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Towards healthy aging in Vietnam

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The Joint Annual Health Review (JAHR) 2016 is the 10th annual review developed in collaboration between the Ministry of Health (MOH) and the Health Partnership Group (HPG). This report aims to review the focal tasks of the health sector for 2016 and the period 2016 - 2020, and assess the organization and implementation of the tasks in the 5-year health sector plan for the period 2016 - 2020 and results of implementing the tasks assigned for 2016. In addition, the JAHR report also provides in-depth analysis on the topic “Towards healthy aging in Vietnam”, examining the problems arising due to population aging and Vietnam’s response.

The 2016 JAHR report was completed with the active support from many organizations and individuals. We wish to express our great appreciation for the valuable contributions from various administrations, departments, institutes and units of the MOH and other related ministries and sectors during the development of this report.

We would particularly like to mention our high appreciation for the technical support and effective feedback of members of the Health Partnership Group and international organizations and individuals, as well as financial support from the Vietnam Country Office of the World Health Organization, the Global Alliance for Vaccines and Immunization (GAVI) and the Delegation of the European Union to Vietnam.

We respectfully express our deep-felt thanks to the national and international experts who directly participated and actively contributed to the process of analysis of available information to develop drafts of each chapter; synthesized information and provided responses to partners and completed the contents of the report. We also thank Mr. Emmanuel Eraly, WHO expert in Vietnam who assisted the JAHR team to develop maps to illustrate geographic differentials in aging-related indicators in Vietnam.

We would particularly like to thank the coordinators who developed the JAHR report, under the leadership of Dang Viet Hung, PhD, deputy director of the Department of Planning and Finance; Assoc. Prof. Nguyen Hoang Long, PhD, director of the Vietnam Administration of HIV/AIDS Control, who along with members of the team, including Tran Thi Mai Oanh, PhD, Hoang Kim Ha, MS, Duong Duc Thien, MS, Phan Thanh Thuy, MS and Vu Thi Hau, MS have participated and actively contributed to the process of organizing, developing and completing this report.

JAHR Steering Committee

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CONTENTS

Acknowledgements .............................................................................................................. ii
Abbreviations and Acronyms .............................................................................................. xii
Introduction .......................................................................................................................... 1

PART ONE. UPDATE ON THE HEALTH SYSTEM ................................................................. 4

Chapter I. Health system governance and health information system ............................... 5
  1. Key tasks relating to health system governance and the health information system in the period 2016 - 2020 and in 2016 ............................................. 5
  2. Performance of health system governance and information systems in 2016 .......... 6
  3. Priority issues ................................................................................................................ 15
  4. Recommendations ......................................................................................................... 16
  5. Overview of implementation of health-related SDGs .................................................... 17

Chapter II. Inputs to health services ................................................................................... 18
  1. Key tasks relating to inputs to health service delivery in the period 2016 - 2020 and in 2016 ................................................................. 18
  2. Performance on tasks related to inputs to health services in 2016 ............................... 19
  3. Priority issues ............................................................................................................... 32
  4. Recommendations ......................................................................................................... 33

Chapter III. Health service delivery .................................................................................... 35
  1. Key tasks relating to health service delivery in the period 2016 - 2020 and in 2016 ................................................................. 35
  2. Review and update of some recently issued policies related to health service delivery............................................................................................... 36
  3. Performance on health service delivery tasks in 2016 .................................................. 36
  4. Priority issues ............................................................................................................... 53
  5. Recommendations ......................................................................................................... 55

PART TWO. TOWARDS HEALTHY AGING IN VIETNAM .................................................... 59

Introduction ........................................................................................................................... 60
  1. International perspectives on healthy aging .............................................................. 60
  2. Vietnam’s policies on older persons ........................................................................... 61

Chapter IV. Population aging and health status of older persons in Vietnam ............... 66
  1. Population aging in Vietnam ........................................................................................ 66
  2. Health status of older persons in Vietnam ................................................................. 75

