Access to social protection among people with disabilities: Evidence from Viet Nam

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Abstract

People with disabilities are frequently targeted as key beneficiaries of social protection due to high levels of poverty and other forms of marginalisation. Little is known, however, on whether people with disabilities are accessing existing programmes, and what factors hinder or promote participation. This study uses a mixed-methods approach to explore access to various disability-targeted and non-targeted social protection programmes in Vietnam, particularly in the district of Cam Le. Overall, coverage of social assistance and health insurance was high among people with disabilities (51% and 96% coverage, respectively). However, access to employment-linked social insurance programmes and other disability-targeted benefits (e.g. vocational training, transportation discounts) was low. Factors that affected access included the geographic and financial accessibility of the application process, disability assessment criteria and procedures, awareness and perceived utility of programmes, broader disability-inclusive planning of linked services, and attitudes on disability and need for social protection.

Introduction

Social protection is increasingly used by governments in low- and middle-income countries as a strategy for ensuring individuals and their households are protected from poverty and other forms of vulnerability across the life cycle [1]. More broadly, aims of social protection include promoting the development of stronger livelihoods, ensuring access to healthcare and other social services, fostering economic and social development, and reducing inequalities [2, 3]. Social protection may encompass a range of policies and programmes, including contributory schemes (social insurance), as well as non-contributory, tax-financed schemes [3]. The latter includes various forms of social assistance, in which beneficiaries receive transfers in cash or kind.

Nationally appropriate “social protection floors” for all – in which States provide their citizens with a set of guarantees such as basic income security and access to healthcare and other essential services – have been advanced by the International Labour Organization’s Social Protection Floor Recommendation (2012) and recognised in the 2015-2030 Sustainable Development Goals (SDGs) as critical for inclusive and sustainable growth and development [4]. While social protection floors should be available for all, coverage is particularly important for individuals or groups who face a higher risk of poverty and other forms of marginalization [2, 5].

There are an estimated one billion people living with disabilities. As a group, people with disabilities are frequently targeted as key beneficiaries in national and international social protection strategies and programmes because they are significantly more likely to be living in poverty and face a wide range of social, economic and cultural forms of exclusion [6-8]. In addition to a needs-based

argument for including people with disabilities in social protection programmes, the right to inclusion in all aspects of society – including in social protection – on an equal basis with others is well-established in international treaties such as the Universal Declaration of Human Rights (Article 22) and the United National Declaration of the Rights of Persons with Disabilities (UNCRPD) (Article 28) [9, 10].

To fulfil the right to inclusion in social protection, States must ensure equitable access for people with disabilities to mainstream social protection programmes – such as health insurance, social security and other benefits where disability is not an explicit condition of eligibility [11]. Additionally, targeted programmes may be needed to address disability-specific concerns, such as access to assistive devices, specialist health and educational services. Account also needs to be made for the higher costs incurred by people with disabilities in participating in society, as a result of needs for accessible transport, carers, assistive devices and so on [3, 11, 12]. According to recent estimates from the International Labour Organization, 27.8% of people with severe disabilities globally receive some form of disability benefit [3]. However, there is considerable regional variation, with coverage lowest in Asia and the Pacific at 9.4% and highest in Eastern Europe (97.9%) [3]. Little is known about inclusion of people with disabilities in mainstream schemes not specifically targeting people with disabilities, or about barriers to accessing either mainstream or targeted social protection [13].

Consequently, this study seeks to explore access to social protection among people with disabilities, using Vietnam as the study setting. In addition to quantitative measures of access, this paper also identifies challenges and facilitators to participation in social protection.

Overview of Social Protection Entitlements in Vietnam

The right to social security is codified in Article 34 of the recently amended Constitution of Vietnam (2013) [14]. Resolution 70/NQ-CP/2012 further describes the State's strategy for strengthening social protection between 2012-2020 [15]. Overall, there are four main components to Vietnam's social protection framework: (1) social assistance to groups deemed at high risk of poverty; (2) social insurance to mitigate financial risks associated with sickness, occupational injuries and from ageing; (3) programmes promoting access to basic services, such as education, healthcare and clean water/sanitation; and (4) policies to improve opportunities for decent work [15].

Within this remit, Vietnam has a range of social protection policies and programmes in place. Non-contributory entitlements include a number of disability-targeted schemes, as well as programmes targeted to other groups deemed to be at high risk of poverty. For contributory schemes, various forms of insurance are mandatory for most formal sector employees, with optional opt-in schemes available to the rest of the workforce.

