistive devices are only provided through specialized hospitals, and gaining a referral to these specialist hospitals can be time consuming – as discussed in section 5.1 (ACDC 2018).

Provision of assistive technology also appears to be limited. Reflecting the law, field research indicated that persons with disabilities do not appear to receive assistive devices via the health system and nor are these devices covered by health insurance. While discussion of this topic was relatively limited, individuals that shared their experiences had generally bought their devices privately, or received them from NGO- or government-funded projects.

[37] https://acdc.vn/en/news/138-regulations-on-some-of-orthopedic-and-rehabilitation-devices-covered-by-health-insurance.html

4.3. Service quality

While not a core focus of the research, the field work revealed various issues relating to service quality across the three countries. As noted in the methodology (see section 1.2), the research was primarily focused on the nature, accessibility and effectiveness of overarching social health protection arrangements, with less focus on service delivery. Nevertheless, a number of common issues related to service quality came out in the research field work, often organically. Perceptions of service quality varied substantially, with some participants sharing positive experiences. However, many also shared issues they had confronted concerning the quality of the care they received. In many cases, these related to broader issues with the health system (such as long wait-times and impolite staff), but some were more strongly linked to issues of disability.

> **"The hospital I take him to there is the Kantha Bopha Children's Hospital. The services were great, he was well taken care of. Plus, he was under 15, so I took him there."**
>
> Caregiver of male, 16, with Down's Syndrome, Phnom Penh, Cambodia

> **"They took care of me and paid good attention. ... They were friendly, they asked [questions], they said hello, and they helped us to complete any forms, and they have ramps for us to walk and the toilets are clean too."**
>
> Focus group participant, visual impairment, Phnom Penh, Cambodia

A commonly discussed challenge was the physical accessibility of health facilities. Many FGD participants with physical impairments reported that health facilities were not adequately designed to support accessibility. Issues included an absence of ramps and elevators, inappropriate design of toilet facilities and a lack of seating. This issue was exacerbated where there were long wait times, and where patients were required to move between different locations in the hospital for both medical reasons (tests and treatment) and administrative processes. These issues were cited as a reason for persons with physical impairments requiring assistance from family members and friends to access health facilities.

> **"My legs hurt, so it is difficult for me to travel. When I visit the hospital, I have to wait for a long time. I can't stand that. I easily get dizzy and tired."**
>
> Female, 58, physical impairment, Phu Tho, Viet Nam

> **"For me, the restroom in the hospital is not suitable for people with disabilities. I use a wheelchair; it is difficult for me to use the toilet in the hospital and other public places, and the restroom is very small for physically disabled people like us."**
>
> Female, 52, physical impairment, Champasak, Lao People's Democratic Republic

> **"I feel in the hospital, it does not have enough things that facilitate people with disabilities. Like there is not appropriate space for using a wheelchair, and the toilet is also not suitable for people with a physical disability. Especially, the toilet that has a short latrine – we cannot sit properly. And some health facilities, there are many floors but there is no elevator. I had this experience when I used ante-natal care for my pregnancy. It is difficult for us to go up and down."**
>
> Female, 35, physical impairment, Vientiane Capital, Lao People's Democratic Republic

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Another issue was the skills, knowledge and attitudes of healthcare staff. Some FGD participants highlighted the lack of staff available to support persons with disabilities to navigate healthcare facilities. A specific issue mentioned for those with hearing impairments was an absence of staff with a knowledge of sign language interpretation. Caregivers of those with intellectual impairments mentioned the limited understanding of staff of these conditions, often linked to the fact these impairments are less immediately visible than other impairments. Some participants also mentioned that they had experienced discrimination from healthcare staff, although this was not a consistent view.

> **"They are so harsh and mean with their words and attitudes. During a checkup of my son, he was required to take off his shirt, and with his mental condition, he doesn't like to take his shirt off, and the doctor would get mad at us. ... That's why, sometimes, I take him to private clinics. We [also] must wait according to waiting numbers at public hospitals. They don't make an exception for us having a child with an intellectual impairment."**
>
> Caregiver of male, 16, with intellectual impairment, Phnom Penh, Cambodia

> **"I accessed the health service, but almost every time, the doctor didn't pay much attention. Even though I am someone who is good at asking [for things] – let's say that I'm moderate and I'm not afraid or hide my feelings at all. But health centres still have discrimination, still have a lot of discrimination."**
>
> Focus group participant, physical impairment, Phnom Penh), Cambodia

> **"Yes, some health service providers are harsh and mean with their words. Sometimes they don't know that we have disabilities; I think that's why they can be harsh. But after upon finding out, they no longer do that but starting to take care of us"**
>
> Focus group participant, visual impairment, Phnom Penh, Cambodia

> **"When I visited the hospital, I had to go to many wards for the tests, but I did not know where the places were. I walked around the hospital, that took time, and I was exhausted. Moreover, it should be the staff in the hospital that assist blind people to go the related wards in the hospital."**
>
> Male, 53, visual impairment, Champasak, Lao People's Democratic Republic

> **"The communication of the staff is still a problem, especially in cases where the mother does not know sign language. I think it would be good if the Ministry of Health / hospitals support or strengthen the nurses' or staff's knowledge about communicating with deaf people and have some tools/materials like pictures or posters for communicating with the [deaf] people and their caretakers."**
>
> Mother of girl, 12 with hearing impairment, Vientiane Capital, Lao People's Democratic Republic

There was a mixed picture of whether persons with disabilities were prioritized over other patients. Given the additional barriers faced by persons with disabilities in accessing healthcare, there is a strong case for their diagnosis and treatment to be prioritized in healthcare facilities. In some cases, persons with disabilities were prioritized when accessing healthcare, and in others they were not. In some cases, persons with disabilities have a legal entitlement to priority access to health check-ups and treatment, for example, as stipulated in Viet Nam's Law on Persons with Disabilities (2010) (article 23). However, in many cases any priority given to persons with disabilities appears to have been based on hospital policies, rather than official regulations. One notable factor discussed was the visibility of disabilities, with a perception that those with less visible impairments (such as hearing or intellectual impairments) were less likely to be prioritized. In this context, some mentioned the role of a disability card in being able to prove their disability status to service providers. There were also some testimonies that indicated that those with certain types of health insurance received a lower quality of service compared to those paying out of pocket. This was mentioned by two participants covered by the NSSF in Cambodia.

> **"I am a member of the health insurance scheme for persons with disabilities. I receive 100 per cent coverage for the health goods and services I use. I am also given priority for examinations. I don't have to wait for my turn to be examined by doctors."**
>
> male, 40, hearing impairment, Phu Tho, Viet Nam

> **"I was given priority when I was seeking for the service."**
>
> Male, 28, visual impairment, Battambang, Cambodia

> **"For those people with a disability but who can walk, we must go through the same process as other people, but if the patient is in a wheelchair or with a walking stick, they will have an exception to go first."**
>
> Caregiver, Phnom Penh, Cambodia

> **"When they see the [NSSF] card, [medical staff] don't pay much attention to us patients. ... During that time, I was seeking for my eye treatment and receiving blood. They didn't charge me for the room fee, but there was tardiness involved in terms of service delivery. They would ignore me when I was using my NSSF card."**
>
> Male, 22, physical impairment, Kampong Speu, Cambodia

> **"I did not have a positive experience. ... My medication was different from the [other patients]. They prioritized people who paid out-of-pocket. I asked for medication three times, but only once did I get it. ... They just didn't really care about those who didn't pay out-of-pocket. For those who paid, the service was fast."**
>
> Female, work injury benefit recipient, Phnom Penh, Cambodia

> **"I also had experiences in hospital – there was no priority for disabled people. I had to get in line and waited for a long time to use the outpatient department in that hospital"**
>
> Male, visual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"The communication aspect is very slow, but I believe that's because public hospital doctors also work outside [the hospital] as well. And in such cases [that is, their work outside the public hospital], they are more responsive because the patients have to pay out-of-pocket expenses a lot, but if we were to use the Poor ID card, we will have to wait for sure."**
>
> Female, 36, visual impairment, Battambang, Cambodia

Gaps in technical knowledge and limited facilities were sometimes linked to perceived issues with the effectiveness of diagnosis and treatment. Some persons with disabilities shared that the treatments they received – particularly those related to their impairments – had limited or no effectiveness. Some participants across the three countries shared that the technical capacities and facilities were not available in their country to diagnose certain kinds of impairments.

> **"I went to Preah Kosomak Hospital to get my knee scanned. After that, they prescribed me some medication and it cost me about 600,000 riel, and the medication didn't even work."**
>
> Male, 33, physical impairment, Kampong Cham, Cambodia

> **"A few years ago, I took her to health facilities very often. However, I stopped doing that last year because all kinds of treatments didn't work."**
>
> Caregiver of female, 25, with complete paralysis, Phu Tho, Viet Nam

> **"I took my child to Mahosot Hospital, and the doctor diagnosed that she is deaf. There is medical equipment for measuring this, but it was not advanced compared to [what they have] in Thailand. In our country, we do not know the cause and what to do next. The provider could not tell exactly how much that she could hear, at which level of hearing. I took her to Thailand, [and] then she got hearing aids, and can hear some and can speak now."**
>
> Mother of girl, 10, with hearing impairment, Vientiane Capital, Lao People's Democratic Republic

There were also mixed perspectives about the quality of services provided by rehabilitation centres and departments within the health system. In some cases, FGD participants highlighted positive experiences, often linked to the greater knowledge of disability among rehabilitation centre staff when compared to other elements of the national health system. However, experiences were also shared about the limitations of rehabilitation centres in terms of technology and staff training, which was sometimes compared to better provision in other countries.

> **"Like my current [prosthetic] hand, I used it for the sake of using. If you ask me, 'Am I satisfied and rate that?' I would say, 'No, I'm not satisfied with that.' And the specialist also recommended to me, 'If you want a beautiful shape or model, they can be imported from a foreign country, but it cost around US$3,000 to US$5,000."**
>
> Focus group participant, physical impairment, Phnom Penh, Cambodia

> **"Their services were great; I was well taken care of. Upon my arrival they came to me for the registration, and when I was sent to wait, they asked for my waiting number, and the doctor had a notepad and was checking my leg to examine it. He was a professional doctor, just like at the hospital."**
>
> Male, 67, physical impairment, Kampong Speu, Cambodia

> **"The services at the rehabilitation centre were good. Patients have to be in line to use the services, and they provide good advice and care about the patient."**
>
> Grandmother of girl, 5, with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"I hope that if possible, the Government should provide the commune health station with a leg stretcher to help us exercise. We still need more medical equipment at the commune health station for stretching exercises, so that we don't have to go far to other health facilities. We also need arm exercising machines for rehabilitation."**
>
> Female, 65, physical impairment, Hung Yen, Viet Nam

5

Financial protection

Key messages

- The costs of healthcare for persons with disabilities need to be understood in the context of broader gaps in financial protection when accessing healthcare in all three countries. Out-of-pocket expenditures are relatively high (between 42 and 64 per cent of current health expenditure) in all three countries.
- Available data from Cambodia also shows that levels of catastrophic health expenditure are more elevated among persons with disabilities than those without, something that is reflected in other countries in the wider region and the world.
- Qualitative data suggests that social health protection schemes have provided some level of financial protection and reduced out-of-pocket spending. However, various costs remain, including:
  - **Medical costs:** Persons with disabilities covered by social health protection schemes often have to cover the cost of goods and services not included in benefit packages. Many also resort to paying for private healthcare and purchasing medicines in pharmacies due lack of availability of relevant services, service quality and convenience. A tendency to pay for higher-level service providers was also observed in Viet Nam, and was linked to challenges in obtaining referrals.
  - **Non-medical costs:** The cost of transportation can be high, particularly for those in remote areas and because most transportation options are not adapted for persons with disabilities. Many persons with disabilities also require assistance from family members or interpreters in accessing health facilities. Non-medical costs may include loss of income due to taking time off of work to seek care, although this did not come out strongly in the field research.
- In the context of these costs, the main coping strategies are to forego healthcare, or to resort to family support and indebtedness to cover the costs.
- Two of the study countries have **non-contributory cash benefits** in place that benefit persons with disabilities. Viet Nam's non-means-tested disability allowance provides a relatively predictable source of income to those assessed as having moderate or severe disability. The landscape of cash benefits in Cambodia is evolving, but remains focused on poverty-targeted household benefits, albeit with adjustments to account for disability.
- The role of cash benefits in covering healthcare costs is more evident in Viet Nam. Limitations to the role of cash benefits in Cambodia and Viet Nam include their relatively low adequacy in both countries, and the more limited coverage and household focus in Cambodia.

