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

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Abstract Although people with disabilities are frequently targeted as key beneficiaries of social protection, little is known on their access to existing programmes. This study uses mixed methods to explore participation in disability-targeted and non-targeted social protection programmes in Viet Nam, particularly in the district of Cam Le. In this district, social assistance and health insurance coverage among people with disabilities was 53 per cent and 96 per cent respectively. However, few accessed employment-linked social insurance and other disability-targeted benefits (e.g. vocational training, transportation discounts). Factors affecting access included the accessibility of the application process, disability assessment procedures, awareness and the perceived utility of programmes, and attitudes on disability and social protection.

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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 (World Bank, 2012). 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 (Gentilini and Omamo, 2011; ILO, 2017). Social protection may encompass a range of policies and programmes, including contributory schemes (social insurance), as well as non-contributory, tax-financed schemes (ILO, 2017). 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 Recommendation concerning National Floors of Social Protection, 2012 (No. 202), and recognized in the 2015–2030 Sustainable Development Goals (SDGs) as critical for inclusive and sustainable growth and development (UN, 2017). 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 (Gentilini and Omamo, 2011; Devereux and Sabates-Wheeler, 2004).

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 (Yeo, 2001; Elwan, 1999; WHO and World Bank, 2011). In addition to the 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 (Articles 22 and 25) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (Article 28) (UN, 1948 and 2006).

To fulfil the right to inclusion in social protection, states must ensure equitable access for people with disabilities to mainstream social protection programmes –

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such as health insurance, social security and other benefits where disability is not an explicit condition of eligibility (Devandas Aguilar, 2017). Additionally, targeted programmes may be needed to address disability-specific concerns, such as access to assistive devices and specialist health and educational services. Account also must 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 (ILO, 2017; Devandas Aguilar, 2017; Mitra et al., 2017). According to recent estimates from the International Labour Organization, 27.8 per cent of people with severe disabilities globally receive some form of disability benefit (ILO, 2017). However, there is considerable regional variation, with coverage lowest in Asia and the Pacific at 9.4 per cent and highest in Eastern Europe (97.9 per cent) (ILO, 2017). These estimates also result from the extrapolation of the 15 per cent global estimate of disability prevalence in each country's population, rather than to direct surveys. Additionally, 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 (Banks et al., 2016).

Consequently, this study seeks to explore access to social protection among people with disabilities, using Viet Nam as the study setting. In the sections that follow, following an overview of social protection in Viet Nam, and in addition to presenting quantitative measures of access, this article identifies challenges and facilitators to participation in social protection.

Overview of social protection entitlements in Viet Nam

The right to social security is codified in Article 34 of the recently amended Constitution of Viet Nam (Government of Viet Nam, 2013a). Resolution 70/NQ-CP/2012 further describes the state's strategy for strengthening social protection across the period 2012–2020 (Vinh, 2016). Overall, there are four main components to Viet Nam's social protection framework: (i) social assistance to groups deemed at high risk of poverty; (ii) social insurance to mitigate financial risks associated with sickness, occupational injuries and ageing; (iii) programmes promoting access to basic services, such as education, healthcare and clean water/sanitation; and (iv) policies to improve opportunities for decent work (Vinh, 2016).

Within this remit, Viet Nam 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 employees, with optional opt-in schemes available to the rest of the workforce.

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Table 1. *Disability-targeted social protection provisions*

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*: VND 405,000 [USD 18] (severe), VND 540,000 [USD 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 [USD 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 recognized centres, preferential loans for self-employed workers, incentives for employers to hire people with disabilities)
Transportation discounts	Access to basic services	Any classification	Free or subsidized public transportation

Source: Authors.

Disability-targeted social protection entitlements

People with disabilities in Viet Nam are eligible for the disability-targeted entitlements listed in Table 1. 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 Viet Nam (National Assembly of Viet Nam, 2010). The DDDC determines both the type and degree of disability using the Joint Circular 37/2012/TTLT-BLĐTBXH-BYT-BTC-BGDĐT,[1] which has two assessment tools (for children younger than age 6, and all others aged 6 or older). 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;

1. Hereafter, Joint Circular 37.

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communicating using speech; and participating in housework such as 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 decision, the applicant is referred to the Medical Examination Council (MEC) (National Assembly of Viet Nam, 2010). 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 per cent and above considered "extremely severe" and 61–80 per cent considered "severe" (MoH and MoLWISA, 2012).