Disability-targeted social protection entitlements

People with disabilities in Vietnam are eligible for the disability-targeted entitlements listed in Table 1. In order to be eligible for these entitlements, people with disabilities must first undergo an assessment of disability. Most assessments are conducted by the Disability Degree Determination Council (DDDC), which is located within the commune-level People's Committee, one of the most decentralized administrative units in Vietnam [16]. The DDDC determines both the type and degree of disability using the Joint-Circular 37/2012/TTLT-BLĐTBXH-BYT-BTC-BGDĐT, which has two assessment tools (for children under six and people over six). The degree of disability ("mild", "severe" or "extremely severe") determines which social protection benefits a person is eligible for. Degree determinations are calculated using a standardized scoring system based on the applicant's ability to perform eight daily life activities (walking, eating and drinking, toilet hygiene, personal hygiene, dressing, hearing and understanding what people say, communicating using speech, and participating in housework like folding clothes, sweeping, washing dishes and cooking.), with or without assistance from others. Assessments are based on in-person observations of functioning as well as interviews with the applicant and/or their caregiver.

If the DDDC cannot reach a decision on the degree of disability, or if the applicant wishes to appeal their conclusion, the applicant is referred to the Medical Examination Council (MEC) [16]. MECs are located in provincial capitals and in Hanoi. In contrast to the DDDC, which uses a functioning-based approach, the MEC evaluates disability degree using solely medical criteria. Disability degree is based on the proportion of bodily injury due to disability, with 81% and above considered "extremely severe" and 61-80% considered "severe" [17].

Entitlement	Social Protection Component	Eligibility (disability degree)	Description of entitlement
Social assistance	Social assistance to groups at high risk of poverty	Severe, extremely severe	*Unconditional minimum monthly cash transfer*: 405,000 VND [US$18] (severe), 540,000 VND [US$24] (extremely severe). Slightly higher amounts for children and older adults. A separate cash transfer is available for caregivers of people with extremely severe disabilities (VND 405,000/month [US$18])
Health insurance	Social insurance, access to basic services	Severe, extremely severe	State pays full premium for health insurance; coverage of 95% of eligible medical expenses
Education supports	Access to basic services	Any classification	Various (e.g. individual education plan, adapted admission criteria;

			exempted tuition fees/scholarship if also poor)
Vocational training & employment supports	Opportunities for decent work	Any classification	Various (e.g. free vocational training at recognised centres, preferential loans for self-employed, incentives for employers to hire people with disabilities)
Transportation discounts	Access to basic services	Any classification	Free or subsidized public transportation.

Table 1. Disability-targeted social protection provisions

Some entitlements, namely subsidised health insurance and social assistance, are reserved for people with the highest degree of disability ("severe", "extremely severe"), while others are open to people with disabilities of any degree classification (e.g. transportation discounts, free vocational training). It is important to note that Table 1 outlines the minimum requirements as codified in national laws and policies. Provinces have leeway in how to implement policies, including in increasing the value of the Disability Allowance, expanding eligibility or in offering additional programmes.

Finally, veterans of the Vietnam-American war who developed a disability during their service or have family members who become disabled due to exposure to Agent Orange are entitled to separate social assistance programmes. These schemes offer a much higher level of support, ranging from VND 1,479,000-3,609,000 (US$65-159) per month [18]. Eligibility criteria is determined by the MEC, based on a defined list of diseases, impairments or abnormalities. Documentation of these conditions can be certified at district- or higher-level hospitals and forwarded to the MEC.

Non-disability targeted social protection entitlements

People with disabilities may also be eligible for programmes aimed at other targeted groups, if they meet their eligibility criteria. For example, unconditional social assistance is available to older adults (aged 80+ with no other sources of income), orphans, single parents, and people living with HIV in poverty [19]. Amounts range from VND 270,000 to 675,000 per month (US$12-30) [19]. However, an individual who is eligible for more than one form of social assistance can only receive one form of support, the one of the highest amount. The only types of social assistance that can be received concurrently with other schemes are the Single Parents' Allowance and the Caregivers of People with Extremely Severe Disabilities Allowance.

While people with "severe" and "extremely severe" disability degrees are one target group for State-subsidised compulsory health insurance (CHI), other social assistance recipients, as well as children under six, students, organ donors, workers in certain industries and individuals living under or near the poverty line are also eligible. Under CHI, the state covers a portion of the premium as well as user fees for eligible medical expenses. Premium subsidies range from 100% for children under 6 to 30% for students [20, 21]. CHI covers 80% of medical expenses, but for certain users (i.e. people with severe disabilities, people below the poverty line, children under six), the State provides a further subsidy to cover user fees (95%-100%) [19, 22]. Coverage in CHI may also be through formal sector employment,

where enrolment is mandatory for workers who have a contract of at least 3 months. In this case, the premium is set to 6% of the employee's monthly salary, of which the employer contributes 4.5% and the employee 1.5% [21, 23]. For individuals not covered by State- or employer- subsidised CHI, voluntary health insurance (VHI) is available for purchase, with premiums equivalent to 4.5% of monthly salary with no employer contribution. For both VHI and employer-subsidised CHI, 80% of eligible health expenses are covered by plans.