Chapter V. Health care to meet the needs of older persons in Vietnam ....................... 103
  1. Key policies on health care for older persons .............................................................. 104
  2. Health care network providing services to older persons ............................................. 112
  3. Human and financial resources for health care of older persons .............................. 127
  4. Provision of health care for older persons ................................................................... 136
Chapter VI. Long term care of older persons in Vietnam ...............................................151
1. Long-term care policies for older persons .................................................................152
2. Long-term care needs of older persons .................................................................156
3. Organization of the provision of long-term care services for older persons ..........159
4. Human resources for long-term care of older persons .............................................177
5. Financing for long-term care for older persons .........................................................184

Chapter VII. Social environment to support healthy aging in Vietnam .........................191
1. Framework for analyzing the relationship between social environment and health among older persons .................................................................191
2. Social environment to ensure material conditions for older persons ......................192
3. Social environment to ensure non-material conditions for older persons ...............195

Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam ..............................................................204
1. Priorities for healthy aging in Vietnam .................................................................204
2. Recommendations for health and related sector response to achieve healthy aging ........................................................................................................211

References ......................................................................................................................221

Appendix. Monitoring and evaluation indicators, 2011-2015, target to 2020 ...............229
List of contributors to the JAHR 2016

The JAHR Steering Committee, coordinators and experts who compiled the JAHR 2016 report would like to express our heartfelt appreciation for the following individuals who contributed comments and feedback in roundtable discussions, workshops, e-mail dialogue, direct conversations and written feedback on the report, while others provided information and statistics, or other support for completing the JAHR 2016 report.

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List of tables

Table 1. Development of legal documents in the health and related sectors .................................9
Table 2. PAR index of the MOH, 2012-2015 ..................................................................................12
Table 3. Constitutional provisions on the rights of older persons ..................................................62
Table 4. Summary of the roles of organizations with contributions to healthy aging .....................65
Table 5. Marital status of older persons, 2011 ...............................................................................70
Table 6. Living arrangements among older people in Vietnam by age, sex and urban/rural residence, 2011 ........................................................................................71
Table 7. Summary of study findings on hypertension in older persons in Vietnam, 2001 - 2015 ........................................................88
Table 8. Summary of research findings on prevalence of diabetes among older persons in Vietnam, 2004 - 2015 ..........................................................90
Table 9. Summary of research findings on prevalence of musculoskeletal disorders in the Vietnamese elderly, 2000 - 2015 ..........................................................91
Table 10. Summary of study findings on COPD in the Vietnamese elderly, 2000 - 2015 ..........92
Table 11. Summary of study findings on prevalence of neurological diseases and mental illnesses in the Vietnamese elderly, 2000 - 2015 ..............................................95
Table 12. Proportion of the burden of disease (DALY) related to risk factors by age group in the Vietnamese elderly, 2015 .................................................................98
Table 13. Share of deaths attributed to known risk factors among older persons in Vietnam, 2015 ........................................................................................................100
Table 14. Health and health service targets for older persons in the Health Care for the Elderly Project for the period 2017 - 2025 ..............................................................107
Table 15. Health insurance entitlements of older persons .............................................................109
Table 16. NCD prevention and care targets for 2020 and 2025 .................................................141
Table 17. Operating conditions according to regulations on social protection establishments ........................................................................................174
Table 18. Some training programs for caregivers of older persons in Vietnam ..........................181
Table 19. Summary of human resource training for social work, 2015 ........................................184
Table 20. Monthly social assistance payments for various categories of older persons, 2017 ..............................................................................................................185
Table 21. Monthly payments for care of older persons at social protection establishments ..........187
List of Boxes

Box 1. Illustration of steps to develop the 2016 Pharmaceutical Law .................................. 10
Box 2. WHO recommended principles of screening for disease ........................................ 144
Box 3. United Kingdom model for routine health checkup .............................................. 144
List of figures