Persons with disabilities may face different kinds of costs in accessing healthcare services. The two main categories of costs are:

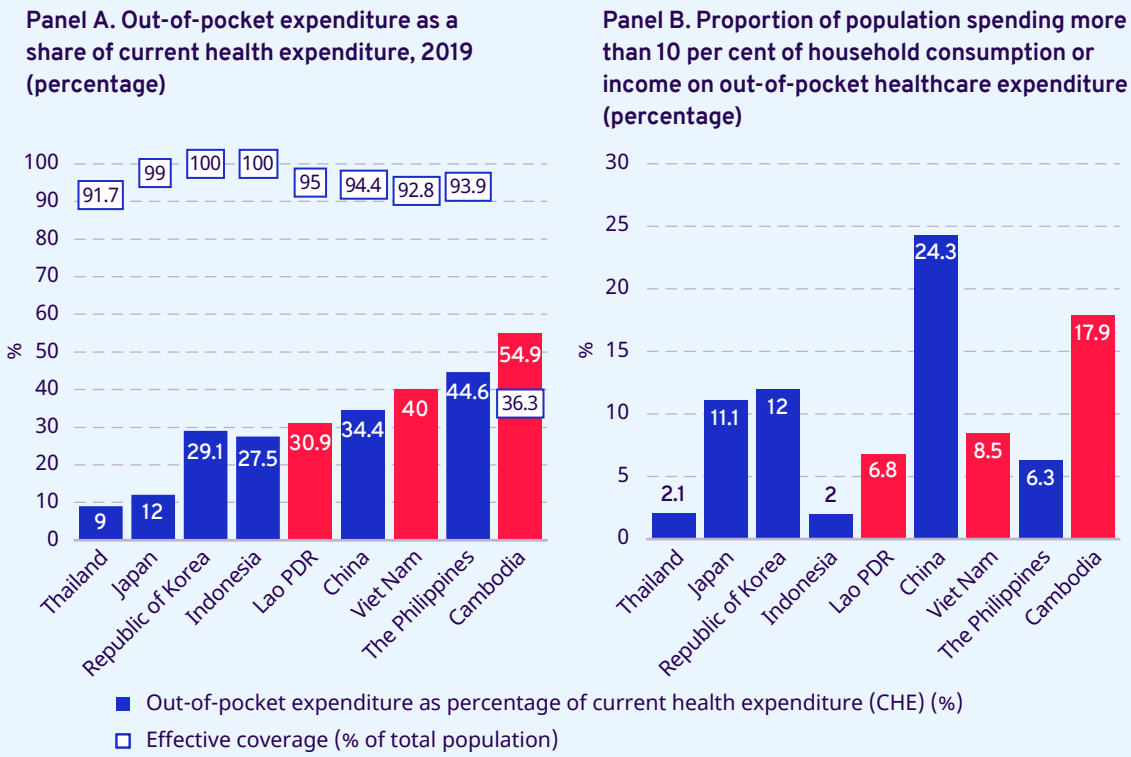
- **Medical costs:** such as for general healthcare services, rehabilitation and specialist health services, assistive devices and community/home-based long-term care; and
- **Non-medical costs:** These can include:
  - **Direct costs:** such as transportation, accommodation and personal assistance or interpretation required when accessing healthcare, which can increase with long waiting times and repetitive visits.
  - **Indirect costs:** such as loss of income or time by persons with disabilities while seeking care, or for other family members who provide personal assistance or caregiving support (UNPRPD 2023).

This section begins by considering medical costs and non-medical costs for persons with disabilities accessing health services via social health protection schemes. It then discusses the coping strategies used by persons with disabilities to manage these costs and the role played by cash benefits.

5.1. Medical costs

The overall level of financial protection provided to the population varies between the three countries. Figure 5.1 shows two key indicators on financial protection for the population as a whole. Panel A shows out-of-pocket expenditures (OOPs) as a share of current health expenditure, as well as compared to total effective population coverage of social health protection. Panel B shows the proportion of households spending more than 10 per cent of their income or consumption on health spending. The latter is an indicator of catastrophic expenditure, which implies a household may not be able to afford other basic needs beyond this threshold. OOPs as a share of current health expenditure are highest in Cambodia – at 55 per cent – which is one of the highest levels in the region. OOPs in the Lao People's Democratic Republic and Viet Nam are in the 30–40 per cent range, which is more typical for other middle-income countries. Nevertheless, they still exceed the levels seen in other Asian countries such as China, Japan, Indonesia, Republic of Korea and Thailand. By the measure used here, catastrophic expenditure is also high in Cambodia by international comparison (affecting 18 per cent of households), compared to less than 10 per cent in the Lao People's Democratic Republic and Viet Nam. It should be noted that the drivers of these indicators are complex. Population coverage is one factor, and the low level of coverage in Cambodia is likely to at least partly explain the high OOPs. However, the scope of the benefits package, personal choice to use facilities outside the health insurance's network of providers, as well as service availability, acceptability and quality are particularly important factors that also contribute to high out-of-pocket spending. If individuals forego healthcare due to a lack of service provision, this may contribute to lower OOPs numbers, but obviously not for positive reasons. Meanwhile, even where services are included in social health protection packages, poor quality of services may drive households to use private services, even when they are more expensive.

Figure 5.1. Key financial protection indicators in Cambodia, Lao People's Democratic Republic and Viet Nam and selected Asian countries

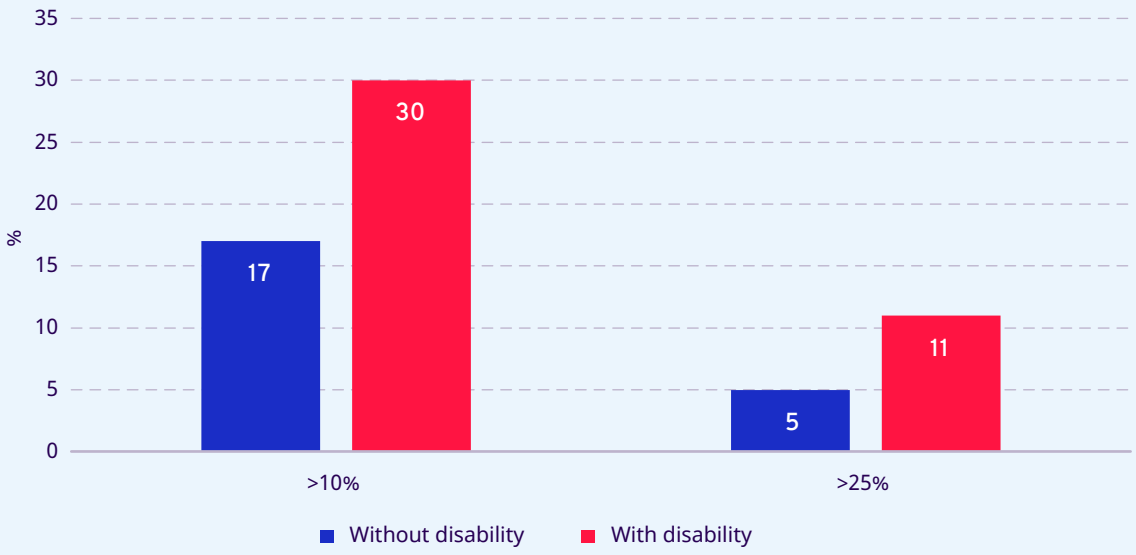


Notes: Year of data is 2021 for Indonesia, Japan and Thailand; 2020 for Viet Nam; 2019 for Cambodia and Lao People's Democratic Republic; 2018 for China and Republic of Korea; and 2015 for Philippines.

Sources: WHO, n.d.-a. WHO, n.d.-b.

Available data on health expenditure by persons with disabilities implies it is higher than those without disabilities. While data on health expenditure by persons with disabilities is limited in the Lao People's Democratic Republic and Viet Nam, this issue has been explored in some detail in Cambodia. Analysis of the CSES 2019–20 (figure 5.2) shows that catastrophic expenditure is significantly higher in households with persons with disabilities than those without disabilities. Whether using the benchmarks of 10 per cent or 25 per cent of household income spent on OOPs, the share of households with a person with a disability with catastrophic health expenditure is around double that of households without a person with a disability. A similar picture is reflected in a previous analysis of historical data on health expenditure by persons with disabilities in Cambodia (de Groot, Fernandes Antunes, and Jacobs 2016). In addition, similar trends have been found in other countries in Asia, including the Republic of Korea and Thailand (Merttens et al. 2021; Lee et al. 2016).

Figure 5.2. Share of individuals in Cambodia living in households experiencing catastrophic health expenditure (above different benchmarks), by disability status, 2019–20 (percentage)



Source: CSES 2019-20.

For persons with disabilities covered by social health protection schemes, these schemes appear to have a positive impact on their level of financial protection. Many FGD participants shared that these schemes meant they had to pay no (or little) cost for health services. Some shared examples of the significant reduction in the costs they incur as a result of this coverage

> **"I went to big hospitals like Kean Klaeng and Ang Doung, which I spent a lot [to do], but that was before I had the disabilities ID card. It has been so great ever since I've received the disabilities ID card. ... The health staff would be told by the doctor that those who have the disabilities ID card must not be charged any fees. It has been great once it has been widely understood by health staff."**
>
> Male, 44, physical impairment, Kampong Cham, Cambodia

> **"Without the [IDPoor] card, we need to pay at least like US$75 a day because there is a fee for everything, including the blood test "**
>
> Female caregiver, Phnom Penh, Cambodia

> **"That's a big support if you think about it, because they don't charge for the health service, and they even give you the daily allowance [5,000 riel per day]. ... If you look at the total bill, it's usually not cheap; so the fact that they don't charge you for the service fee is a lot. ... It is a big support because we can see this on the total bill, it's not cheap. There are expenses on medication."**
>
> Female, 29, physical impairment, Kampong Speu, Cambodia

> **"Last year I was admitted in provincial hospital for three weeks, and I paid only 30,000 kip. Health staff in the hospital just asked me about my family book, then I was admitted"**
>
> Male, 32, physical impairment, Champasak, Lao People's Democratic Republic

> **"If it were not for being a member of the health insurance scheme, I would not be able to afford the treatment for my disease."**
>
> Female, 53, physical impairment, Phu Tho, Viet Nam

> **"Health insurance helps me save a lot of money after each visit to health facilities for examination and treatment."**
>
> Carer of male, 8, intellectual impairments, Hung Yen, Viet Nam

However, even for those covered by social health protection, various factors limited the level of financial protection provided. The scale of cost and level of financial protection are influenced by a wide range of dynamics, including individuals' need for health services, the nature of the impairments they face, the organization of health services in each country and the location where persons with disabilities live. Despite these various issues, there are a number of common factors that affect the level of financial protection provided by social health protection schemes for persons with disabilities.

Limited scope of benefit packages under social health protection schemes

One important driver of medical costs are the limits applied to the range of services and goods included in social health protection benefit packages. As discussed in Section 4, the benefit packages of the social health protection schemes tend to often exclude a range of goods and services sought by persons with disabilities, be they more directly related to their disability (such as rehabilitation and assistive devices) or more general. As a consequence, persons with disabilities across the three countries reported having to pay out of pocket for items that were excluded from their benefit packages. These sums were often significant. Unsurprisingly, these costs appear to have been more significant for those experiencing major illnesses, who had significant ongoing healthcare needs or who required more expensive assistive devices.

> **"I was admitted to provincial hospital in June. I had a lung disease, specifically pleural effusion. They said that the health insurance only covered some medicines. I was hospitalized in Hung Yen Lung Hospital. I was there for 22 days. I had to pay 5 million dong [US$195.77] in advance. They said that the health insurance only covered one–two types of medicine, and the rest had to be bought out of pocket. Every week, they asked me to pay 5 million dong, and after three weeks, it added up to 15 million dong [US$590.32]. When I was discharged from hospital, I was not reimbursed. They clearly said that additional medicines were necessary for the treatment. I had to spend 5 million dong a week, and when I was discharged, they gave me another prescription. I had to buy the medicine at the hospital gate, and it cost me 800,000 dong [US$31.48]."**
>
> Male, 75, physical impairment, Hung Yen, Viet Nam

> **"We have to pay for brain tonics and medicine for epilepsy when accessing health services under the health insurance at health facilities."**
>
> Caregiver of female, 38, with intellectual impairment and epilepsy, Hung Yen, Viet Nam

> **"Many times when I take her to the doctors, I am informed that her medicine is not paid for by health insurance or is temporarily out of stock. The doctors give me the prescription and show me the pharmacy where I can buy the medicine. And then I just go to that pharmacy."**
>
> Caregiver of female, 39, with intellectual impairment, Phu Tho, Viet Nam

> **"Medicine costs more than 1 million dong [US$39.35] per month. Transport costs 800,000 dong [US$31.48]. Now I buy eye drops. I do not have to buy oral medications like I used to. Hospital beds are covered by health insurance. I have to pay for medicine out of pocket. In addition, I am given priority when accessing health services. However, I have to cover scanning costs, as they are not paid for by health insurance. I always access services using the health insurance, but the coverage remains limited. Eye disease is not like hand and foot disease, which can be cured quickly with injection. I was taken to Phu Tho Provincial Eye Hospital for treatment, but there was no improvement. Therefore, I was taken to a hospital at the central level. The place of registration for primary care is the Provincial Traditional Medicine and Rehabilitation Hospital. So when I was taken straight to Vietnam National Eye Hospital, it was accessing higher levels without a referral. If I follow the referral process, it takes a lot of time. Therefore, I decide go straight to hospital at the central level and accept to pay for goods and services out of pocket."**
>
> Male, 48, visual impairment, Phu Tho, Viet Nam

> **"I and his parents are the member of SASS [health insurance for civil servants], but I am often using it. For my nephew, usually we go to the rehabilitation centre, and we pay for the services. If it is a common illness, we will go to a clinic; if he does not recover, then we go to the central hospital."**
>
> Caregiver (aunt) of boy, 6, with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"For me, I do not want to wait for long time. I hired someone who made armpit crutches for me, and I paid about 1,000 baht."**
>
> Female, 58, physical impairment, Champasak, Lao People's Democratic Republic

> **"In the past its price [for a walking aid stick] was about 2,000 baht, now it is 3,500 baht. For a normal stick it was 500 baht, but now it is more than that."**
>
> Male, 29, visual impairment, Vientiane Capital, Lao People's Democratic Republic

Co-payments

Co-payments can also contribute to medical costs for those covered by social health protection schemes. Co-payments apply in two main scenarios. First, as discussed in Section 3, certain categories of people covered by social health protection schemes are still obliged to make co-payments to access healthcare services. These include those covered by the NHI in the Lao People's Democratic Republic (with the exception of some categories) and certain groups under Viet Nam's health insurance system who are required to pay 20 per cent of healthcare costs (such as where contributions are shared between an employer and employee). Individuals covered by social health protection schemes in Cambodia and via the disability allowance in Viet Nam are not required to make co-payments for health services (see figure 3.1 and figure 3.4). In general, the impact of this type of co-payment did not come out prominently in the field work, partly because the FGD participants in Cambodia and Viet Nam who had social health protection coverage were generally in categories that were exempt from co-payments, while the co-payments in the Lao People's Democratic Republic were generally perceived to be small.