Finally, social insurance regimes are available through either compulsory social insurance (CSI) or voluntary social insurance (VSI). CSI – which is mandatory for formal sector employees with at least a one-month contract – covers sickness, maternity, labour accidents and occupational disease, retirement and survivor allowances [34]. CSI contributions are set at 26% of the employee's monthly salary, of which employers contribute 18%. In contrast, anyone can opt into VSI, which covers only retirement and survivor allowances, and requires a monthly contribution by the employee of 22% of their self-declared income [34].

Methods

A mixed-methods approach was used to evaluate the extent to which people with disabilities are accessing existing social protection programmes, including barriers and facilitators to access. First, a national policy analysis was conducted to provide an overview of available social protection entitlements, and how their design and implementation may affect access for people with disabilities. Second, qualitative and quantitative research was conducted in one district of Vietnam to measure coverage and uptake of specific entitlements and explore factors influencing access in greater depth. While the focus was predominantly on disability-targeted entitlements, access to non-targeted schemes was also assessed where feasible.

Ethical approval for this research was granted from the Ethics Committees at the London School of Hygiene & Tropical Medicine and the Hanoi University of Public Health. Informed written consent was obtained from all study participants before beginning any interviews. For children below 18 years (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy.

All data was collected between May-December 2016.

Setting

Vietnam was selected as the study site for this research as it was identified in a rapid policy analysis as having a strong social protection system that has made concerted efforts to be inclusive of people with disabilities. As such, it presented a good opportunity to describe examples of good practice in the design and delivery of disability-inclusive social protection.

While the policy analysis was national in scope, district level data collection was used to explore access to social protection among people with disabilities in practicef. Cam Le, part of the province of Da Nang in Central Vietnam, was selected as the study district after consultations with stakeholders. During these consultations, Cam Le was highlighted as an area with a well-functioning social protection administration and a strong network of Disabled People's Organisations (DPOs) and disability-support services. Cam Le's disability-targeted social protection entitlements

also go above the national minimum. Specifically, CHI coverage is expanded to children under 17 with “mild” disability degree classifications and Disability Allowance allotment are topped up for the poor and older adults with a disability, if they receive monthly social assistance of less than 500,000 VND. As such, using Cam Le as the setting for district-level data collection meant that potential strengths of the system in terms of disability-inclusion could be identified.

National policy analysis

A national policy analysis was conducted in order to describe the overall social protection landscape in Vietnam, including the strengths and challenges associated with ensuring access to social protection for people with disabilities. Data was compiled through three avenues: (1) a literature review, (2) in-depth interviews with key stakeholders and (3) a consultative workshop. For the literature review, relevant legal frameworks, policies and programmes in Vietnam as well as existing research on the issue were identified through a scoping review of academic and grey literature in both English and Vietnamese. To complement the literature review, in-depth interviews were conducted with sixteen key stakeholders within relevant government ministries, United Nations agencies, non-governmental organisations (NGOs), and Disabled Peoples’ Organizations (DPOs). Participants were identified based on a review of existing projects and programmes related to disability and/or social protection. Interviews explored the design and delivery of social protection particularly for disability-targeted entitlements, factors influencing access for people with disabilities, strengths and challenges of programmes and priorities for reform. Findings were analysed thematically. Finally, a consultative workshop of over 50 stakeholders working in disability and social protection across Vietnam was held in May 2016 to further explore challenges and facilitators to access.

Quantitative research in Cam Le

Quantitative data collection was comprised of a population-based survey of disability across Cam Le, with a nested case-control study to compare knowledge of and participation in social protection between people with and without disabilities.

For the population based survey, the 2009 national census was used as the sampling frame [24]. A two-stage sampling strategy was employed based on a methodology used in other surveys [25]. In the first stage, probability-proportionate-to-size sampling was used to select 75 clusters in Cam Le. Clusters were “Population Groups”, the lowest administrative unit in Vietnam (average size: 162 people). In the second stage, compact segment sampling was used to select households within clusters. With this method, maps of each selected cluster were divided with the assistance of village leaders or staff at nearby health centres into equal segments of approximately 80 people. One segment was then randomly selected, and households were visited systematically beginning from a random start point, until the sum of members aged 5+ across households reached 80 people. A minimum sample size of 3,000 people was needed to measure the prevalence of disability (with expected prevalence of disability = 5%, precision required = 20%, design effect = 1.5, response rate = 90% and confidence = 95%). However, the sample was increased to 6,000 to account for uncertainty in the expected disability prevalence estimate and to ensure adequate numbers for the case control.