Figure 1. Framework of health system components ..............................................................4
Figure 2. Some changes to the organization of the local health system.............................8
Figure 3. Necessary regulations for re-organization and re-arrangement of the local health system ...........................................................................................................8
Figure 4. Health insurance payment per medical care contact, 2015 - 2016 .......................24
Figure 5. Purpose of socially mobilized investments by 2016 .............................................27
Figure 6. Source of socially mobilized funds for investment in the health sector by 2016...27
Figure 7. Healthy aging analytic framework ..................................................................61
Figure 8. Vietnam’s age structure and the proportion of population aged 60 and older, 1979 - 2049 ...........................................................................................................67
Figure 9. Aging process in Vietnam, 2006 - 2049 ..............................................................67
Figure 10. Aging index, Vietnam, 1979 - 2049 .................................................................68
Figure 11. Aging index (age 65+) of ASEAN nations, 2015 .............................................68
Figure 12. Dependency ratio, Vietnam, 1979 - 2049 .......................................................69
Figure 13. Age structure trends among older age groups in Vietnam, 1979 - 2049 ..........69
Figure 14. Sex ratio by age group among older persons, 1979 - 2049 .........................70
Figure 15. Living arrangements among older persons in Vietnam, 2002 - 2012 ..........71
Figure 16. Population pyramid for older persons by urban/rural residence, 2015 ..72
Figure 17. Projection of elderly share of the population by urban/rural residence compared to threshold of super-aged population, 2015 - 2049 .............................................73
Figure 18. Proportion of population aged 60 and older, 65 and older by region, 2015 ....73
Figure 19. Geographic variation in the aging index, 2015 ...............................................74
Figure 20. Healthy life expectancy (HALE), average years lived with disability (YLD) and life expectancy at birth by sex among ASEAN nations, 2015 .................75
Figure 21. Healthy life expectancy, average years lived with disability and life expectancy at age 60 by gender for ASEAN nations, 2015 .............................................76
Figure 22. Self-assessment of health among older persons in Vietnam by demographic and geographic characteristics, 2011 ..............................................................77
Figure 23. Percentage of older persons aged 60 and older in Vietnam with functional disabilities by type, 2009 ..............................................................................78
Figure 24. Living arrangements for older persons in Vietnam with difficulties or inability to perform basic functions, 2009 .........................................................78
Figure 25. Structure of vision-related burden of disease (DALYs) among older persons in Vietnam, 2015 ..............................................................................79
Figure 26. Difficulties in mobility among older persons in Vietnam by age group, 2011 ...80
Figure 27. Impairment in performing ADLs among older persons in Vietnam, 2011 ..........81
Figure 28. Explanation of concepts about DALYs ..........................................................82
Figure 29. Main causes of DALYS and death among older persons in Vietnam, 2015 ....82
Figure 30. Trends in DALYs by main disease group among older persons aged 60 and older in Vietnam, 1990 - 2015 .................................................................83
Figure 31. Patterns of cause of burden of disease measured in DALYS among older persons in Vietnam, 2015 .................................................................84
Figure 32. Patterns of cause of death among older persons in Vietnam, 2015 .................................................................85
Figure 33. Morbidity patterns among elderly patients treated at the National Geriatric Hospital, 2008 ....................................................................................86
Figure 34. Morbidity patterns among older persons seeking curative care by level of facility, 2014 .................................................................................87
Figure 35. Trends in burden of disease due to cardiovascular disease among older persons in Vietnam by age, 1990 - 2015 ........................................................................89
Figure 36. Trends in burden of disease due to diabetes among older persons in Vietnam by age group, 1990 - 2015 .................................................................90
Figure 37. Structure of burden of disease (DALY) due to musculoskeletal disorders among older persons in Vietnam, 2015 ................................................................91
Figure 38. Trends in burden of disease due to musculoskeletal disorders among older persons in Vietnam by age group, 1990 - 2015 ........................................92
Figure 39. Trends in burden of disease due to chronic lung disease among older persons in Vietnam by age group, 1990 - 2015 ................................................93
Figure 40. Structure of cancer types among older persons in Vietnam, 2012 .................................................................................94
Figure 41. Trends in burden of disease due to cancer among older persons in Vietnam by age group, 1990 - 2015 .................................................................94
Figure 42. Disease structure of burden of disease (DALYs) due to neurological and mental disorders among older persons in Vietnam, 2015..........................96