A second scenario for co-payments is where certain types of goods and services that are covered by social health insurance require some (or a higher) level of co-payment. For example, in Viet Nam, health insurance only pays between 30 and 50 per cent of the cost of some healthcare services, including injections for a range of conditions, treatment for hepatitis C and robotic laparoscopic surgery. Meanwhile, certain scans – such as a PET-CT scan – will only be covered by health insurance once every 12 months.[38] Similarly in the Lao People's Democratic Republic, specific co-payments (either in absolute values or as a percentage of healthcare service cost) apply for treatments such as brain and orthopaedic surgery, various scans, chemotherapy and hospitalization resulting from road accidents (ILO 2021).

> **"By using the disabilities ID card, you would [think you would] be fully covered on all services at that hospital, but that's actually not the case. The actual situation is you would still need to pay out-of-pocket for services like surgery, getting ultra-sound scan, and getting blood tested, etc. – but only 50 per cent of the total cost for you, and only medication service is free for you."**
>
> Focus group participant, physical impairment, Kampong Cham, Cambodia

> **"I would like the hospital fee to be covered 100 per cent by the health insurance. Currently, I only have 80 per cent coverage."**
>
> Male, 38, work injury benefit recipient, Phu Tho, Viet Nam

> **"I have to pay for services that are not covered by health insurance. I sometimes have to buy medicine out of pocket; however, I don't have to buy medicine 100 per cent out of pocket. The health insurance can only cover services to a certain extent. It does not cover everything."**
>
> Female, 33, visual impairment, Phu Tho, Viet Nam

[38] Circular No. 35/2016/TT-BYT (2016).

Social health protection coverage gaps

Unsurprisingly, some of the highest costs were for those incurred by persons not covered by social health protection schemes. These experiences emerged from the FGDs in Cambodia and the Lao People's Democratic Republic, where at least some of the participants were not covered by health insurance.

> **"When I was admitted, I paid for staying in hospital. The cost was over 500,000 kip. The total I paid was about 2 million kip, because that time I did not have a family book in this province."**
>
> Male, 31, visual impairment, Champasak, Lao People's Democratic Republic

> **"For me, the last time that I went to hospital, I paid for all the things like treatment, drugs, blood test and transport. I paid about 700,000 kip for the blood test."**
>
> Male, physical impairment, Vientiane Capital, Lao People's Democratic Republic

> **"If a child is suffering from dengue fever, upon arriving at the hospital, you'll be automatically required to pay 400,000 riel [US$97.37]. The 400,000 is the total fee until the patient's fully recovered and out of the hospital."**
>
> Male without any health insurance card, 35, visual impairment, Kampong Speu, Cambodia

Seeking care outside of the dedicated network of service providers

FGD participants in all three countries also described resorting to private healthcare services outside of the network of service providers contracted by the social health protection schemes due to a range of factors. The mixed use of public and private facilities was particularly evident in the FGDs in Cambodia and in Vientiane Capital, while in Viet Nam there appeared to be a much greater use of public facilities. There were various drivers for persons with disabilities making use of private facilities, which tend to cost more than public facilities (especially where individuals would be covered by social health protection schemes):

- **Availability:** Relevant services are not always available in public facilities, meaning that individuals resort to private healthcare. This also applies to access to rehabilitation and particularly to assistive devices, which are often purchased privately.
- **Service quality:** Some participants shared that they trusted the quality of private services more than public services; although this was not a consistent view, with some sharing the opposite opinion.
- **Convenience:** A common comment in Cambodia was that private health services were much quicker to access, compared to the long waiting times found in public facilities. In some cases, private facilities are also closer to the participants' homes.

A somewhat mixed picture emerges in terms of which kind of services people seek in public and private facilities. On the one hand, some participants shared that they accessed more routine healthcare services in private facilities, but for more severe cases they would access public facilities – due to the comparatively low cost. On the other hand, some shared that they accessed public facilities for more routine services – for example, due to the proximity of health centres – but accessed private facilities for more severe cases, due – for example - to their greater trust in the quality of services.

> **"For my eyes, I go to the private clinic ... or buy eye drops at the pharmacy. But in terms of general health issues that are not serious, I go to the communal hospital."**
>
> Focus group participant, visual impairment, Battambang, Cambodia)

> **"There was a time when I went to Ang Doung Hospital and the type of scan I needed wasn't available. So, I was referred to a private clinic to get the scan done, and it cost me so much, about 800,000 riel. [This was] because I had to get a surgery done. It was not available here in Batheay District."**
>
> Female, 60, physical impairment, Kampong Cham, Cambodia

> **"I have used the LSSO, and based on my experiences, the quality of service is not good, it is very slow, and there are insufficient medicines. Some drugs are not covered, and I will buy them outside. By comparison a clinic or private [hospital] is faster, [and] yes, I know that cost is higher that a public hospital. But for the rehabilitation centre, I think they provide a good service, and they have advised what to do at home."**
>
> Caregiver of girl, 5, with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"I don't often seek healthcare. I only visit health facilities for check-ups when I'm severely ill. If the illness is mild, I visit the commune health centre. If it's severe, I visit hospital and buy medicines out of pocket. Every time I visit the hospital for a check-up, I'm given few medicines such as vitamin B1 and some antibiotics."**
>
> Female, 67, physical impairment, Phu Tho, Viet Nam

> **"When I visit the hospital, it is difficult for me to travel and I have to wait for a long time. I can't stand that. So I visit private health facilities. I rarely visit public health facilities – say, once a year or once every two years. I hardly ever access services using the health insurance."**
>
> Female, 58, physical impairment, Phu Tho, Viet Nam

> **"[We use public hospitals] because the private clinic does not have enough expertise in every disease or enough machines and facilities. If we are in a serious condition, they will transfer us to a public hospital anyway. I also would like to add one point, public hospitals have good medicine – if we bought from the pharmacy outside, the medication is not so effective."**
>
> Male caregiver, Phnom Penh, Cambodia

> **"Even I have LSSO [coverage], but sometimes I need to pay, because there is no medicines in the hospital."**
>
> Female, 58, physical impairment, Vientiane Capital, Lao People's Democratic Republic

> **"Usually I go to a clinic, because it is faster than the provincial hospital. I have diabetes, so I need to see a doctor every month. Mainly I paid for medicines and blood tests; it is about 500,000 to 600,000 kip."**
>
> Female, 60, physical impairment, Champasak, Lao People's Democratic Republic

A notable experience in the Lao People's Democratic Republic was participants resorting to accessing healthcare services in Thailand. Experiences of seeking care in Thailand were shared in many FGDs. This decision is strongly influenced by the geography of the Lao People's Democratic Republic, with the most densely populated areas of the country being along the Thai border, including the two field work locations in this research (Vientiane Capital and Champasak). Use of healthcare services in Thailand was often related to the perceived greater expertise and quality of technology for both diagnosis and

treatment of different impairments. However, participants shared that the costs of these services was often high, especially when accounting for the cost of transportation and accommodation. It should be noted that the use of services in Thailand may not be representative of the Lao population of persons with disabilities as a whole, and likely reflects both the location of field work and possibly the inclusion of persons with comparatively higher incomes in the FGDs.

> **"For me, after treatment in Thailand, I had to go to hospital every two–three months. I had travelled like that for almost three years, then I could not afford it [anymore], and I stopped going to hospital there. Actually, I had an appointment to see doctor there every year, but [now] I cannot."**
>
> Male, 39, visual impairment, Champasak, Lao People's Democratic Republic

> **"Since I know that I have osteoarthritis, I go to Mahosot Hospital [public hospital in Vientiane] every three to four months for treatment and rehabilitation. In 2014, I travelled to Nongkhai Hospital in Thailand for eight months. I went there every 15 days for treatment. After that, I went to Mahosot again, especially for rehabilitation."**
>
> Female, 61, physical impairment, Vientiane Capital, Lao People's Democratic Republic

Bypassing referrals

Another driver of costs is where individuals pay to directly access higher-level services without referral. This issue came out particularly clearly in Viet Nam. The costs of health services are covered by health insurance in district-, provincial- and central-level health facilities, but only when an individual has been referred by a health facility at a lower level. Some participants shared that they accessed and paid for higher-level facilities directly rather than going through referral processes, which were perceived to be time consuming. In some cases this was due to participants needing routine care in higher-level health facilities that specialized in their impairment. This issue emerged particularly strongly in discussions in Phu Tho Province.

> **"I would like to change my place of registration for primary care covered by health insurance to the provincial level. If I want to visit the provincial hospital, I have to go to the Traditional Medicine Hospital to ask for a referral certificate in the morning. After that, I go to the provincial hospital for examination. Travelling too much is hard for me. And when I arrive at the provincial hospital, I have to wait for my turn. It takes a whole day. My illness, as well some other people's illnesses, require treatment at the provincial hospital. Obviously, this process is time-consuming, money-consuming and tiring. That is the reason why patients are not willing to visit health facilities."**
>
> Female, 53, physcial impairment, Phu Tho, Viet Nam

> **"I access higher levels without a referral, and I accept paying out of pocket. Visual impairment is different from other diseases. Travelling to the Traditional Medicine and Rehabilitation Hospital takes nearly half the day. It also takes too much time to ask for a referral to the Vietnam National Eye Hospital."**
>
> Male, 48, visual impairment, Phu Tho, Viet Nam

> **"The goods and services I use when accessing healthcare are 100 per cent covered by the health insurance. If I visit health facilities without a referral and have to use the X-ray service, I have to pay out of pocket, as it is not covered by the health insurance."**
>
> Female, 40, hearing impairment, Phu Tho, Viet Nam

5.2. Non-medical costs

5.2.1. Transport and meals

Across all three countries, transport was identified as a common cost, and as a significant cost for many participants. The scale of this cost depends on factors such as geographical location and the availability of health services. The qualitative nature of this research means it is not possible to gain a comprehensive quantitative assessment of the scale of transport costs, but it should also be noted that the FGDs for this study did not take place in remote areas, which means that they likely did not capture some of the highest levels of transportation expenses.

> **"[The hospital] is far away, and I spent 30,000 riel [US$7.30] for a tuk-tuk one-way. Well, I spent like 80,000 riel for one-way to Kien Klang."**
>
> Caregiver, Phnom Penh, Cambodia

> **"I need to pay around 30,000 to 40,000 riel [US$7.30–US$9.74] for transportation roundtrip. ... If only transportation, yes, this amount, but if I buy food, it might be more."**
>
> Focus group participant, visual impairment, Phnom Penh, Cambodia

> **"On average, the food costs are 200,000 dong [US$7.87] and transport costs are 250,000 dong [US$9.84]. Hospital bills cost around 200,000 dong, excluding medicine."**
>
> Female, 53, physical impairment, Phu Tho, Viet Nam

The support available to cover transportation and meals during hospital admissions varies between countries. The precise situation is difficult to decipher given that only some FGD participants shared experiences of using inpatient services, and their treatment and referral pathways were diverse. Nevertheless, some relevant aspects that emerged include:

- **Cambodia** has some notable measures in place to cover costs for inpatients. These include the 5,000 riel (US$1.22) per day allowance (described in section 3.1), which was received positively by those eligible under the Health Equity Fund. Another notable measure are the reimbursements for food and transportation provided by physical rehabilitation centres, which are discussed in section 4.2.1.
- In **the Lao People's Democratic Republic**, one notable issue is that the NHI provides food allowances and transport allowances for admitted patients, but only for those on the list of poor households. While this issue did not arise specifically in the field work, the fact that persons with disabilities are not included in this category may limit their protection.[39]

[39] Article 4.1.6 of the Instruction of the Minister of Health on Contribution Collection, Payment Mechanisms and Calculation of Service Fees of the National Health Insurance (No. 0476/MOH) states: "Admitted patients, pregnant women and children under 5 in the list of poor households ... will receive food allowance and transport allowance for round trip home hospital."