Within the population-based household survey, household heads reported on the functioning of all household members aged 5 years and older, using the Washington Group Short Set Questionnaire [26]. The Washington Group Short Set comprises six questions on an individual's ability to perform everyday activities (seeing, hearing, walking, remembering/concentrating, self-care and communicating). Respondents select one of four possible response options on level of difficulty in performing each activity: "none", "some", "a lot" or "cannot do". People who were reported to experience "a lot of difficulty" or "cannot do at all" for at least one question were considered to have a disability. This cut-off is in line with international guidelines. It is also closely aligned with the eligibility criteria for disability-targeted social protection, particularly social assistance, as outlined in Joint-Circular 37/2012/TTLT-BLĐTBXH-BYT-BTC-BGDĐT. In addition to measuring disability, the household survey also included questions on household socio-economic status and participation in social protection programmes.

Any individual who was identified during the household survey as having a disability was invited to take part in a case-control study. The case-control questionnaire explored in greater depth knowledge of and participation in various social protection programmes, amongst other indicators. In addition to recruitment through the population-based household survey, 72 people with disabilities who were participating in disability-targeted schemes were selected as additional cases from registers of the Disability Allowance; selection was based on proximity to included clusters (i.e. within the same ward/commune). Each case (whether identified from the survey or the register) was matched to a control without a disability (according to the Washington Group Short Set), who was of the same gender and area of residence, and similar in age (+/- 5 years). Controls could not be from households with members with disabilities.

All questionnaires were administered in Vietnamese by trained data collectors using computer tablets. Data was analysed using STATA 15. Among people recruited through the population-based survey, multivariate regression was used to compare participation in various schemes between respondents with and without disabilities, controlling for age and gender.

Qualitative research in Cam Le

In-depth, semi-structured interviews were carried out with people with disabilities who were and were not benefiting from social protection (namely disability-targeted programmes), as well as district- and community-level stakeholders. Interviews with people with disabilities focused on their knowledge of disability-targeted programmes and their experience of accessing relevant schemes. Key informant interviews centred on understanding the ways in which the planning and implementation of social protection programmes facilitates or impedes access for people with disabilities.

A purposive sample of 32 participants with disabilities were identified, using data collected through the population-based survey, selected to reflect variation in terms of impairment type, sex, age (children, working-age and older adults) and geographic distribution. A total of 19 provincial, district- and community-level stakeholders were selected through snowball sampling, comprising disability service providers,

representatives of DPOs, and decision makers/administrators responsible for social protection and related services.

Interviews with all participants were transcribed in Vietnamese and a thematic approach was used to analyse findings.

Findings

Description of the study samples

In a population-based survey of over 6,705 household members were selected and 6,379 screened for disabilities (response rate: 95.1%). Overall, 150 individuals were identified as having a disability (prevalence: 2.5%, 95% CI:2.1-2.9%). Prevalence of disability did not differ by gender (Men: 2.3%, 95% CI: 1.8-2.9%, Women: 2.6%, 95% CI: 2.1-3.2%), but increased substantially with age (from 1.1% in children 5-18, to 13.2% in adults 76+, $p<0.001$). In total, 444 people took part in the case-control study (150 people with disabilities recruited from the population based study, 72 Disability Allowance recipients recruited from registers and 222 age-sex-cluster matched controls without disabilities). The response rate was high (98%), with only eight controls refusing to participate. Cases and controls were well matched by age and gender, as there were no significant differences in these characteristics between groups.

For the qualitative research, 32 people with disabilities were included (response rate=100%). Of 32 people, 24 were interviewed directly and for eight participants, information was gathered through their caregivers (for people with disabilities under 18 and one adult with severe physical and communication impairments). Twenty respondents were receiving the Disability Allowance. By impairment type, the following breakdown was observed: physical/mobility (n=17), communication (n=10), vision (n=5), hearing (n=5), psychosocial (n=5), intellectual/cognitive (n=5); 14 respondents had multiple impairments. Respondents ranged in age from 5-84 years old (5-17 years: n=7, 18-64 years: n=19, 65+ years: n=5) and there was a near equal mix by gender (female, n=18).

Social protection access

Over half (52.7%) of all people with disabilities identified in the survey were recipients of some type of social assistance, which was significantly higher than for people without disabilities (11.7%) (Table 2). The Disability Allowance was the predominant source of social assistance accessed among people with disabilities (71% of recipients of social assistance). Overall, coverage of the Disability Allowance was 40%, with no participants accessing the scheme who did not meet the study's definition of disability.

Coverage of health insurance was universally high for both people with and without disabilities, although people with disabilities were slightly more likely to be recipients. Among people with disabilities, health insurance was primarily CHI, due to disability or other reasons (e.g. recipient of another type of social assistance).

No people with disabilities in the survey were accessing social insurance, due in large part to exclusion from the labour market, particularly the formal sector. In contrast, approximately a fifth of people without disabilities reported enrolment in social insurance, higher than among people with disabilities, yet still indicating low

coverage among workers of retirement pensions and protection against risks such as workplace injury.