Figure 43. Trends in burden of disease due to neurological and mental health disorders among older persons in Vietnam, 1990 - 2015 ........................................96
Figure 44. Share of burden of disease (DALY) related to the 3 main risk factor categories by age group among older persons in Vietnam, 2015 ..................................97
Figure 45. Share of burden of disease (DALYs) attributed to behavioral risk factors by age and sex among older persons in Vietnam, 2015 ..................................99
Figure 46. Share of burden of disease (DALY) attributed to metabolic risk factors by age group and sex among older persons in Vietnam, 2015 .....................99
Figure 47. Proportion of deaths attributed to risk factor groups among older persons by gender in Vietnam, 2015 .................................................................101
Figure 48. Contents of interventions aimed at the goal of healthy aging ......................103
Figure 49. Healthcare interventions and long-term care for healthy aging throughout the life cycle .........................................................................................104
Figure 50. Diagram of design to integrate health care for older people into Vietnam’s health care network .................................................................114
Figure 51. Map of geriatric specialization development, 2017 ........................................115
Figure 52. Structure of health service contacts among people aged 60 and older, 2012 ....116
Figure 53. Older persons as a share of total health service contacts by type of facility and type of service, 2012 .................................................................122
Figure 54. Structure of type of services used by facility type among older persons, 2012 ..123
Figure 55. Structure of out-of-pocket expenditures for health services among older persons by service type and facility type, 2012 ................................................................. 123
Figure 56. Structure of facility type for use of different types of health services by age of older persons, 2012 ........................................................................................................ 124
Figure 57. Structure of facility type used by older persons for health checkups by demographic characteristics, 2012 ........................................................................... 125
Figure 58. Structure of facility type for outpatient contacts among older persons by demographic characteristics, 2012 ................................................................. 125
Figure 59. Structure of inpatient admissions among older persons by demographic characteristics, 2012 ...................................................................................... 126
Figure 60. Structure of living standards of older persons using different types of health facilities, 2012 ........................................................................................................ 131
Figure 61. Proportion of older persons with health insurance coverage by age group, 2006 - 2014 ........................................................................................................ 132
Figure 62. Structure of health insurance types by age group, 2012.............................................. 133
Figure 63. Proportion of older persons with health insurance by individual characteristics, 2006 - 2014 ........................................................................................................ 134
Figure 64. Structure of health insurance type by characteristics of older persons, 2012..... 134
Figure 65. Average annual number of outpatient contacts and inpatient visits per older person by health insurance coverage, 2014 ..................................................... 135
Figure 66. Average costs per outpatient and inpatient contact among older persons by health insurance coverage, 2014 ................................................................. 136
Figure 67. Kaiser pyramid of care for older persons .............................................................. 151
Figure 68. Comparison of institutional and community-based long-term care models ....... 155
Figure 69. Structure of the level of disability among older persons, 2015.......................... 158
Figure 70. Projection of the number of older persons facing difficulties or incapacity in vision, hearing, mobility, concentration/memory, 2019 - 2049. .................. 158
Figure 71. Projection of the number of older persons facing difficulties with ADLs, 2019 - 2049 ........................................................................................................................................ 159
Figure 72. Types of services under two long-term care models for older persons .......... 160
Figure 73. Governance of long-term care models for older people in the community ...... 162
Figure 74. ISHC activity areas ............................................................................................... 163
Figure 75. Map of the development of the ISHCs in Vietnam by the end of 2016 ............. 165
Figure 76. Mechanism for establishment of residential long-term care facilities for older persons .................................................................................................................. 172
Figure 77. Number of older persons with severe disabilities, number and proportion of older people in institutional care by region, 2014 ........................................ 176
Figure 78. Main workforce for long term care for older persons ......................................... 178
Figure 79. Social environment and health of older persons ................................................. 191
# Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
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<tr>
<td>ADR</td>
<td>Adverse Drug Reaction</td>
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<td>ARV</td>
<td>Anti-retroviral (drug)</td>
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<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>CASCD</td>