- In **Viet Nam** travel and food expenses are covered for individuals living in poor households, but not for the rest of the population, including persons with disabilities who are not poor.

5.2.2. Human assistance

Many persons with disabilities reported that they required the support of a family member or caregiver to access health facilities. The need for assistance in accessing health facilities was most evident for persons with hearing, visual and intellectual impairments, as well as some persons with physical impairments. The lack of adaptation of medical facilities for persons with disabilities – such as use of braille formats for those with visual impairments – was described as a factor prompting the need for human assistance. Another factor was the limited accessibility of public transportation, with support required to navigate these systems.

Generally, the level of human assistance provided by health facilities appears to be limited. Some examples were shared of where hospital staff provided assistance, for example, in pushing people with wheelchairs. However, the overarching perception across the three countries was that such assistance was generally not available.

> **"It's our challenge in this part. We can't go there by ourselves, so we need a care-taker or an assistant; so the expenses add up."**
>
> Focus group participant, visual impairment, Phnom Penh, Cambodia)

> **"The hospital didn't have reasonable accommodation for us. We need to hire an interpreter by ourselves. In case the interpreter is busy, we will video call them and ask them to interpret with the doctor."**
>
> Focus group participant, hearing impairment, Phnom Penh, Cambodia

> **"I paid a person who went to hospital with me about 100,000 to 150,000 kip for half a day. I went to the clinic and also needed to pay for travel, and expenditures at the clinic were also expensive."**
>
> Male, 27, visual impairment, Champasak, Lao People's Democratic Republic

> **"I had experiences with high expenditure for the person [assistant]. I paid about 700,000 to 800,000 kip for the person that accompanied me, because she spent the whole day with me at hospital."**
>
> Female, 51, visual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"I always need to be accompanied by a family member when visiting health facilities for examinations. My father often takes me to the doctor. My family is poor and we cannot afford to travel by coach or taxi."**
>
> Female, 18, visual impairment, Phu Tho, Viet Nam

> **"I cannot speak, so I am unable to communicate with health workers. Every time I visit health facilities for examination, I must be accompanied by someone."**
>
> Female, 52, hearing impairment, Hung Yen, Viet Nam

> **"I wish I could receive medicine at the commune health station or the Traditional Medicine Hospital. I don't want to ask for help from my children when I have to travel to far away facilities. They still have to work. I'm old and sick and I can't travel due to my impairment."**
>
> Male, 68, physical impairment, Phu Tho, Viet Nam

> **"Every time she visits health facilities for examination, we have to pay for transportation, food and additional medicine costs. She always needs someone to accompany her and take care of her."**
>
> Caregiver of women with intellectual impairment, Hung Yen, Viet Nam

> **"At the hospital, there are assistants. They will push the wheelchairs"**
>
> Male, 71, physical impairment, Hung Yen, Viet Nam

> **"Most people with visual impairment need their family members' support when visiting health facilities for examination. There is not yet information adapted for us. There are no accessible communication formats like braille on the health insurance card."**
>
> Female, 18, visual impairment, Phu Tho, Viet Nam

The cost of family and caregiver support to access health facilities can be significant. In some cases, this constituted a direct cost, as in the case of persons with visual or hearing impairments who described having to pay for an interpreter or assistant to support them in accessing healthcare. The use of video calls to provide sign language interpretation was described as a lower cost solution by some participants. Meanwhile, the support of family members or friends can constitute an important indirect cost, with these individuals having to take time off from paid work activities to provide such support, thereby impacting their incomes.

5.2.3. Indirect costs

A final relevant cost are the indirect costs (or opportunity costs) of accessing healthcare. These take different forms. First, indirect costs can be related to the cost of persons with disabilities having to take time off from work to access health facilities. This can be a particular issue given their higher healthcare needs compared to persons without disabilities and the more limited services on offer. This issue did not come out prominently in the field work, which may relate to the profile of the persons with disabilities in the FGDs, and the fact that the employment situation of participants was not explored in detail. Second, indirect costs can be related to the costs faced by those providing care and support to persons with disabilities when they take the time to support a person with disabilities to access to healthcare. This was mentioned by various persons with disabilities and by caregivers of persons with disabilities. It also relates to the role of family members providing assistance to persons with disabilities to access healthcare, as discussed above.

> **"I rarely take her to health facilities for regular check-ups because I don't have time."**
>
> Caregiver of female with intellectual impairment, Phu Tho, Viet Nam

> **"My parents had to pay a lot for travel and food costs when taking me to health facilities to seek treatment for my deafness and mutism. They had to take time off work to take me there. However, the treatment didn't work, and therefore, in order to save money, I do not seek healthcare anymore."**
>
> Female, 40, hearing impairment, Phu Tho, Viet Nam

> **"When hospitalized, I have to pay extra for daily meals, personal items, and if family members come to take care of me, they also need food and have to take time off work."**
>
> Male, 77, visual impairment, Hung Yen, Viet Nam

> **"I think there are many impacts. My wife and I are often absent from work to take our child to the [rehabilitation] centre."**
>
> Father of boy, 4, with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

5.3. Coping strategies

FGD participants reported a range of coping strategies in the context of the various costs associated with accessing healthcare. One commonly mentioned coping strategy was to forego healthcare, especially for cases that were considered to be less serious, in the hope that the they would recover without treatment. When in a situation where they had to pay high costs for healthcare, FGD participants mentioned having to seek financial support from family members or having to go into debt.

> **"I live with my younger brother. I eat what he feeds me. Sometimes he and my younger sister give me some money to buy medicine. I am not willing to visit the hospital, as I have little money. My daughter is married and lives far from me. She faces difficulties in her life, too."**
>
> Female, 67, physical impairment, Phu Tho, Viet Nam

> **"It costs a lot of money to buy medicine out of pocket. In addition to my eye condition, I also have kidney failure and it costs a lot of money for treatment. My parents also have to save money to support me in accessing examination and treatment services."**
>
> Female, 18, visual impairment, Phu Tho, Viet Nam

> **"We do not take her to the doctor because we cannot afford it. The family is not received as a poor or at-risk household. We are old and cannot take her to seek healthcare anywhere, even the commune health station, which is 1 km from the house. If she is sick, I will buy medicine for her at the pharmacy."**
>
> Caregiver of female, 35, with intellectual impairment, Phu Tho, Viet Nam

> **"My child is an autistic child with hyperactivity. He needs rehabilitation services, but we cannot afford them. The reason is that it takes time and costs a lot of money to take him to the city for these services. Every day, he has to practise one hour in the morning and one hour in the afternoon. Private lessons cost about 150,000–200,000 dong [US$5.90–US$7.87] an hour. Totally, it costs 5 million dong [US$196.77] per month. We cannot afford it."**
>
> Caregiver of male, 6, with autism, Hung Yen, Viet Nam

> **"If the health services are not covered by health insurance, I still need to take him to see a doctor. If I don't have enough money, I will borrow it from others. I just can't let him stay at home when he has such a health problem. It costs 100,000 dong [US$3.94] for examination and medicine each visit, we can pay for this. If it costs 500,000 dong [US$19.68], I have to borrow money from others. However, no one is willing to help. Each visit to a private clinic for examination costs 50,000 dong [US$1.97]. It costs 80,000 dong [US$3.15] to get blood tests, ultrasound and X-rays. I cannot afford it if it costs more than 100,000 dong [US$3.94]."**
>
> Caregiver of male, 38, with intellectual impairment, Hung Yen, Viet Nam

> **"I used to have a problem with my stomach and I could usually hold it in, but I held it in long enough to make me faint and suffer severely until I decided to go [to seek medical attention]. I held it in because I was struggling financially. ... At that time, I did not have the poor ID card yet, and if I had decided to go, the only option would be to go to private clinics, and it would then cost a fortune. ... [In the end] I was taken to the hospital.... I ended up in debt because of that."**
>
> Male, 18, visual impairment, Battambang, Cambodia

> **"One of the challenges is not being able to have money to pay on time, so I would have to go in debt here and there."**
>
> Male, 67, physical impairment, Kampong Speu, Cambodia

> **"For me, first I used my savings money, and then I mortgaged family land. And I also borrowed money and sold my gold."**
>
> Female caregiver of male, 8, with autism, Champasak, Lao People's Democratic Republic

5.4. Role of cash benefits

Cash benefits – including non-contributory benefits like Viet Nam's disability allowance and contributory benefits such as employment injury benefits – can potentially contribute to covering (extra) costs associated with accessing healthcare for persons with disabilities, though this is not usually the objective of these benefits. While cash benefits should not be considered a solution to major gaps in financial protection stemming from the healthcare system, there are various types of costs such benefits can cover. Cash benefits are particularly relevant for covering the non-medical costs described above, such as transportation to health facilities or opportunity costs associated with accessing healthcare (both for persons with disabilities and those supporting them). Cash benefits can also compensate for lost working time during periods of sickness, in the absence of sickness benefits. These non-medical costs are less likely to be covered by social health protection benefit packages, especially in relation to outpatient services. Cash benefits may also contribute to covering the cost of both general and disability-related medical goods and services. The role of cash benefits in covering such goods and services needs to be considered carefully, as monthly cash benefits are not suited to covering the unpredictable and often significant costs of healthcare, rehabilitation and assistive devices. However, it could be argued that cash benefits could have a role to play in covering smaller and more regular expenditures, such as lower-cost assistive devices (for example, diapers) and consumables (such as, batteries for hearing aids). Cash benefits also have a role in securing livelihoods, supporting access to employment opportunities, and supporting overall access to essential goods and services (education, nutrition and housing), all of which are crucial determinants of health.

5.4.1. Non-contributory cash benefits

Cambodia and Viet Nam provide non-contributory cash benefits that reach people with disabilities, while the Lao People's Democratic Republic has no such schemes in place. The schemes in the two countries vary considerably in their design.

Cambodia has had two non-contributory cash benefits in place that are relevant to persons with disabilities. However, both of these are in the process of being replaced by a new "Family Package".

- The **Cash Transfer for Persons with Disabilities (CT-PWD)** targets persons with disabilities with an IDPoor card. As of 2020, the CT-PWD reached nearly 17,000 persons with disabilities, paying a benefit of between 10,000 and 20,000 riel per month. It appears that only one participant in the FGDs was receiving this benefit.
- **The Cash Transfer for Poor and Vulnerable Households during COVID-19 (CTP-COVID)** was introduced in early 2020 as a response to the COVID-19 crisis and continued to make payments until early 2024. The scheme was targeted at poor households (IDPoor Levels 1 and 2) with a monthly benefit paid to the household head. The scheme has a complex benefit structure, providing a minimum of US$20, but with the total amount varying on the basis of household characteristics, including household size, geographical location, and presence of young children, persons with disabilities, older persons and persons living with HIV/AIDS. At its peak, the scheme reached around 700,000 households, including more than 2.5 million individuals (UNICEF, forthcoming; World Bank 2021).[40] Around 70,000 households received a larger benefit payment based on a person with disability being in the household. Many FGD participants reported that their household received this benefit, although this scheme was understood to be coming to an end in March–April 2024 (when the FGDs were conducted).
- At the time of writing, Cambodia is in the process of rolling out a new **"Family Package"** cash benefit, which is intended to replace both the CTP-COVID and the CT-PWD. This scheme appears to have been implemented since April 2024, targeting poor households (IDPoor Levels 1 and 2).

[40] Publicly available data from the IDPoor database indicates that, as of 1 March 2024 (the final month of CTP-COVID payments), there were 673,214 poor households (IDPoor 1 or 2) encompassing 3,541,039 individuals (22.97 per cent of the total population) (Cambodia, IDPoor, n.d.).

The benefit package consists of a household benefit (paid to the household head) and benefits paid to pregnant women and children under 2 years old, people with disabilities, older persons (aged 60 and over) and people living with HIV/AIDS. The monthly household benefit is 34,000 riel (US$8.28) per month, with the individual benefit for persons with disabilities being 28,000 riel (US$6.87). There was some awareness of this scheme within the FGDs, although there was a lack of clarity on the specific parameters at this point in time.

Viet Nam has a complex system of social allowances addressing both disability and other kinds of social risks. As discussed in section 3.3, receipt of these allowances provides a key channel to health insurance coverage.