	People with disabilities (n=150)	People without disabilities (n=222)	aOR (95% CI)
Social assistance			
Any social assistance	82 (52.7%)	26 (11.7%)	9.6 (5.6-16.5)*
Disability Allowance	60 (40.0%)	0(0 %)	n/a
Old Age Allowance (among adults, aged 80+)	10 (38.5 %)	10 (43.5%)	0.7 (0.2-2.5)
Other social assistance	15 (10.0%)	15 (6.8%)	1.4 (0.7-3.1)
Health insurance			
Any health insurance	144 (96.0%)	196 (88.3%)	2.9 (1.1-7.2)*
State-subsidised health insurance	109 (72.7%)	60 (27.0%)	7.7 (4.7-12.5)*
Social insurance			
Social insurance (among people who worked in the last year)	0 (0%)	24 (21.2%)	n/a

*Statistically significant

Table 2. Social protection enrolment among people with and without disabilities in Cam Le district.

As outlined in Table 1, disability-targeted benefits other than the Disability Allowance and health insurance are available to all disability degree classifications. In the population-based survey, only one person had received a mild classification. Along with the 132 Disability Allowance recipients (60 population-based sample, 72 recruited from registers), uptake of these other benefits was very low (Table 3).

Disability-targeted entitlement	Aware (%)	Uptake$^{\Omega}$ (%)
Transportation discounts	6 (4.5%)	2 (1.5%)
Educational discounts (among children under 18)[a]	5 (23.8%)	2 (8.3%)
Livelihoods supports (vocational training, preferential loans), among people 15-65[b]	19 (14.2%)	17 (17.1%)
Allowance for caregivers	14 (10.6%)	12 (8.9%)

$^{\Omega}$Among people aware of entitlement

[a] n=24

[b] n=99

Table 3. Uptake of entitlements among recipients of disability-targeted social protection in Cam Le district (n=135)

In comparing characteristics of people with disabilities who were and were not receiving disability-targeted social protection, coverage decreased with increasing age (89% for children under 18 to 21% for adults over 75). Coverage was lowest for people with sensory impairments. There was no difference between recipients and non-recipients by severity of disability.

	Receiving Allowance (n=132)[a]	Not receiving Allowance (n=78)	aOR (95% CI)[b]
General characteristics			
Female	70 (52.2%)	50 (56.8%)	1.1 (0.6-2.1)
Age group			
- 5-18 years	24 (88.9%)	3 (11.1%)	Reference
- 19-40 years	48 (76.2%)	15 (23.8%)	0.4 (0.1-1.5)
- 41-60 years	36 (63.2%)	21 (36.8%)	0.2 (0.06-0.8)*
- 61-75 years	19 (46.3%)	22 (53.66%)	0.1 (0.03-0.4)*
- 76+ years	7 (20.5%)	27 (79.4%)	0.03 (0.01-0.1)*
Functional limitation			
- Physical	30 (56.6%)	23 (43.4%)	Reference
- Sensory (visual/hearing)	6 (28.6%)	15 (71.4%)	0.2 (0.4-0.5)*
- Remembering	15 (79.0%)	4 (21.1%)	1.2 (0.3-4.5)
- Self-care	6 (75.0%)	2 (25.0%)	1.2 (0.2-6.7)
- Communication	5 (83.3%)	1 (16.7%)	2.7 (0.2-28.5)
- Multiple	46 (39.0%)	72 (61.0%)	0.8 (0.4-1.7)
	Mean	**Mean**	**Coefficient (95% CI)[b]**
Severity score	5.4	5.6	0.5 (-0.4 – 1.4)

[a] Includes people recruited from Disability Allowance registers

[b] Adjusted by age, sex

[c] Total across six Washington Group domains (0=no difficulty, 1=some, 2=a lot, 3=cannot do for each domain); maximum score is 18

* Statistically significant

Table 4: Characteristics of Disability Allowance recipients compared to non-recipients with disabilities

Factors influencing access to social protection among people with disabilities

From both the national policy analysis and research in Cam Le, several factors emerged which affected access to social protection among people with disabilities. These factors concerned: (1) geographic accessibility, (2) financial accessibility, (3) disability assessment criteria and procedures, (4) awareness and perceived utility of programmes, (5) broader disability-inclusive planning, and (6) attitudes on disability and need for social protection.

While the focus was predominantly on disability-targeted schemes – as they were by far the most known and accessed by people with disabilities – many challenges and facilitators are applicable to non-targeted schemes.

Geographic accessibility

In Vietnam, applications for all forms of social protection are conducted at the local commune-level People's Committees, one of the lowest administrative units. Prior to the introduction of Decree No. 28/2012/ND-CP in 2012, applications for disability-targeted programmes were conducted at the provincial capital. The shift in application location was widely cited by key informants at the national and local level as improving coverage of disability-targeted programmes.