Some entitlements, namely subsidized 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 increasing the value of the Disability Allowance, extending eligibility or in offering additional programmes.

Finally, veterans of the Resistance war against the United States (the Viet Nam 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 1,479,000–3,609,000 Viet Nam Dong (VND) (approx. USD 65–159) per month (Government of Viet Nam, 2017). 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 (Government of Viet Nam, 2013b). Amounts range from VND 270,000 to VND 675,000 per month (approx. USD 12–30). Any individual who is eligible for more than one form of social assistance can only receive the one providing the highest amount. The only types of social assistance that can be received

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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-subsidized compulsory health insurance (CHI), other social assistance recipients, as well as children younger than age 6, 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 per cent for children younger than age 6 to 30 per cent for students (Government of Viet Nam, 2009; National Assembly of Viet Nam, 2008). CHI covers 80 per cent of medical expenses, but for certain users (i.e. people with severe disabilities, people below the poverty line, children younger than age 6), the state provides a further subsidy to cover user fees (95 per cent–100 per cent) (Government of Viet Nam, 2013b; Nguyen and Hoang, 2017). Coverage under the CHI may also be extended to workers in formal employment, where enrolment is mandatory for workers who have a contract of at least 3 months. In this case, the premium is set at 6 per cent of the employee's monthly salary, of which the employer contributes 4.5 per cent and the employee 1.5 per cent (National Assembly of Viet Nam, 2008 and 2014). For individuals not covered by state- or employer-subsidized CHI, voluntary health insurance (VHI) is available, with premiums equivalent to 4.5 per cent of monthly salary with no employer contribution. For both VHI and employer-subsidized CHI, 80 per cent 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 employees with at least a one-month contract – covers sickness, maternity, labour accidents and occupational diseases, retirement and survivor allowances (UNFPA, 2011). CSI contributions are set at 26 per cent of the employee's monthly salary, of which employers contribute 18 per cent. In contrast, anyone can opt into VSI, but this covers only retirement and survivor allowances and requires a monthly contribution by the employee of 22 per cent of their self-declared income (UNFPA, 2011).

Methods

A mixed-methods approach was used to evaluate the extent to which people with disabilities are accessing existing social protection programmes, including an evaluation of the effects of 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

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was conducted in one district of Viet Nam to measure coverage and uptake of specific entitlements and to 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 younger than age 18 (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 from May to December 2016.

Setting

Viet Nam 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 practice. Cam Le, part of the province of Da Nang in Central Viet Nam, 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 Organizations (DPOs) and disability-support services. Cam Le's disability-targeted social protection entitlements also are more generous than the national minimum. Specifically, CHI coverage is expanded to children younger than age 17 with "mild" disability degree classifications and Disability Allowance payments 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 Viet Nam, including the strengths and challenges associated with ensuring access to social protection for people with disabilities. Data was compiled through three avenues: (i) a literature review, (ii) in-depth interviews with

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key stakeholders and (iii) a consultative workshop. For the literature review, relevant legal frameworks, policies and programmes in Viet Nam 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 16 key stakeholders within relevant government ministries, United Nations agencies, non-governmental organizations (NGOs), and 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 Viet Nam 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 (GSOV, 2010). A two-stage sampling strategy was employed based on a methodology used in other surveys (Kuper, Polack and Limburg, 2006). 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 Viet Nam (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 per cent, precision required = 20 per cent, design effect = 1.5, response rate = 90 per cent, and confidence = 95 per cent). 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+, using the Washington Group Short

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Set Questionnaire (Washington Group on Disability Statistics, 2009). 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 the 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. 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, from the same 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.

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A purposive sample of 32 participants with disabilities was identified, using data collected through the population-based survey, selected to reflect variation in terms of impairment type, sex, age (children, working-age or 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, 6,705 household members were selected and 6,379 screened for disabilities (response rate: 95.1 per cent). Overall, 150 individuals were identified as having a disability (prevalence: 2.5 per cent, 95 per cent; CI: 2.1–2.9 per cent).[2] Prevalence of disability did not differ by gender (Men: 2.3 per cent, 95 per cent; CI: 1.8–2.9 per cent, Women: 2.6 per cent, 95 per cent; CI: 2.1–3.2 per cent), but increased substantially with age (from 1.1 per cent in children aged 5–18, to 13.2 per cent in adults aged 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 per cent), 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 per cent). Of 32 people, 24 were interviewed directly and for eight participants, information was gathered through their caregivers (for people with disabilities younger than age 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 ages 5–84 (5–17 years: n=7,

2. CI = confidence interval. CI measures the probability that a population parameter will fall between two set values.

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18–64 years: n=20, 65+ years: n=5), and there was a near equal mix by gender (female, n=18; male, n=14).

Social protection access

Over half (52.7 per cent) of the 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 per cent) (Table 2). The Disability Allowance was the predominant source of social assistance accessed among people with disabilities (71 per cent of recipients of social assistance). Overall, coverage of the Disability Allowance was 40 per cent, with no participants accessing the scheme who did not meet the study's definition of disability. There were no statistically significant differences by sex across any social protection programme.

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).

In the survey group, no one with a disability was accessing social insurance, due in large part to their exclusion from the labour market, particularly the formal

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

	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+; or 60+ and below the poverty line)	12 (35.3%)[a]	12 (35.3%)[a]	0.8 (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-subsidized 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

Notes: aOR: adjusted odds ratio (adjusted for age and sex); Statistically significant: *$p \leq 0.05$, **$p \leq 0.01$, ***$p \leq 0.001$. [a]Includes two individuals between ages 60–79 who were not below the poverty line based on household income.

Source: Authors.

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economy. 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 for retirement pensions and for protection against risks such as workplace injury (Table 2).

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).

In comparing the characteristics of people with disabilities who were and were not receiving disability-targeted social protection, coverage decreased with increasing age (from 89 per cent for children younger than age 18 to 21 per cent for adults older than age 75). Coverage was highest for people with communication difficulties and lowest for people with sensory impairments. It is important to note that 92 per cent of people with communication difficulties had multiple functional limitations (compared to 51 per cent of people with disabilities overall). There was no difference between recipients and non-recipients by severity of disability (Table 4).

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: (i) geographic accessibility, (ii) financial accessibility, (iii) disability assessment criteria and procedures, (iv) awareness and

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

Disability-targeted entitlement	Aware (%)	Uptake***(%)
Transportation discounts	6 (4.5%)	2 (1.5%)
Educational discounts (among children younger than age 18)*	5 (23.8%)	2 (8.3%)
Livelihoods supports (vocational training, preferential loans), among people aged 15–65**	19 (14.2%)	17 (17.1%)
Allowance for caregivers	14 (10.6%)	12 (8.9%)

Notes: *n=24, **n=99, ***among people aware of entitlement.
Source: Authors.

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

	Receiving allowance (*n*=132)[a]	Not receiving allowance (*n*=78)	
	n (%)	n (%)	aOR (95% CI)
Female	70 (58.3%)	50 (60.8%)	1.0 (0.6–1.9)
Age group			
5–18 years	23 (85.2%)	4 (14.8%)	Reference
19–40 years	48 (76.2%)	15 (23.8%)	0.6 (0.2–1.9)
41–60 years	35 (61.4%)	22 (38.6%)	0.3 (0.08–0.9)*
61–75 years	19 (46.3%)	22 (53.7%)	0.2 (0.04–0.5)**
76+ years	7 (20.6%)	27 (79.4%)	0.05 (0.01–0.2)***
Functional limitation[d]			
Mobility	61 (52.6%)	55 (47.4%)	1.3 (0.6–1.8)
Sensory (visual/hearing)	23 (45.1%)	28 (54.9%)	1.1 (0.6–1.9)
Remembering	62 (70.5%)	26 (29.6%)	1.7 (0.9–3.2)
Self-care	43 (54.4%)	36 (45.6%)	1.0 (0.5–1.9)
Communication	53 (73.6%)	19 (26.4%)	2.0 (1.0–4.0)*
Multiple	69 (61.1%)	44 (38.9%)	1.2 (0.6–2.2)
	Mean	**Mean**	**Coefficient (95% CI)**[b]
Severity score[c]	5.4	5.6	0.5 (-0.4–1.4)

Notes: aOR: adjusted odds ratio (adjusted for age and sex); Statistically significant: *p≤0.05, **p≤0.01, ***p≤0.001; [a]Includes people recruited from Disability Allowance registers; [b]Adjusted for age, sex; [c]Severity score: Total across six Washington Group domains (0=no difficulty, 1=some, 2=a lot, 3=cannot do for each domain); maximum score is 18; [d]Not mutually exclusive (i.e. sum >100%).
Source: Authors.

perceived utility of programmes, (v) broader disability-inclusive planning, and (vi) attitudes on disability and the 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 Viet Nam, 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

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conducted at the provincial capital. The shift in application location was widely cited by key informants at the national and local level as having helped improve coverage under 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 younger than age 6 and people with mental health conditions were noted to be particularly likely to be referred to the MEC. Additionally, if an applicant contests the result of their assessment, they can appeal the decision, but re-evaluations are done by the MEC. While over 80 per cent 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; approx. USD 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; approx. USD 50), key informants noted that while this fee may protect against excessive contestations, it disproportionately impacts poorer applicants.

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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 schooling.

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 a 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. By 2014, the figure 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. The 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:

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> 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 younger than age 6 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, in 2013, it had only 63 commune-level DPOs (HPC and HDPA, 2014).

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 interviewed in the quantitative survey, almost 60 per cent 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-subsidized or otherwise) were both the most well-known and deemed the 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 a girl aged 11 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 any more. (32 year old man who is not receiving the Disability Allowance)

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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 per cent 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 subsidized 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.

Broader disability-inclusive planning. 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 employment skills based on their individual abilities and the demands of the local job market. Similarly, while transportation discounts address financial barriers to access, the 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. But, 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 instance, many working-aged people with disabilities were either not employed or were engaged in irregular, low pay-work, almost exclusively in the informal economy. Consequently, they were not eligible for employer-subsidized 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 the need for social protection. Norms around who is considered "deserving" of social protection, particularly social assistance, could

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influence decisions to apply for support as well as assessment outcomes. For example, functional decline due to ageing was often not considered by people with disabilities and administrators alike to be a "legitimate" form of disability, and some argued that the benefit should be targeted at 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 eligibility for disability-targeted social protection is based officially only on the presence of disability as determined by the scoring system outlined in Joint Circular 37, some officials noted that consideration 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 be 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, categorization 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 gatekeeping 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 Viet Nam and explore factors that support or hinder participation in relevant programmes. This research contributes to a relatively limited evidence

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base on the inclusion of people with disabilities in social protection, which is needed to inform the planning and delivery of systems (Banks et al., 2016).

Participation

Few studies have measured the participation of people with disabilities in targeted and non-targeted social protection in a population-based sample, or have compared the access of people with disabilities to people without disabilities. Overall, this research found a 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 economy 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 per cent 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 travel from their local area to a central level of administration to make their application. Some of these challenges, particularly challenges in administering disability assessment and low levels of awareness of the availability of programmes, have been noted in other research (Banks et al., 2016; Gooding and Marriot, 2009; Kuper et al., 2016; Goldblatt, 2009; Graham, Moodley and Selipsky, 2013; Macgregor, 2006).

Still, this research also highlighted several strengths to the design and delivery of social protection in Viet Nam. The coverage of disability-targeted benefits in Cam Le (40 per cent), was much higher than previous estimates for Viet Nam (9.7 per cent) and the Asia-Pacific region (9.4 per cent) (ILO, 2017). Part of these differences may reflect differences in methodology, as this study used a direct survey approach, while other reported figures are estimates derived from applying the 15 per cent global disability prevalence to Viet Nam. However, the access of people with disabilities to many disability-targeted and non-targeted programmes appears to have expanded in recent years. For example, the number

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of Disability Allowance recipients almost doubled from 2009 to 2014, from less than 385,000 to over 700,000 (Hoi, 2014; UNFPA, 2011). Similarly, in 2001–2002, only 19 per cent of people nationally with severe disabilities reported having health insurance (Palmer and Nguyen, 2012). Although this study broadens the scope of disability, it still found that over 90 per cent of people with disabilities had health insurance.

Some recent policy changes are likely to have had positive impacts on access. Notably, the introduction of Decree 28 and the Joint Circular 37 were 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 both awareness of programmes and the 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 specialized resources and expertise (Devandas Aguilar, 2017; Mont et al., 2016; Schneider et al., 2011; Gooding and Marriot, 2009; Mitra, 2005, p. 39). While evidence from Cam Le indicates most 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 Viet Nam to improve assessments for these groups, identifying appropriate tools is a global challenge (Mactaggart et al., 2016).

Further research is needed to understand how access to social protection varies in other regions of Viet Nam, 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 (ILO, 2017; Gooding and Marriot, 2009). 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 (Banks et al., 2016; Gooding and Marriot, 2009; Mitra et al., 2017). One study in Viet Nam found that consideration of disability-related costs would increase the poverty rate among people with disabilities from 16.4 per cent to 20.1 per cent (Braithwaite and Mont, 2009), 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) (Gooding and Marriot, 2009; Mont, 2006).

In Viet Nam and other countries, studies indicate that people with disabilities are more likely to be living in poverty and experience barriers to inclusion in

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areas such as work, education and social participation (WHO and World Bank, 2011; UNFPA, 2011; Mont and Cuong, 2011; Palmer et al., 2015; Mitra, Posarac and Vick, 2013; Mizunoya, Mitra and Yamasaki, 2016; Bernabe-Ortiz et al., 2016), 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 Viet Nam. 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 with children younger than age 5 (Groce and Mont, 2017). 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 Viet Nam.

Conclusion

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

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essential for fulfilling the commitment in the UNCRPD and the 2030 SDGs of "social protection for all".

Bibliography

Banks, L. M. et al. 2016. "Disability and social protection programmes in low-and middle-income countries: A systematic review", in *Oxford Development Studies*, Vol. 45, No. 3.

Bernabe-Ortiz, A. et al. 2016. "Inclusion of persons with disabilities in systems of social protection: A population-based survey and case–control study in Peru", in *BMJ Open*, Vol. 6, No. 8.

Braithwaite, J.; Mont, D. 2009. "Disability and poverty: A survey of World Bank poverty assessments and implications", in *ALTER-European Journal of Disability Research,* Vol. 3, No. 3.

Devandas Aguilar, C. 2017. "Social protection and persons with disabilities", in *International Social Security Review*, Vol. 70, No. 4.

Devereux, S.; Sabates-Wheeler, R. 2004. *Transformative social protection* (Working paper, No. 232). Brighton, Institute for Development Studies.

Elwan, A. 1999. *Poverty and disability: A survey of the literature* (Social protection discussion paper, No. 9932). Washington, DC, World Bank.

Gentilini, U.; Omamo, S. W. 2011. "Social protection 2.0: Exploring issues, evidence and debates in a globalizing world", in *Food Policy*, Vol. 36, No. 3.

Goldblatt, B. 2009. "Gender, rights and the disability grant in South Africa", in *Development Southern Africa*, Vol. 26, No. 3.

Gooding, K; Marriot, A. 2009. "Including persons with disabilities in social cash transfer programmes in developing countries", in *Journal of International Development*, Vol. 21, No. 5.

Government of Viet Nam. 2009. *Quy định chi tiết và hướng dẫn thi hành một số điều của Luật Bảo hiểm y tế* [Decree on detailing and guiding a number of articles of the law on health insurance] (Decree No. 62/2009/ND-CP). Hanoi.

Government of Viet Nam. 2013a. *The Constitution of the Socialist Republic of Viet Nam*. Hanoi.

Government of Viet Nam. 2013b. *Quy định chính sách trợ giúp xã hội đối với đối tượng bảo trợ xã hội* [Regulation on social assistance for social protection beneficiaries] (Decree No. 136/2013/ND-CP). Hanoi.

Government of Viet Nam. 2017. *Quy định mức trợ cấp, phụ cấp ưu đãi đối với người có công với cách mạng* [Regulations on the levels of assistance and allowances for persons with meritorious services to the Revolution] (Decree No. 70/2017/ND-CP). Hanoi.

Graham, L.; Moodley, J.; Selipsky, L. 2013. "The disability–poverty nexus and the case for a capabilities approach: Evidence from Johannesburg, South Africa", in *Disability & Society*, Vol. 28, No. 3.

© 2019 International Social Security Association

Groce, N. E.; Mont, D. 2017. "Counting disability: Emerging consensus on the Washington Group Questionnaire", in *The Lancet Global Health,* Vol. 5, No. 7.

GSOV. 2010. *The 2009 Viet Nam Population and Housing census: Completed results*. Hanoi, General Statistics Office of Viet Nam.

HPC; HDPA. 2014. *Báo cáo hot động ca Hội ngu'i khuyết tt Hà Nội năm 2013 và Kế hoch hành động năm 2014* [Activity report of Hanoi Disabled People Association in 2013 and action plan for 2014]. Hanoi, Hanoi People's Committee, Hanoi Disabled People Association.

Hoi, N. V. 2014. *Những bu'ớc tiến quan trọng trong công tác bảo trợ xã hội* [Important advances in social protection]. Hanoi, Ministry of Labour, Invalids and Social Affairs.

ILO. 2017. *World social protection report 2017–19: Universal social protection to achieve the Sustainable Development Goals*. Geneva, International Labour Office.

Kuper, H.; Polack, S.; Limburg, H. 2006. "Rapid assessment of avoidable blindness", in *Community Eye Health*, Vol. 19, No. 60.

Kuper, H. et al. 2016. "Social protection for people with disabilities in Tanzania: A mixed methods study", in *Oxford Development Studies*, Vol. 44, No. 4.

Macgregor, H. 2006. "'The grant is what I eat': The politics of social security and disability in the post-apartheid South African State", in *Journal of Biosocial Science,* Vol. 38, No. 1.

Mactaggart, I. et al. 2016. "Field testing a draft version of the UNICEF/Washington Group Module on child functioning and disability: Background, methodology and preliminary findings from Cameroon and India", in *ALTER-European Journal of Disability Research/Revue Européenne de Recherche sur le Handicap*, Vol. 10, No. 4.

Mitra, S. 2005. *Disability and social safety nets in developing countries* (Social protection working paper, No. 509). Washington, DC, World Bank.

Mitra, S. et al. 2017. "Extra costs of living with a disability: A review and agenda for future research", in *Disability and Health Journal*, Vol. 10, No. 4.

Mitra, S.; Posarac, A.; Vick, B. 2013. "Disability and poverty in developing countries: A multidimensional study", in *World Development*, Vol. 41.

Mizunoya, S.; Mitra, S.; Yamasaki, I. 2016. *Towards inclusive education: The impact of disability on school attendance in developing countries* (Innocenti working paper, No. 3). Florence, UNICEF Office of Research.

MoH; MoLWISA. 2012 *Determination of the degree of disability by Medical Examination Council* (Joint circular). Hanoi, Ministry of Health and Ministry of Labour, War Invalids and Social Affairs.

Mont, D. 2006. *Disability in conditional cash transfer programs: Drawing on experience in LAC* (Conference paper, Third International Conference on Conditional Cash Transfers, Istanbul, 26–30 June). [S.l.].

Mont, D.; Cuong, N. V. 2011. "Disability and poverty in Vietnam", in *The World Bank Economic Review*, Vol. 25, No. 2.

Mont, D. et al. 2016. *Disability identification cards: Issues in effective design* (Working paper, No. 29). London, Leonard Cheshire Disability and Inclusive Development Centre.

© 2019 International Social Security Association

National Assembly of Viet Nam. 2008. *Law on Health Insurance*. Hanoi.

National Assembly of Viet Nam. 2010. *Law on persons with disabilities*. Hanoi.

National Assembly of Viet Nam. 2014. *Amendments to the law on health insurance*. Hanoi.

Nguyen, L. H.; Hoang, A. T. D. 2017. "Willingness to pay for social health insurance in Central Vietnam", in *Frontiers in Public Health*, April.

Palmer, M. G.; Nguyen, T. M. T. 2012. "Mainstreaming health insurance for people with disabilities", in *Journal of Asian Economics*, Vol. 23, No. 5.

Palmer, M. et al. 2015. "The economic lives of people with disabilities in Vietnam", in *PLoS One*, 21 July.

Schneider, M. et al. 2011. "Reflections on including disability in social protection programmes", in *IDS Bulletin*, Vol. 42, No. 6.

UN. 1948. *Universal Declaration of Human Rights* (General Assembly, Paris, 10 December). Paris.

UN. 2006. *Convention of the rights of persons with disabilities*. New York, NY.

UN. 2017. *Sustainable Development Goal 1: End poverty in all its forms everywhere* (Sustainable Development Knowledge Platform). New York, NY.

UNFPA. 2011. *People with disabilities in Viet Nam: Key findings from the 2009 Viet Nam Population and Housing Census*. Hanoi, United Nations Population Fund in Viet Nam.

Vinh, D. Q. 2016. *Social protection in Vietnam* (PowerPoint presentation, United Nations Expert Group Meeting on Poverty Eradication, New York, NY, 1–3 June). Hanoi, Ministry of Labour, Invalids and Social Affairs – Institute of Labour Science and Social Affairs.

Washington Group on Disability Statistics. 2009. *Understanding and interpreting disability as measured using the WG short set of questions*. Hyattsville, MD.

WHO; World Bank. 2011. *World report on disability*. Geneva, World Health Organization.

World Bank. 2012. *Resilience, equity, and opportunity*. Washington, DC.

Yeo, R. 2001. *Chronic poverty and disability* (Background paper, No. 4). Manchester, Chronic Poverty Research Centre.

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