- The **disability social allowance** is paid to individuals who have been assessed as having either severe or extremely severe disability. The benefit level ranges between 540,000 and 900,000 dong (US$21.25–US$35.42) per month, based on severity of disability and age. The way in which focus groups for this study were sampled meant that virtually all of the participants received this benefit. Persons with severe and extremely severe disability who are pregnant or raising a child aged 0–36 months also receive additional non-contributory benefits.
- A **caregiver benefit** is also in place for those providing care and support to persons with extremely severe disabilities. The benefit also ranges between 540,000 and 900,000 dong (US$20.25–US$35.42) per month, with a higher benefit for caregivers of children.
- **Other social allowances** target groups such as orphans, single parents, older persons and persons living with HIV/AIDS. As discussed in section 3.3, old age benefits in particular can be an important channel for some persons with mild disabilities to receive cash benefits and health insurance, given the higher levels of disability seen at more advanced ages.

There are currently no such schemes in place in **the Lao People's Democratic Republic**, however, the Decree on the Rights of Persons with Disabilities (2014) describes the potential for allowances to support persons with disabilities or those caring for them, although no such allowance is currently in place. The National Social Protection Strategy 2025 also recommends establishing benefit support for persons with disabilities (alongside other groups)[41] and includes costing of the gradual roll out of a disability benefit (Lao People's Democratic Republic, MLSW 2020). UNICEF Lao PDR is also in the process of implementing a pilot programme in Xieng Khouang Province that combines a cash benefit to children with disabilities with the provision of assistive devices.

There were some indications in Viet Nam that social allowances played a role in helping persons with disabilities cover healthcare costs. Various FGD participants mentioned this role in relation to affording medicine, although the role of family members in helping to cover these costs was also mentioned. Experiences of social allowances covering healthcare costs seem to have been more common among older persons, indicating that the role of cash benefits may be more obvious for individuals with ongoing chronic illnesses, rather than more infrequent (but potentially larger) costs.

> **"I spend my social allowance on medicine. If I can't afford medicine, I'll ask my children for help."**
>
> Male, 68, physical impairment, Phu Tho, Viet Nam

> **"I can't live on the social allowance. My children sometimes give me money to buy medicine."**
>
> Male, 70, physical impairment, Phu Tho, Viet Nam

[41] "Provide services and benefits to different types of persons with disabilities who are not able to work, not able to help themselves, or belong to low-income families, including UXO survivors with a disability and gender-based violence survivors" (Lao People's Democratic Republic, MLSW 2020, 14).

> **"I have to ask someone to take me to hospital because I am old and weak and it's far away from my house. I also often buy medicine at a private pharmacy which is near my house because I do not have to ask for help from other people. I can afford medicine for a minor illness thanks to the social allowance I receive."**
>
> Female, 90, hearing impairment, Hung Yen, Viet Nam

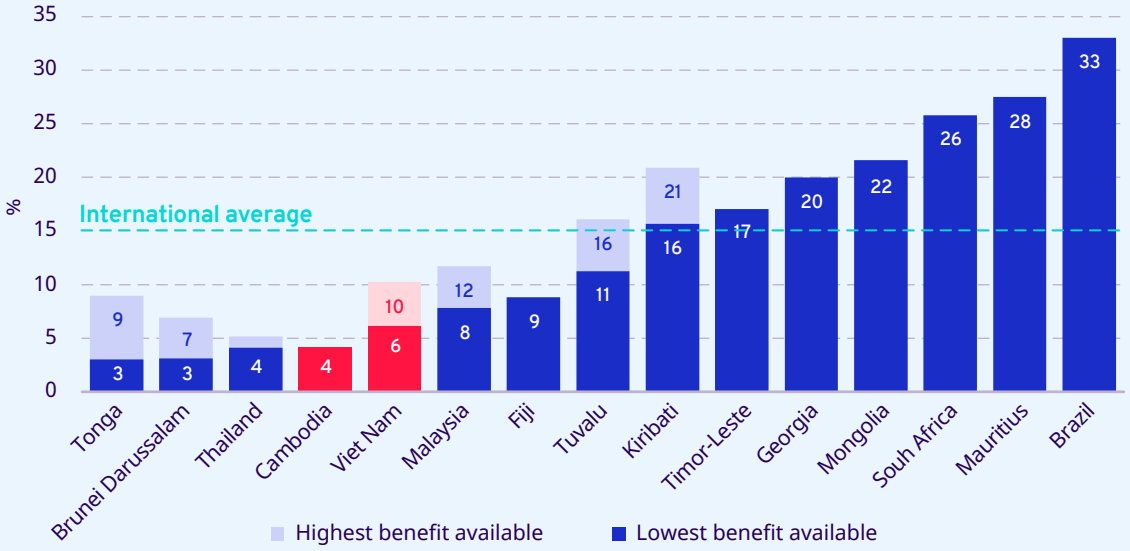
> **"He receives a social allowance. However, it only helps him to cover part of the health expenditure"**
>
> Caregiver of male, 13, with intellectual impairment, Hung Yen, Viet Nam

The role of non-contributory cash benefits for covering healthcare costs is less clear in Cambodia. This may be, in part, due to the lower degree of coverage by cash benefits in Cambodia, and also the way in which the field work for this study was conducted. More time was spent in the FGDs on establishing who received different kinds of benefits, rather than on the impact of these benefits. Another aspect is that the most common cash benefit discussed (the CTP-COVID) is a household benefit paid to the household head, which was often not the individual with disabilities participating in the FGD. Evidence from other countries – such as Timor-Leste – indicate that household benefits are potentially less likely to be allocated to the specific needs of persons with disabilities than individual disability benefits (Knox-Vydmanov, Cote and Wodsak 2021).

Financial protection provided by schemes in both countries is limited by the low level of cash benefits. Figure 5.3 shows the benefit level of the disability social allowance in Viet Nam and the disability component of the Family Package in Cambodia in comparison with similar benefits in other countries. Benefit levels are shown as a percentage of gross national income (GNI) per capita, which provides an indicator of adequacy relative to the level of economic development in a given country. The lowest-level benefits available in both countries (4 per cent of GNI per capita in Cambodia and 5 per cent in Viet Nam) are well below the international average for non-contributory disability benefits, which sits at around 15 per cent of GNI per capita (ESCAP and ILO 2020), and are even further below the benefits offered in countries such as Brazil, Mauritius and South Africa. Another measure is how benefits compare to the relevant international poverty line for each country (figure 5.4).[42] Cambodia's disability benefit under the Family Package is equivalent to only a fifth of the relevant international poverty line. Viet Nam's benefit is higher, at around 70 per cent of the international poverty line for the minimum available benefit (540,000 dong (US$21.25)) and above the poverty line for the highest available benefit (900,000 dong (US$35.42)). Nevertheless, given that the higher benefits are targeted at some of those with the most extreme forms of disability, and consequently of the greatest need, a benefit that sits so close to the poverty line is still relatively modest. And, once again, the benefits fall far below those found in countries such as Brazil, Mauritius and Mongolia, where disability benefits far exceed the relevant international poverty lines.

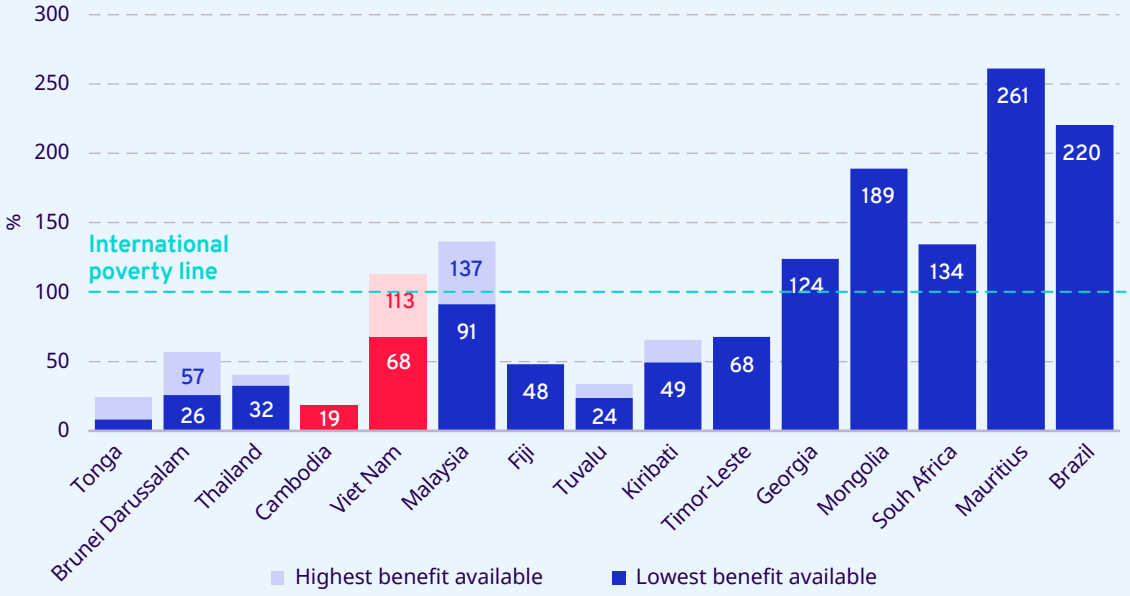
[42] The World Bank suggests using different international poverty lines in different countries according to their country income group. These are PPP$2.15 per day for low-income countries, PPP$3.65 for lower-middle-income countries (Cambodia, the Lao People's Democratic Republic and Viet Nam all fall into this group) and PPP$6.85 for upper-middle-income countries. The denominator in figure 5.4 is adjusted for each country on this basis (WHO and World Bank 2023).

Figure 5.3. Benefit levels of non-contributory disability benefits in selected countries as share of GNI per capita, latest available year (percentage)



Sources: UNICEF, forthcoming; authors' calculations for Cambodia and Viet Nam based on IMF 2024 and World Bank, n.d.

Figure 5.4. Benefit levels of non-contributory disability benefits in selected countries as share of relevant international poverty line, latest available year (percentage)



Note: As per the World Bank, the poverty line is set at PPP$2.15 per day for low-income countries, PPP$3.65 for lower-middle-income countries and PPP$6.85 for upper-middle-income countries. Sources: UNICEF, forthcoming; authors' calculations for Cambodia and Viet Nam based on IMF 2024 and World Bank, n.d.

FGD participants in Viet Nam made strong calls for increases in the level of social allowances. When asked about the kinds of additional support that would benefit persons with disabilities, an increase to allowances was a common responses. The predominance of this theme in Viet Nam (compared to Cambodia) is likely linked to the fact that all of the FGD participants received an allowance that was provided specifically to themselves (as opposed to the household-level benefits in Cambodia), as well as the fact that social allowances are much more established as a guaranteed and predictable benefit in Viet Nam.

5.4.2. Contributory benefits

Employment injury benefits are the most established form of cash benefit provided by social insurance schemes across the three countries. The benefit structures of these schemes are generally divided between a periodic (monthly) benefit provided to those with a loss of work capacity above a given threshold,[43] while those determined to be below the threshold receive a lump sum benefit. The benefit levels are determined by a combination of the degree of disability and a reference point for salaries/wages. Cambodia also provides a temporary income replacement benefit while those affected by work injuries are receiving medical treatment. FGD participants receiving work injury cash benefits across the three countries shared information about the benefits they received (which matched the respective scheme parameters). However, the discussions did not touch upon the extent to which these benefits provide financial protection from healthcare costs.

General disability cash benefits provided via the social insurance system are much less developed. The Lao People's Democratic Republic has had a disability benefit in place since the early stages of development of its social security system. Cambodia's NSSF recently established a pension scheme in 2022, which includes old-age, disability and survivors' benefits, however, it is unclear whether there are any beneficiaries of this scheme to date. Viet Nam has no specific disability benefit in place via the social insurance system, although early retirement benefits are provided on the basis of loss of capacity to work.

It should be noted that the coverage of disability-related cash benefits under social insurance schemes remains very low and should be considered an important gap. In Cambodia, 826 individuals were receiving the periodic work injury benefit as of 2022 (Cambodia, NSSF 2023), compared to around 300,000 registered under the new Disability ID Card system. In the Lao People's Democratic Republic, 189 people were receiving the periodic work injury benefits as of 2022. In Viet Nam, 2,361 individuals were receiving the periodic work injury benefits, which can be compared to the more than 1 million receiving the disability social allowance in the same year. More significant are early retirement pensions, which reach more than half a million recipients in Viet Nam. It should be noted that the coverage of benefits under social insurance schemes, such as work injury benefits, focus on a very specific group of persons with disabilities who have acquired an impairment in a specific set of circumstances. In this respect, they are not directly comparable to registries and benefits targeting persons with disabilities in general. That said, the very low levels of coverage do highlight that such benefits often constitute a very small portion of the overall support provided to persons with disabilities by the social protection system.

[43] Those thresholds are: 20 per cent in Cambodia; 41 per cent in the Lao People's Democratic Republic; and 31 per cent in Viet Nam.

6

Long term care

Key messages

- The legal framework for long-term care remains very limited across the three study countries. While laws on disability make some reference to care and support services, dedicated legislation on these services is largely absent.
- Reflecting the legal framework, in practice there are very limited formal care and support services in place in any of the three countries. Existing services are primarily provided by NGOs, although Viet Nam has some residential care facilities and nursing homes.
- The requirement for care and support services varied significantly among FGD participants, from those with minimal requirements for care and support, to those with significant difficulties with activities of daily living that require significant care.
- Existing care and support is almost exclusively provided by family members, and sometimes by friends and community members. The impact of caregiving responsibilities on family members can be significant, including sometimes requiring them to exit the labour market to provide support to persons with disabilities. As global evidence indicates, the impact of care responsibilities tends to fall particularly on women.
- In this context, the absence of formal care and support arrangements that are accessible without financial hardship represents a significant policy gap. There is also space for considering the (greater) role of cash benefits to cover the costs of social care, such as the caregiver benefit in Viet Nam.

The discussion of long-term care in this report uses a relatively broad definition of the term. Definitions of long-term care vary along various dimensions[44] including:

- Which **age groups** the services relate to – for example, whether limited to older persons or relating to persons of all ages with care and support needs.
- The kinds of **care and support needs** that services seek to address. For example, whether relating only to activities of daily living (focused on self-care) or instrumental activities of daily living (encompassing wider dimensions of independent living).
- The **nature of services** provided – for example, those only related to health-related issues, or a wider set of services addressing the kinds of care and support needs mentioned above.

This research took a relatively broad approach, considering care and support needs for persons with disabilities of all ages. In terms of the types of needs, both the "activities of daily living" and the "instrumental activities of daily living" were used as reference points for discussion in the field research.[45] Research questions were also relatively open on what kinds of services might be relevant for those with different support needs, not being limited to those that would necessarily be accessed via social health protection benefits.

The legal framework for long-term care remains very limited in all three countries. Long-term care is not included within the social health protection benefit packages in any of the countries. There also appears to be no legal framework for the provision of long-term care in Cambodia and the Lao People's Democratic Republic. National laws on disability do make reference to care and support services, but not generally in a way that has resulted in meaningful services being put in place. In Viet Nam, there have been some notable policy developments in relation to long-term care of older persons. While the 2009 Law on the Elderly put an emphasis on the role of the family in providing care, some reference is made to formal services. A National Program of Action on Ageing also includes some policy measures in

[44] See Tessier, De Wulf and Momose (2022) for further discussion.
[45] Activities of daily living relate to self-care activities such as eating, bathing, dressing, getting in and out of bed, going to and from the toilet, and managing incontinence. Instrumental activities of daily living encompass a broader range of tasks, including shopping, laundry, cleaning, cooking, managing finances and communication.

relation to long-term care. These include an emphasis on ageing in place, building a market for private elderly care services, and improvements in training family caregivers, as well as encouraging greater collaboration between the two relevant line ministries: the Ministry of Health and the Ministry of Labour, Invalids and Social Affairs (ADB 2022a).

It is notable that many countries across the Asia Pacific region have been exploring options to extend long-term services. These include attempts to introduce long-term care insurance, as illustrated by the case of the Republic of Korea in Box 6.1. One dynamic highlighted in this case is the separation of systems of care and support for older people from those for persons with disabilities.

▶ Box 6.1. Long-term care insurance in the Republic of Korea

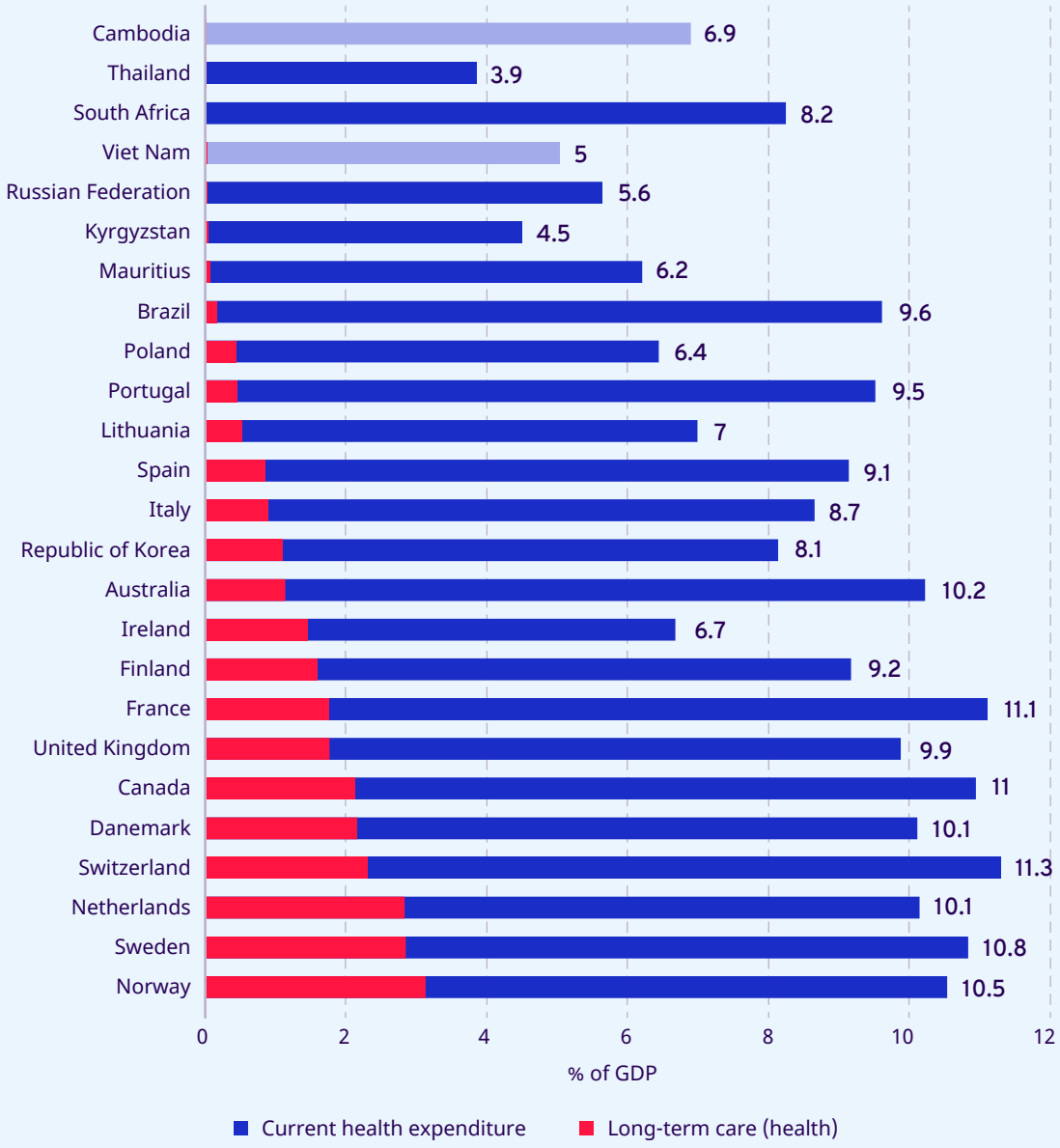
The Republic of Korea's long-term care system, financed by mandatory social insurance, was established in 2008. The scheme provides benefits to those who meet the eligibility criteria, primarily targeting older people aged 65 and above and younger individuals with age-related long-term care needs. The focus of the scheme is more on the ageing population than on persons with disabilities. Care services, such as living support for persons with disabilities, are provided by a non-contributory welfare scheme through a separate system from long-term care. Generally, care services for persons with disabilities are more generous than those offered by the long-term care scheme. The long-term care benefit package includes home and community-based benefits such as home visits, home-visit bathing, home-visit nursing, day and night care, short-term respite care, and assistance with purchasing or borrowing equipment. It also covers facility benefits for aged care facilities and senior congregate housing (Kim and Kwon 2021).

Reflecting the legal framework, in practice there are very limited formal care and support services in place in any of the three countries. In Cambodia and the Lao People's Democratic Republic, existing care and support services appear to almost exclusively be provided through NGOs, including organizations of persons with disabilities. The key informant interviews and FGDs in both countries involved direct interactions with such organizations, which included associations linked to specific impairments (for example, visual impairments, hearing impairments and autism), as well as schools for children with disabilities that sometimes provide other care and support services to families with children with disabilities. The most notable formal care services provided by government are found in Viet Nam, where the Ministry of Labour, Invalids and Social Affairs runs some residential social welfare centres and nursing homes. Another notable development in relation to ageing has been the development of a model of Intergenerational Self-Help Clubs, under the Viet Nam Association of the Elderly and supported by HelpAge International, which have been used to develop home-based and community-based care models (ADB 2022a).

Existing data also suggests virtually no health expenditure dedicated to long-term care. Figure 6.1 presents international data on current health expenditure on long-term care (health) [46] as a share of GDP compared to total current health expenditure as a share of GDP for a selection of high- and middle-income countries. For Cambodia and Viet Nam – the two study countries where data is available – levels of expenditure on long-term care are so low as to be virtually invisible on the chart. This reflects the situation in many other middle-income countries, however, it stands in contrast with the situation seen in a range of higher income countries where current health expenditure on long-term care ranges between 1 and 3 per cent of GDP.

[46] According to the System of Health Accounts, long-term care (health) "consists of a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency" (OECD, Eurostat, and WHO 2011, 88). This is considered distinct from long-term care (social), which encompasses a set of activities more closely related to instrumental activities of daily living.

Figure 6.1. Current health expenditure and long-term care (health) expenditure in selected countries as a share of GDP, 2019 (percentage)



Source: WHO, n.d.-a.

The requirement for care and support services varied significantly among FGD participants. The nature of a person's disability clearly has a major influence on their requirements for care and support. FGD participants with hearing and visual impairments generally said they could manage self-care and activities around the home. The main support they needed was to navigate outside the house. Those with visual impairments reported needing support to visit the market or hospitals. Persons with hearing impairments reported the need for an interpreter in certain situations (such as hospital visits). Among the FGD participants with physical disabilities, most said they could manage self-care activities, but sometimes required support to travel outside the home, especially when navigating public transportation systems that were not accessible. Persons with intellectual impairments had the greatest difficulties in terms of self-care activities, and FGDs with their caregivers revealed significant care needs.

> **"Persons with intellectual disabilities are those who really need to be taken care of. We can do all these things ourselves. We take care of ourselves."**
>
> Male, 60, physical impairment, Hung Yen, Viet Nam

> **"After preparing food in the morning, we lift him from bed to the toilet, then back to the wheelchair and clean up, such as washing his face and brushing his teeth, combing his hair. At around 9–10 a.m., he needs another lift for toilet break. I do it all alone and I need to lift him four–five times on average per day."**
>
> Female caregiver, Phnom Penh, Cambodia

> **"I can do everything by myself, such as bathing, eating, going to and from the toilet. Food and drinks are prepared for me. I just wander around the house. As I have lived in my house for many years, I'm familiar with it and I can do everything myself. When I need to go somewhere else, I ask my children and grandchildren to take me there."**
>
> Male, 77, visual impairment, Hung Yen, Viet Nam

> **"I can take care of myself. I don't ask for help from anyone. I only need to be accompanied when I go to buy medicine or see a doctor."**
>
> Female, 40, hearing impairment, Phu Tho, Viet Nam

> **"I need assistance; for example, if I go to the market, I might need a friend to go with me."**
>
> Female, 42, visual impairment, Battambang, Cambodia

> **I have difficulty in washing my clothes and I cannot cook as well. I cannot do [these things] by myself, and when go out, I need to go with my friends, because I cannot see."**
>
> Male, 26, visual impairment, Champasak, Lao People's Democratic Republic

> **"It is difficult to go to shopping. I need someone to take me to market."**
>
> Female, 28, physical impairment, Vientiane Capital, Lao People's Democratic Republic

Existing support was almost exclusively provided by family members or friends. This was the case for the diversity of care and support provided. The role of family members in providing care and support was most apparent among caregivers of persons with more severe intellectual impairments. In some exceptional cases, families had hired caregivers at their own expense. Older persons with disabilities also mentioned having to rely on family members for care and support, but the care provided was often limited by factors such as family members having other commitments or living at a distance. For taking trips outside the house, the source of support was more varied, and often involved the assistance of families, friends or other persons with disabilities from organizations of persons with disabilities. Some persons with hearing impairments reported having to pay for interpreters, although this support was also often provided by family members. The question of care and support was not explored in adequate depth to provide a clear picture on the gender distribution of care. However, reflecting patterns found across the region and the world, responsibility for providing care and support within families is likely to fall most heavily on women (ADB 2022b; ILO 2018).

> **"I try to take care of myself, although it takes time to put on trousers or go to and from the toilet. I sometimes feel very sorry for myself. My children live far from me. I live with my younger brother. He is busy with his work, so I have to manage myself. I do things myself. I ask for help from no one."**
>
> Female, 67, physical impairment, Phu Tho, Viet Nam

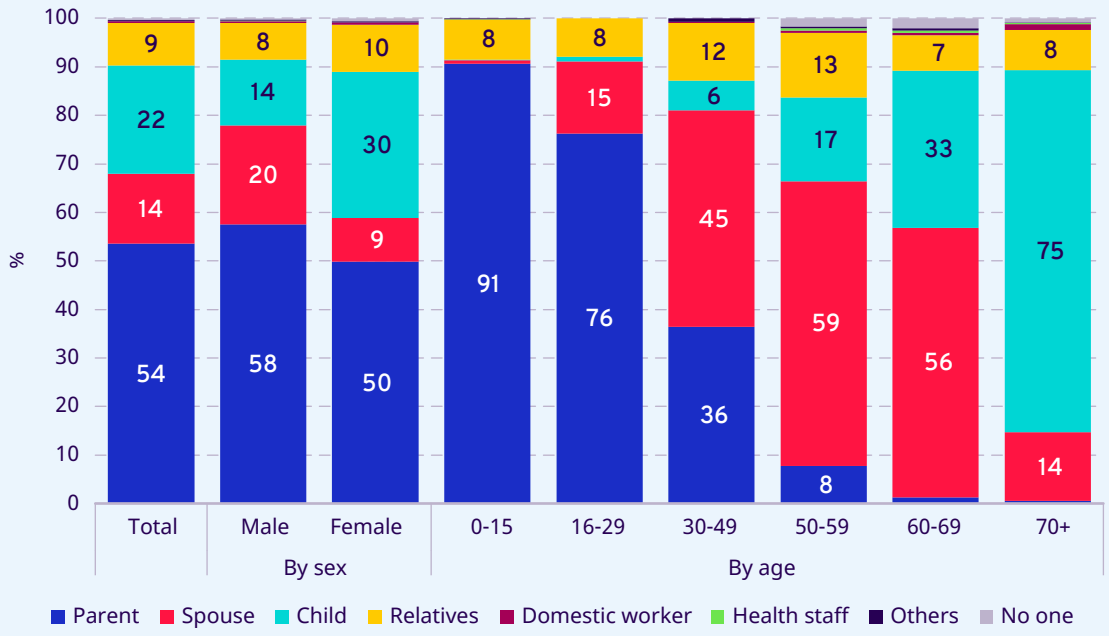
> **"My old age, poor eyesight and neurological condition make me afraid of falling in the kitchen. I have a son, but I live alone and cook for myself. I'm afraid of burning down the house or falling in the kitchen. There is a grandchild staying at home all day, but he doesn't even care about me."**
>
> Female, 55, visual impairment, Hung Yen, Viet Nam

> **"For my family, we need to hire someone to take care of our child because my wife and I have to go to work. I hire [a caregiver] for over 2 million kip per month. This person is someone that we know well and lives near us. If I were to hire a different person, I think it would not be for this amount. And I pay for her food as well."**
>
> Father of boy, 8 with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"I was born deaf and mute. ... I can only communicate by using my hands. I always have my wife accompany me and interpret for me wherever I go."**
>
> Male, 54, hearing impairment, Hung Yen, Viet Nam

The significant role of family members is illustrated by available quantitative data in Viet Nam. While the role of families is clear from qualitative evidence, data on the sources of care and support is relatively limited across the three countries. An exception is the VDS 2016 in Viet Nam, which explored the situation of the population with health problems who required and were receiving support with daily activities. For this population, the vast majority of support came from family members Figure 6 2. Unsurprisingly, the source of support varied according to the age of persons with disabilities, with children and younger individuals more likely to receive support from parents, middle-aged individuals more likely to receive support from spouses, and older individuals more likely to receive support from children. Women with disabilities were also more likely to receive support from children, which likely reflects factors such as longer life expectancy, and a greater likelihood of being widowed in old age.

Figure 6.2. Share of Vietnamese population who have health problems and were supported for daily activities by who provided the support, 2016 (percentage)



Source: Viet Nam, General Statistics Office 2018.

The impact of caregiving responsibilities on family members can be significant. This was most evident in the FGDs with caregivers, who described the often significant caregiving responsibilities they had. Some also described the direct impact that their care responsibilities had on their ability to participate in the labour market, with many saying that they had to give up on employment. Various parents also shared their concerns about who would care for their children with disabilities when the parents grow old and pass away.

> **"My wife gave up her earning opportunity to be a full-time caretaker."**
>
> Male caregiver, Phnom Penh, Cambodia

> **"I am a widow who must take care of a 13-year-old child with disability, and I have to take him to school and pick him up. I want to go to work at the garment factory, but it is not possible."**
>
> Female caregiver, Phnom Penh, Cambodia

> **"I was a seller in a fresh market. After I realized my daughter was like this, I had to stop working and be at home to take care of my daughter."**
>
> Mother of girl, 7, with intellectual impairment, Vientiane Capital, Lao People's Democratic Republic

> **"He suffers from such a disease, and we have to arrange for one person to stay at home and take care of him. We still face financial difficulty. Therefore, if possible, we would like to receive more financial support."**
>
> Caregiver of male, 33, with intellectual impairment, Hung Yen, Viet Nam

Linked to these issues, various participants highlighted the need for more formal provision of care and support services. This discussion was clearest among caregivers, and often linked to the concern of parents of children with disabilities about who would provide care for their children into the future. The discussion of formal care services was most evident in Viet Nam, with participants sometimes referring to the possibility of care in institutional settings. Home-based care was frequently mentioned in other discussions.

> **"I'm still in good health at the moment and I can take care of him. However, when I get older, I think he will need attention and financial support from the authorities. If I cannot take care of him, his sisters and brothers must be responsible for taking care of him."**
>
> Caregiver of male, 27, with intellectual impairment, Phu Tho, Viet Nam

> **"He really needs support from a care provider and from the society because he cannot take care of himself, [even] with simple things such as managing incontinence. It is very hard for me when taking him to places far from home. He can run away anytime. He is just sitting like this, but when he runs it's very hard to catch him. I applied for a place in a rehabilitation centre in Tien Lu District for him, but he was not accepted because he could not take care of himself. I was told that there were no [appropriate] care providers and support there, which upset me quite a lot."**
>
> Caregiver of male, 13, with intellectual impairment, Hung Yen, Viet Nam

> **"He needs support for all activities related to living independently. He cannot do anything himself and has to rely completely on family members. As we get older, we cannot take care of him forever. We would like to send him to a mental health-care centre."**
>
> Caregiver of male, 38, with intellectual impairment, Hung Yen, Viet Nam

> **"A person with severe disabilities needs to be taken care of, and this is mainly done by family members. If they are not taken care of by a family member, they need to hire caregivers and have to pay them. Currently, there are no services to support these subjects. It is very difficult for them, especially, to integrate into society and the community."**
>
> Male, 54, physical impairment, Hung Yen, Viet Nam

> **"I just really want to have someone support me in communicating with others. I'm in good health. I can do things myself. I don't need any other kind of support."**
>
> Female, 52, hearing impairment, Hung Yen, Viet Nam

> **"I think I would like the Lao Government to provide, like, home care for elderly people and people with disabilities that have no place to go. They can live there, as well as encouraging appropriate jobs for these people."**
>
> Female, 32, physical impairment, Champasak, Lao People's Democratic Republic

Another area of discussion was the provision of cash benefits to cover care and support. As noted in section 5.4.1, Viet Nam is the only one of the three countries that has a specific benefit paid to caregivers. Some caregivers who participated in the FGDs in Viet Nam shared that they received this benefit; while participants in other countries suggested that a caregiver benefit would be a positive development. While the scheme in Viet Nam provides an additional financial supplement to caregivers, the value of the allowance was generally considered to be low relative to the significant costs of caregiving, particularly when the caregiver has had to give up working in order to provide care. A notable feature of the caregiver benefit is that it is paid to the caregiver, rather than to the person with disability themselves. Another approach to providing cash benefits – which is often considered to provide greater autonomy and choice to persons with disabilities - would be to provide a "third person support" allowance to the individual with disabilities, which they could use to pay for care, either privately or to a family caregiver (Cote, Knox-Vydmanov, and Lippi 2024).

> **"In fact, it is very difficult for people who are severely disabled. Firstly, it is difficult for their daily lives. Secondly, the allowances they receive are not enough to cover their living expenses. In fact, in a society like ours, the Government needs to increase the allowances for person with severe disabilities because they are living in hard conditions. The current allowance is only 700,000 dong [US$27.55]. The caregivers also receive an allowance of 300,000 dong [US$11.81]. However, it is still very challenging for them. They have to eat, and live, but they cannot do other things because they have to take care of the disabled people. Therefore, I propose an additional allowance for them and a higher allowance for persons with disabilities."**
>
> Male, 51, physical impairment, Hung Yen, Viet Nam

> **"He receives a monthly social allowance. His mother, who takes care of him, also receives a social allowance. I don't know how much it is. I think it only helps cover part of the health expenditure. His mother has to take care of him. She has no time to work and therefore she has no source of income."**
>
> Caregiver of male, 8, with cerebral palsy, Hung Yen, Viet Nam

> **"If the Government would consider offering some monthly allowance for a person with disabilities' caretaker."**
>
> Male caregiver, Phnom Penh, Cambodia

7

Conclusion and recommendations

The overarching conclusion of this report is that the specific circumstances of persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam require dedicated attention in the pursuit of universal health coverage. Persons with disabilities tend to have both more and more specific healthcare needs – and, consequently, higher related costs – and therefore will suffer more from gaps in social health protection systems. Meanwhile, the various other costs and barriers faced by persons with disabilities, such as higher levels of poverty and lower access to employment, training and education, can create additional challenges in relation to accessing social health protection schemes.

All three countries provide positive examples of efforts to expand social health protection, and these efforts have benefitted persons with disabilities – but major gaps remain. Progress in this space includes measures to expand the population coverage of social health protection measures in recent years, which has helped to provide increasing levels of financial protection to persons with disabilities. Meanwhile, a variety of approaches have been taken to expand the provision of services with particular relevance for persons with disabilities, such as rehabilitation and assistive devices. Nevertheless, in all three countries important gaps remain in the levels of population coverage, services coverage and financial protection provided by social health protection systems, while formal long-term care systems are largely absent from the policy landscape.

7.1. Design and implementation of social health protection scheme

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7.1.1. Population coverage

All three countries have taken notable steps to expand population coverage of social health protection, which have benefitted persons with disabilities. The success of these approaches has been greatest when part of broader efforts to expand population coverage towards universal coverage, as illustrated by developments over the last decade in the Lao People's Democratic Republic and Viet Nam. Cambodia's new Roadmap on Universal Health Coverage has potential to support similar developments. Within these efforts, dedicated government budgetary allocations and subsidized contributions are particularly critical, as they particularly benefit persons with disabilities. Expanding the eligibility for payment exemptions and subsidies to persons with disability certification has also played an important role in extending coverage in Viet Nam, and has potential in Cambodia and the Lao People's Democratic Republic. Nevertheless, continued efforts are required to improve the coverage, accessibility and inclusivity of disability assessment and determination systems.

Recommendations: Population coverage

- **Countries should continue broader efforts to expand universal population coverage** of social health protection schemes, by putting a comprehensive legal framework and effective policies in place to meet these goals.
- While legal provisions on the scope of coverage should ensure universality without singling-out persons with disabilities, **specific provisions should be made to facilitate coverage of persons with disabilities and ensure non-discrimination**. This includes adjusting eligibility criteria and providing contribution subsidies.
- Given the significant extra health costs and other costs faced by persons with disabilities across the income distribution, there is a strong case to **remove means-testing requirements** for persons with disabilities to be included on a non-contributory basis. In Cambodia, this could involve extending HEF coverage to all persons with moderate and severe disabilities, and in the Lao People's Democratic Republic this could involve including persons with disabilities as a dedicated category under the NHI (in addition to others including households on the poor list).
- Countries should continue efforts to **build accessible, comprehensive and reliable systems of disability assessment, determination and certification**. While there is room for continuous improvement, the approaches used in Cambodia and Viet Nam provide a reference point among low- and middle-income countries in terms of aligning with the approach of the CRPD. This includes using a community-level approach to assessment that seeks to support accessibility, and a move away from a focus on medical impairments to incorporate assessment of functional limitations and support needs. These systems can provide a valuable reference point for the ongoing development of a disability card in the Lao People's Democratic Republic.
- There is a need for **greater clarity and effective communication** on social health protection entitlements. This involves more clearly defining the healthcare entitlements for persons with disabilities at a legal and policy level, including those linked to disability cards. It also requires active awareness campaigns to sensitize persons with disabilities to their entitlements, with communication approaches appropriate to their needs and circumstances.

7.1.2. Benefit packages

There are major gaps in coverage in relation to rehabilitation and assistive devices within the current social health protection benefit packages, as well as gaps related to coverage for general health services, for which persons with disabilities may have greater need. Viet Nam is most advanced in integrating rehabilitation into its social health insurance benefit package, yet gaps remain in the legal framework, particularly in regard to assistive devices being largely uncovered. There also appear to be gaps in the provision of rehabilitation services in practice. Cambodia and the Lao People's Democratic Republic rely more heavily on rehabilitation centres that are run relatively independently from the wider health system and are generally not well integrated with social health protection benefit packages. These centres often depend on financing from international organizations. Many of these centres have been innovative in continually improving and expanding the services and assistive devices they provide (often for free), but coverage remains patchy and there is little continuum of care between these services and those provided within the health system and under social health protection benefit packages. Another key area for attention is the various exclusions within social health protection benefit packages in relation to general health services, the costs of which may particularly affect persons with disabilities.

Recommendations: Benefit coverage

- Steps should be taken to gradually **include a greater range of rehabilitation services and assistive devices in social health protection benefit packages**.
- Attention should also be paid to removing **exclusions of (or additional co-payments for) certain general health services** that persons with disabilities may have higher usage of. Indeed, given the more frequent need for healthcare services of persons with disabilities and the extra costs they are facing, there is **rational for considering covering disability-related and additional general services and goods for persons with disabilities**. Eligibility for such services could be linked to disability assessment and determination systems.
- Extending benefits packages to address the needs of persons with disabilities requires **investments in making these services available, acceptable and of sufficient quality**. In many countries, this may involve increasing the provision of equipment and expanding the training of the necessary workforce. One area for careful consideration is how to integrate such services into an improved continuum of care while still building on the expertise of dedicated rehabilitation centres and benefitting from donor financing.
- Countries may adopt a **progressive approach** to extension of benefits, considering fiscal constraints.
- **Evidence** on the cost-efficiency and pricing of assistive devices is crucial for guiding the revision of the benefit packages.
- Revision of benefit packaged should be informed through **consultations with persons with disabilities or their representatives** to ensure they cover a broad scope reflecting the diversity of disabilities and medical needs.

7.1.3. Financial protection

Despite the increasing population coverage of social health protection schemes across the three countries, there are important limits to the level of financial protection that disproportionately affects persons with disabilities. These limits should be understood in the context of gaps in financial protection for the population as a whole, with relatively high-levels of out-of-pocket expenditure in the three countries. Persons with disabilities often face significant medical costs due to the gaps in overall population coverage, the scope of benefit packages and level of financial protection provided by the social health protection scheme. Both the Lao People's Democratic Republic and Viet Nam apply co-payments at the point of service as part of their health insurance policies, although Viet Nam does exempt persons with extreme disabilities from these co-payments.

High out-of-pocket spending also stems from issues of service availability, quality (real or perceived) and accessibility. These factors lead persons with disabilities to seek more expensive private care, often outside of the network of providers of the social health protection scheme, and therefore without the financial protection of the scheme. Non-medical costs can also be substantial, such as transportation to and from medical facilities, the need for human assistance to access services, and indirect/opportunity costs. The combination of these costs can result in impoverishment, foregone healthcare or deteriorating health conditions. Cash benefits – which exist in Cambodia and Viet Nam – are a complementary measure that have gone some way to address these costs; however, benefit levels remain relatively low by international standards.

Recommendations: Financial protection

- Improving financial protection will be strongly related to **improvements in population coverage and enhancement of the adequacy of benefits covered (both the scope of benefits and the level of financial protection)**, as well as addressing questions of service availability and quality.
- One measure for consideration is the **removal of co-payments** for persons with disabilities, as exists in the case of Viet Nam and for all health insurance members in Cambodia. The Lao People's Democratic Republic offers a clear case where an exemption of co-payments could be extended to persons with disabilities based on the introduction of a disability card. However, the effectiveness of this approach in any country will be limited where there are major exclusions to benefit packages.
- Countries should also ensure that **transport allowances and inpatient allowances** are extended to persons with disabilities, ideally without resorting to means-testing.
- Countries should seek to introduce or strengthen **social protection cash benefits** as a way that helps to cover non-medical costs associated with accessing healthcare. Of particular relevance is the need to strengthen the coverage and adequacy of cash benefits targeted at persons with disabilities, including those seeking to address the costs of care. Meanwhile, persons with disabilities will also benefit from efforts to strengthen mainstream benefits as part of a comprehensive social protection system, including benefits addressing old age, sickness and employment injury.

7.1.4. Long-term care

Formal long-term care arrangements remain extremely limited in the three countries, which is compounded by gaps in old-age pension coverage. Persons with disabilities have a diverse spectrum of care and support needs, which range from significant support with self-care activities, to assistance in navigating outside the home to markets and services, including healthcare. However, as it stands, most care and support provided to persons with disabilities comes from family members. There is no clear legal basis for the extension of long-term care in any of the countries, although Viet Nam has set out plans to extend long-term care in the context of population ageing. Viet Nam also has a caregiver cash benefit, although the benefit level is relatively low and coverage is limited. Existing formal service provision for long-term care is currently limited to that which is provided by NGOs or a very limited set of institutional care settings.

Recommendations: Long-term care

- Countries should take steps to **build a concrete strategic and legal framework** for the provision of long-term care services – with a vision to progressively expand provision of formal services – as well as the provision of financial protection for those in need of long-term care services.
- Efforts to expand provision of long-term care services need to **consider the role of different actors in both the healthcare system and the social welfare/affairs space** and their required coordination in the financing and delivery of services.
- Expansion of provision of long-term care services means **addressing labour shortages in the sector** as well as decent work deficits, particularly in relation to labour and social security rights.
- **Extending financial protection to long-term care** implies identifying which kind of care and support services may be covered as a matter of priority, and defining the financing and institutional models to administrate these benefits.
- By adopting a life-cycle approach, social protection systems can help prevent disabilities by **addressing social determinants of health**, ensuring effective and affordable access to long-term care, and promoting decent work within the care economy. This requires that social protection systems establish strong coordination among healthcare, social care, and other social and employment policies.
- There is also a need to c**onnect policy discussions on care and support services for persons with disabilities with discussions on long-term care for older persons** in relation to population ageing. The two matters are inseparably linked given the impact that ageing has on the incidence of disability, and separating these discussions risks fragmentation in the provision of care and support services.

7.2. Cross-cutting recommendations

Beyond the thematic discussions summarized above, there are some cross-cutting recommendations that emerge from the research. These are especially related to ensuring that disability is incorporated across various dimensions of scheme legislation, financing and implementation.

Cross-cutting recommendations

Legislation

- Steps should be taken to **actively include consideration of disability within social health protection legislation and adjust design parameters accordingly**. This can help to ensure that different elements of social health protection regulation relating to population coverage, service coverage and financial protection take specific account of disability-related issues.
- One concrete step would be to formally include persons with disabilities and their representatives as stakeholders in the formulation and implementation of social health protection schemes.
- Given that the implementation of social health protection schemes involves implementation by a range of organizations, **legal provisions supporting institutional coordination** can support access among persons with disabilities.

Financing

- Increasing population coverage, extending benefits and increasing the level of financial protection as recommended above require mobilizing additional financing resources. In pursuing universal coverage, **countries should consider specific government-funded subsidies to the contributions or tax-based financing** of healthcare for persons with disabilities. This can help prioritize population coverage for persons with disabilities.

Awareness-raising

- Information on entitlements is closely related to access to benefits. Awareness-raising campaigns should intentionally seek to reach out to persons with disabilities, using adapted communication approaches and media.
- Developing partnerships with organizations of persons with disabilities could be particularly instrumental to the development of communication strategies and tools.

Disability-inclusive administration of social protection

- Disability sensitization trainings would benefit social security officials, who in turn may initiate discussions within their institutions on necessary adjustments to the administration and implementation of the scheme in order to adapt to the specific needs of persons with disabilities.
- A comprehensive assessment of the compatibility of internal processes relating to registration, contribution payment, access to benefits, grievance mechanisms and so on, with the specific needs of persons with disabilities should be initiated, with the objective of adopting disability-inclusive operational procedures.

Data and research

- Steps should be taken to **systematically include indicators on persons with disabilities within health system administrative data**. In many cases, data on disability is not collected in healthcare data systems, or not routinely reported. Indicators on disability can be included by making linkages to disability certification, or by adding standard survey questions (such as the Washington Group questions) to management information systems. This should be done in a way that also allows for data to be disaggregated by other dimensions, including age and sex.
- Relatively minor **adjustments to national survey questionnaires** could provide a rich source of quantitative data on social health protection for persons with disabilities. Among the three countries, only Cambodia has an income expenditure survey that includes questions on disability, which allows for analysis of various topics such as catastrophic health expenditure and the coverage of health insurance cards. The Lao People's Democratic Republic and Viet Nam could both address this gap in their income and expenditure surveys.

In conclusion, advancing disability-inclusive social protection is vital to realizing countries' commitment to universal and equitable access to social health protection. Better access to healthcare can, in turn, promotes broader social inclusion of and economic participation by persons with disabilities. Such inclusive systems also enhance financial security for individuals and their families, mitigating poverty linked to disability and healthcare costs.

Ensuring that social protection frameworks address the needs of persons with disabilities requires a holistic approach, encompassing population coverage, adequacy of benefits and financial protection. By embedding these principles and rights in legal frameworks and policy, countries can ensure that social health protection systems contribute to a more inclusive and resilient society, aligned with international standards.

The ILO's vision of inclusive social protection underscores the need for countries to take concrete steps towards integrating persons with disabilities as stakeholders who can advocate for coordinated policy efforts and adequate financing to achieve universal social health protection.

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Appendix 1. Research questions

Research questions	Key evidence sources	KIIs	FGD
0. What is the broader context in which access to social health protection schemes and long-term care can be situated?			
0.1 Are national legal and strategic frameworks on social health protection conducive to the protection of the rights of persons with disabilities? (Reference PwD? CRPD compliant?)	Laws and regulations		
0.2 What are the PwD profiles in the selected countries including income status, age, gender, education level, type of disability? Is data compliant with CRPD?	National literature and data		
0.3 Who are the stakeholders involved in the protection of PwDs (mapping), what roles are they playing?	Laws and regulations, other literature	Social Security Institutions, OPDs	
0.4 What other social protection benefits are in place for PwD?	National literature		
0.5 What systems of disability assessment are in place in the country? (Linked specifically to SP, social health protection or otherwise / medical or social models)	Laws, regulations and national literature	SSI, organization undertaking disability assessment; OPDs	
1. Are persons with disabilities covered by social health protection schemes? [POPULATION COVERAGE]			
1.1 What is the extent of legal coverage of PwD by social health protection schemes?			
1.1.1 What social health protection schemes are PwD eligible for?	Laws and regulations	SSI	
1.1.2 Are there specific provisions for PwD? What kinds/ levels of disability does this relate to?	Laws and regulations	SSI	
1.2 What is the extent of effective coverage of PwD by social health protection schemes?			
1.2.1 What are the health services utilization levels of PWD, as compared to the general population?	National survey data (and administrative data?)	Ministry of Health	Y
1.2.2 Are PwD aware of social health protection schemes and entitlements?			Y
1.2.3 Are social health protection communication materials and channels adapted to PwD?		SSI; OPD	
1.2.4 What proportion of PwD are effectively covered by social health protection? (and how compares to general population)	National survey and administrative data	SSI	Y
1.2.5 Are social health protection administrative processes (registration/claims) physically accessible? (Any support provided?)		SSI; OPD	Y
1.2.6 Are staff members equipped and trained to address needs to PWD?		SSI; OPD	Y
1.2.7 Have SSIs adopted minimum standards to increase inclusiveness?		SSI	
2. Do social health protection benefit packages adequately take account of the needs of persons with disabilities? [SERVICE COVERAGE]			
2.1 What specific medical goods and services do people with disabilities require? (early intervention, assistive devices, rehabilitation)?	International literature on Assistive Technologies, rehabilitation National data	OPD, Ministry of Health, rehabilitation centres	Y

2.2 To what extent do social health protection benefit packages include these goods and services?	National legislation	Ministry of Health; OPDs; SSI	Y
2.3 Are PwD able to access goods and services that are included in benefit packages?	National data (if available)	OPDs; Rehabilitation centres	Y
2.4 What are the consequence of gaps in benefit packages? Treatment foregone? Access privately?	Data on health utilization	OPDs	Y
3. What costs do PwD face in accessing healthcare? [Or - To what extent do social health protection schemes provide financial protection to PwD?] [FINANCIAL PROTECTION]			
3.1 What direct medical-related costs do PwD incur when accessing healthcare (when covered by social health protection)?		OPDs; rehabilitation centres	Y
3.2 What direct medical-related costs do PwD incur when accessing healthcare (when **NOT** covered by social health protection)?		OPDs; rehabilitation centres	Y
3.3 What direct non-medical costs to PwD incur when accessing healthcare (transport etc.)? **(not social health protection-specific)**		OPDs; rehabilitation centres	Y
3.4 How significant are these costs?	Data on OOPs and catastrophic health expenditure	OPDs; rehabilitation centres	Y
3.5 What are the consequences of costs of accessing healthcare?	Data on health utilization	OPDs	Y
3.6 How much do other social protection mechanisms (cash benefits) support PwD to cover costs?	Analysis of benefit adequacy against national/international benchmarks	OPDs	Y
4. What is the role of formal long-term care services?			
4.1 What kind of long-term care services do PWD require?	National data on disability prevalence	OPDs	Y
4.2 What is the coverage of long-term care services (for those that require)?	National data (if available)	SSI, OPDs	Y
4.3 In absence of long-term care services, who (if anyone) provides care?	National data (if available)	OPDs	Y
4.4 What are the consequences of a reliance on families for care and support?		OPDs	Y
4.5 Do other forms of social protection (disability allowances, caregiver benefits) support access to care?		OPDs	Y

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