> *"Now [the disability assessment] moves to the People's Committee because the People's Committee is the closest to people in the community, which avoids missing cases. Before the Council was at provincial-level and there were so many severely disabled in the province, they could not cover them all, they could not meet all the people with disabilities."* (Key informant)

> *"The empowerment of the Commune authority is one of its advantages. Commune authorities are more active in identifying people with disabilities. They are also closer to the targeted group who need to be identified...[As] the [DDDC] needs to directly meet the person to identify the form and level of disabilities, it is much easier and more accessible for a person to visit the commune hall compared with visiting [provincial] city hall."* (Key informant)

Additionally, local officials noted that home visits were offered for applicants with severe functional limitations who were unable to travel to assessment locations, which they felt improved access.

However, not all people receive their assessment of disability at the local level. When the DDDC cannot make a determination on an assessment, cases must then be referred to the Medical Evaluation Council (MEC), which is located at provincial level. Children under six and people with mental health conditions were noted to be particularly likely to be referred to the MEC. Additionally, if an applicant contests the results of their assessment, they can appeal the decision, but re-evaluations are done by the MEC. While over 80% of disability-targeted social protection recipients in the quantitative survey completed their application at the commune-level and reported little issue with getting to application points, the remainder of recipients as well as key informants noted that travel to the provincial capital presented challenges to access. These barriers could be prohibitive, particularly for people with mobility limitations or who live in remote areas without adequate transportation links.

Financial accessibility

Direct application costs are low (VND 50,000, about US$2). For appeals, however, applicants must cover the assessment fee by the MEC if their contestation is not supported. As the appeal assessment fee is high (VND 1,150,000, about US$50), key informants noted that while this fee may protect against excessive contestations, it disproportionately impacts poorer applicants.

Additionally, indirect and opportunity costs of making the appeal could also be high, particularly for cases requiring re-evaluation at the MEC. While the assessment fee is waived for DDDC referrals and successful appeals, travel to the provincial centre and associated costs (e.g. accommodation, food) are not. Furthermore, applicants and anyone accompanying them must forgo time spent on other activities, such as work or school.

Disability assessment criteria and procedures

In 2012 the assessment criteria for determining eligibility, and importantly, 'disability degree' classifications were updated through Joint-Circular 37. With the implementation of this policy tool, assessments changed from a system based primarily on medical classification of impairments to one focusing more on

functioning. For example, as part of the disability degree classification under Joint Circular 37, the DDDC assesses whether a person can walk independently, with some help or not at all, based on self-reporting or in-person observation. In contrast, the MEC would diagnose a musculoskeletal impairment, and then consult Circular 20/2014/TT-BYT, which has a list of percentage "bodily injury" for a range of impairment types and health conditions. The main assessment body also switched from the MEC, which is comprised of medical professionals, to the DDDC, which is comprised of a range of representatives from different local government bodies, as well as DPO members where possible.

These changes to disability assessment procedures have been credited by key informants with greatly expanding access to social protection, which is reflected in national enrolment figures. In 2009, fewer than 385,000 people with severe disabilities nationally were receiving the Disability Allowance, but by 2014, that had doubled to more than 700,000 recipients.

The use of a tool that does not require medical expertise greatly expands the capacity of the State to conduct assessments, particularly in areas of the country where medical resources are in short supply. Further, new procedures and policies are now more in line with the UNCRPD. For example, the involvement of DPOs promotes participation of people with disabilities in the implementation of social protection. Additionally, the move towards more functioning-based assessment criteria is closer to definitions of disability promoted in the UNCRPD.

Still, the policy review and key informants noted several limitations to the disability assessment criteria and procedures. Criteria focus disproportionately on physical functioning and self-care, and tend to underestimate the impact of certain impairments, notably profound hearing and communication impairments as well as mental health conditions. Key informants involved in assessments noted this could lead to lower degree classifications, or exclusion altogether:

> *"Deaf people receive nothing from social welfare because they can walk, eat, have a bath, etc. without help. They can do all of this. Some cannot speak but it is not enough for receiving social welfare. So, they are excluded."* (Key informant)

Additionally, providing assessments to children under six using Joint Circular 37 was reported as a persistent challenge. Consequently, most young children are referred to the MEC, which as mentioned previously creates additional barriers to access, as well as delays the receipt of needed support at a critical age.

There are also concerns that DDDC assessors are inadequately trained to conduct assessments, leading to inconsistent implementation and outcomes between communes and districts. Further, while, the DDDC is supposed to include the head of the commune-level DPO, in practice very few communes have a legal DPO. For example, the capital of Hanoi has 584 commune-level administrative units but by 2013 it had only 63 commune-level DPOs [27].

Awareness and perceived utility of programmes

The shift of the application process to the commune-level has also been credited by key informants with improving awareness of disability-targeted programmes, as local

officials are more involved in outreach. Among people with disabilities in the quantitative survey, almost 60% were aware of disability-targeted social protection programmes, and almost half had heard about them from programme officials directly. The Disability Allowance and health insurance (State-subsidised or otherwise) were both the most well-known and deemed most useful among people with disabilities.