<td>Center for Aging Support and Community Development</td>
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<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
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<tr>
<td>CHS</td>
<td>Commune health station</td>
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<tr>
<td>CME</td>
<td>Continuing medical education</td>
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<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<td>DALY</td>
<td>Disability adjusted life years</td>
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<td>DHC</td>
<td>District health center</td>
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<td>DOH</td>
<td>Department of Health (provincial level)</td>
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<td>DOLISA</td>
<td>Department of Labor, Invalids and Social Affairs (provincial level)</td>
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<tr>
<td>DRG</td>
<td>Diagnostic Related Groups (payment mechanism)</td>
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<td>EPI</td>
<td>Expanded program on immunization</td>
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<td>GAVI</td>
<td>Global Alliance on Vaccines and Immunization</td>
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<td>GBD</td>
<td>Global Burden of Disease</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GMP</td>
<td>Good Manufacturing Practice</td>
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<tr>
<td>GNI</td>
<td>Gross National Income</td>
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<td>GOPFP</td>
<td>General Office of Population and Family Planning (MOH)</td>
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<td>GSO</td>
<td>General Statistics Office</td>
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<td>HAIV</td>
<td>HelpAge International in Vietnam</td>
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<td>HALE</td>
<td>Health Life Expectancy</td>
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<td>HCMC</td>
<td>Ho Chi Minh City</td>
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<td>HFG</td>
<td>Health Finance and Governance (USAID project)</td>
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<td>HIS</td>
<td>Health information system</td>
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<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/ Acquired immunodeficiency syndrome</td>
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<td>HPG</td>
<td>Health Partnership Group</td>
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<td>International Classification of Disease (version 10)</td>
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<td>ICPS</td>
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<td>IEC</td>
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<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>ISHC</td>
<td>Inter-generational Self-help Clubs</td>
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<td>ISO</td>
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<td>IT</td>
<td>Information technology</td>
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<td>JAHR</td>
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<td>LTC</td>
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<td>Acronym</td>
<td>Description</td>
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<td>MCNV</td>
<td>Medisch Comité Nederland-Vietnam</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MERS-CoV</td>
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<td>MMR</td>
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<td>MMT</td>
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<td>Tuberculosis</td>
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<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollar</td>
</tr>
<tr>
<td>VAE</td>
<td>Vietnam Association of the Elderly</td>
</tr>
<tr>
<td>VHLSS</td>
<td>Vietnam Household Living Standards Survey</td>
</tr>
<tr>
<td>VHW</td>
<td>Village health worker</td>
</tr>
<tr>
<td>VNAS</td>
<td>Vietnam Aging Survey</td>
</tr>
<tr>
<td>VNCA</td>
<td>Vietnam National Committee on Aging</td>
</tr>
<tr>
<td>VND</td>
<td>Vietnamese dong</td>
</tr>
<tr>
<td>VSS</td>
<td>Vietnam Social Security</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Introduction

Purpose of the JAHR report

As agreed upon by the Health Partnership Group (HPG), since 2007, the Joint Annual Health Review (JAHR) has been developed to assess the situation and determine which issues in Vietnam’s health sector should be prioritized to support development of the MOH annual plans and to serve as the basis for choosing the focus for dialogue and cooperation between the health sector and international partners.

Every year, the JAHR report serves the following purposes: (i) update the situation of the health system, including reporting on new policies and assessing progress in implementation of tasks and in achieving targets that were proposed in the health sector plans, as well as assessing progress in implementing Sustainable Development Goals (formerly Millennium Development Goals) in Vietnam and (ii) analysis and in-depth assessment on some aspect of the health system or some important topics that are the focus of attention of health sector policymakers.

Contents and structure of JAHR 2016

The JAHR report has gone through two cycles of five-year plans. Depending on the situation each year, the structure and contents of the JAHR report are varied to meet the objectives and specific requirements of health sector planning and choice of focal area for cooperation and dialogue between the Vietnamese health sector and international development partners.

In 2007, the first JAHR report was compiled, providing a comprehensive update of the major building blocks of the Vietnamese health system, including: (i) Health status and determinants; (ii) Organization and management of the health system; (iii) Health human resources; (iv) Health financing; (v) