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Social Protection Spotlight

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Social health protection

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

Key points

- Persons with disabilities have higher healthcare needs than those without disabilities. This includes both a higher need for general healthcare services and for more disability-related provisions, such as rehabilitation and assistive devices.
- Persons with disabilities are particularly affected by issues of service quality in the delivery of health services. Issues related to physical accessibility in healthcare facilities (such as a lack of ramps, appropriate toilet facilities and lack of seating) create major barriers for persons with physical disabilities.
- Direct medical costs but also non-medical expenses, such as transportation, and indirect costs, such as loss of income for family member who provide personal assistance support, can be substantial for persons with disabilities when accessing healthcare
- Social health protection coverage among persons with disabilities is strongly related to coverage among the population as a whole
- All three countries define rights to healthcare in disability-related legislation, but disability is largely absent from social health protection legislation.
- Recognition of disability status as a criterion for access to subsidized health protection coverage can play an important role in extending coverage. However, it requires accessible and inclusive disability assessment systems.
- Across the three countries, provision of rehabilitation and assistive devices has a greater emphasis on physical impairments, although there are some moves to expand the scope.
- Cash benefits can play an important role in covering some costs related to accessing healthcare. However, their potential is limited by gaps in adequacy and coverage.
- The legal framework for long-term care remains very limited across the three countries.

Background

The ILO, in partnership with the Agile, in Cambodia, Lao Tropical and Public Health Institute, and Viet Nam Health Strategy and Policy Institute, conducted a study to examine the extent to which persons with disabilities can access existing social health protection measures across the region.

The study was carried out in 2024 by the ILO's Global Flagship programme *Building Social Protection Floors for all: support to the extension of social health protection in Asia*, financed by the Grand Duchy of Luxembourg. It received

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This brief presents the key findings of the report "Fostering inclusion : Advancing social health protection for persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam" (ILO 2025).

Introduction

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

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

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

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

Context

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

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

All three countries define rights to healthcare in disability-related legislation, but disability is largely

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

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

Population coverage

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

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

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

Benefit packages and availability of services

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

The extent to which rehabilitation services and assistive devices are included in social health protection packages varies across the three countries.

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

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

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

Financial protection

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

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

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

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

Cash benefits can play an important role in covering some costs related to accessing healthcare. However, their potential is limited by gaps in adequacy and coverage. Cash benefits are most relevant in covering non-medical costs. However, while not their primary

objective, they may also contribute to covering medical costs when social health protection systems offer limited protection in terms of benefits or level of financial protection. Two of the study countries have non-contributory cash benefits in place that benefit persons with disabilities. Viet Nam's non-means-tested disability allowance provides a relatively predictable source of income to those assessed as having moderate or severe disability. The landscape of cash benefits in Cambodia is evolving, but remains focused on poverty-targeted household benefits, albeit with adjustments to account for disability. The role of cash benefits in covering healthcare-related costs is more evident in Viet Nam due to the higher coverage of the disability allowance, and also its higher benefit level. Nevertheless, the benefit adequacy for both schemes is below the global average for disability benefits, with recipients generally describing them as only making a partial contribution to covering the healthcare-related costs that they face.

Long-term care

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

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

Recommendations

The overarching conclusion of this brief is that the specific circumstances of persons with disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam require dedicated attention in the pursuit of universal health coverage. Continued efforts are needed to improve population coverage, enhance benefits, strengthen financial protection, and expand support for long-term care.

Population coverage

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

Benefit coverage

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

Financial protection

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

Long-term care

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

- There is also a need to **connect policy discussions on care and support services for persons with disabilities with discussions on long-term care for older persons** in relation to population ageing. Separating these discussions risks fragmentation in the provision of care and support services.

Cross-cutting recommendations

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

Legislation

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

Financing

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

Awareness-raising

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

Disability-inclusive administration of social protection

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

Data and research

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

Conclusion

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

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

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

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Contact information

International Labour Organization
Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +66 2 288 1234
F: +66 2 280 1735
E: BANGKOK@ilo.org
W: www.ilo.org/asia