> *"I think that health insurance brings a lot of benefit, we should buy a health insurance card in case of illness. My entire family bought health insurance because of having fears about being ill."* (Caregiver of an 11-year-old girl, who is not receiving the Disability Allowance)

Still, many people with disabilities were unclear about the eligibility requirements for programmes. The lack of clarity could dissuade people from applying, or result in confusion and frustration if applications were unsuccessful.

> *"I cannot move my left hand, my right hand is weak. I had polio when I was young. I made a dossier and tried to apply several times but was not successful. Some other people who are like me receive monthly social welfare but I do not. I don't know why. I tried many times but always failed. That's why I don't want to try more"* (32 year old man who is not receiving the Disability Allowance)

While awareness of the Disability Allowance and CHI was high, few people (including people who were already receiving the Disability Allowance) were aware of the full range of entitlements available to them. For example, as illustrated in Table 3, among Disability Allowance recipients fewer than 15% were aware of most other benefits. Lack of awareness of benefits such as transportation discounts and free vocational training likely dissuades applications from people with less severe impairments, who although not eligible for social assistance or subsidised health insurance, could still benefit from other programmes. Programme administrators similarly had little awareness of these other benefits, and thus were not in a position to offer information to recipients on how to access them. Among people with disabilities who were aware of additional entitlements, they were generally perceived to be of little value.

For many disability-targeted entitlements, the perception of low utility was in large part linked to concerns about the quality and availability of the linked services. For example, vocational training tends to be urban-based and was reported to not provide people with disabilities with employable skills based on their individual abilities and the demands of the local job market. Similarly, while transportation discounts address financial barriers to access, limited availability and accessibility of public transportation restricts the utility of this benefit.

> *"For people [with disabilities], they can have an exemption for using a public bus. However, there was no way for people with a wheelchair to get onto a public bus. It's a problem."* (Key informant)

Additionally, physically inaccessible facilities and the absence of information provided in alternative formats could also serve as a barrier to applying for both disability-targeted and non-targeted programmes, as well as using benefits once approved. Social exclusion could also prohibit participation in non-targeted schemes.

For example, many working-aged people with disabilities were either not employed or in irregular, low pay-work, almost exclusively within the informal sector. Consequently, they were not eligible for employer-subsidised social insurance and, due to high levels of poverty and the irregularity of their work, the high monthly premiums attached to voluntary schemes were prohibitive.

Attitudes on disability and need for social protection

Norms around who is considered "deserving" of social protection, particularly social assistance, could influence decisions to apply as well as assessment outcomes. For example, functional decline due to ageing was often not considered to be a "legitimate" form of disability, by people with disabilities and administrators alike, and some argued that the benefit should be targeted for people who are poor.

> *"The Government should support children with congenital abnormalities not elderly people like us. It is good if the government has social support for elderly people like us, we are getting old and weak, often being sick and difficult to move around. However, I don't make a dossier [to apply for the Disability Allowance]. I think it should be for people who are living in poorer living conditions than me. It is ok if they come to see me and make a dossier for me, if not, I am not going to ask for it."* (65-year-old woman, not receiving the Disability Allowance)

Furthermore, although officially eligibility for disability-targeted social protection is based only on the presence of disability as determined by the scoring system outlined in Joint Circular 37, some officials noted considerations of other circumstances could sway assessment outcomes.

> *"Using forms in Decree 28 and the Joint Circular sometimes is difficult. Children for example, if they are children and cannot be in the severe category, we need to flexible, for children to receive social welfare."* (Key informant)

> *"We consider about living conditions, if they are in economic difficulty, we can be more flexible. It is not in the guideline but we can adjust it in practice."* (Key informant)

Typically, this use of discretion by assessors was reported to result in favourable outcomes for applicants (i.e. approval of application, categorisation to a higher degree). However, in certain cases straying from official guidelines could result in exclusion from disability-targeted programmes. For example, it was noted that local programme officials often play a gate-keeping role in encouraging or dissuading applications. In particular, people who would be unlikely to qualify for social assistance were often dissuaded from applying, even if they would be eligible for benefits earmarked for people with 'mild' disability degree classifications.

Discussion

This study aimed to measure access to social protection among people with disabilities in Vietnam and explore factors that support or hinder participation in relevant programmes. This research contributes to a relatively limited evidence base

on inclusion of people with disabilities in social protection, which is needed to inform planning and delivery of systems [13].

Few studies have measured participation of people with disabilities in targeted and non-targeted social protection in a population-based sample, or have compared access to people without disabilities. Overall, this research found relatively high uptake of many social protection programmes among people with disabilities. Health insurance was almost universally accessed, while slightly over half of people with disabilities were social assistance beneficiaries (predominantly the Disability Allowance). People with disabilities were more likely to be recipients of both health insurance and social assistance compared to people without disabilities. In contrast, no person with a disability reported participating in social insurance, with many ineligible as they were not employed in the formal sector or worked too irregularly to afford regular contributions.

While access to disability-targeted social assistance and health insurance was high, a large proportion of people with disabilities were not participating in programmes that they were eligible for. In addition to the 45% of people with disabilities not receiving any form of disability-targeted social protection, many social protection beneficiaries were not accessing the full spectrum of benefits that were available to them. Key challenges to accessing social protection included: low awareness or perceived utility of certain entitlements, poor quality and availability of linked services, biases in assessment criteria and among programme staff, and geographic and financial barriers for people with disabilities who needed to go to a central level to make their application. Some of these challenges, particularly challenges in administering a disability assessment and low levels of awareness of availability of programmes, have been noted in other research [13, 28-32].

Still, this research also highlighted several strengths to the design and delivery of social protection in Vietnam. The coverage of disability-targeted benefits in Vietnam (40%) was much higher than the regional average of 9.4% [3]. Access of people with disabilities to many disability-targeted and non-targeted programmes appears to have expanded in recent years. For example, the number of Disability Allowance recipients almost doubled from 2009 to 2014, from less than 385,000 to over 700,000 [33, 34]. Similarly, in 2001-2002, only 19% of people with disabilities nationally reported having health insurance [35], while over 90% of people with disabilities in this survey were insured.

This expansion in access likely reflects the positive impact of recent policy changes. Notably, the introduction of Decree 28 and the Joint Circular 37 was credited by key informants in this study as substantially reducing geographic and financial barriers to access. These policies also transferred authority to local government bodies, increasing awareness of programmes and ease of administration. The benefits of moving away from purely medical assessments to more functioning-based protocols is supported in other research as more equitable, in line with a rights-based approach and easier to implement as they are not reliant on often limited specialised resources and expertise [11, 28, 36-39]. While evidence from Cam Le indicates most social recipients undergo the predominantly functioning-based assessment at the DDDC, determinations for certain groups – for example young children and people with mental health conditions – still rely heavily on medical assessments. While

policy changes are still being explored in Vietnam to improve assessments for these groups, identifying appropriate tools is a global challenge [40].

Further research is needed to understand how access to social protection varies in other regions of Vietnam, as well as in other contexts internationally. For example, means-testing and conditionality attached to the receipt of social assistance are common features of social protection programmes in other countries [3, 28]. Yet emerging evidence suggests that people with disabilities may face additional challenges accessing these types of schemes. For example, with means-testing, eligibility thresholds rarely consider extra disability-related costs, which can alter determinations of who is considered to be poor [12, 13, 28]. One study in Vietnam found that consideration of disability-related costs would increase the poverty rate among people with disabilities from 16.4% to 20.1% [41], which would have important implications if programmes were means-tested. People with disabilities may also have reduced access to conditional cash transfers, due to greater challenges complying with conditions (e.g. school attendance for children with disabilities in the absence of accessible schools) [28, 42].

In Vietnam and other countries, studies indicate that people with disabilities are more likely to be living in poverty and experience barriers to inclusion in areas such as work, education and social participation [8, 34, 43-47], indicating a high need for social protection and other interventions. Studies are now needed to assess the effectiveness of social protection programmes in meeting their intended aims of reducing poverty, increasing access to key services and improving livelihoods.

Strengths and limitations

There are several limitations that should be considered when interpreting the findings of this study. Cam Le is urban, relatively affluent, and was identified by stakeholders as having a relatively well-functioning social protection system and adequate availability of disability-related services. Consequently, some of the district-level results from this study may not reflect the situation across all of Vietnam. Coverage is likely lower in other areas, while certain barriers might be more pronounced elsewhere, particularly in remote districts.

Additionally, the Washington Group questions used to define disability in the quantitative surveys do not capture all forms of functional limitations. In particular, no questions ask about mental health, such as depression/anxiety, and it is not intended for use in children under five [48]. Our use of this tool would therefore have led to underrepresentation of these groups in our study. However, the experience of these groups is explored through the policy analysis and qualitative research.

Strengths include the use of mixed methods, which allows for a more comprehensive investigation into our research aims. The use of qualitative and quantitative research in addition to a national policy analysis enables us to corroborate and contrast findings across different methods and respondents, which ultimately both broadens and deepens our understanding of the strengths and weaknesses of designing and delivering social protection that is accessible to people with disabilities in Vietnam.

Conclusion

Access to social protection among people with disabilities in Cam Le, Vietnam is relatively high, particularly for disability-targeted social assistance and health insurance. While Vietnam's social protection system includes many examples of good practice in disability-inclusive social protection, gaps remain in extending coverage and increasing use of certain benefits. Addressing these challenges is essential for fulfilling the commitment in the UNCRPD and the SDGs of "social protection for all".

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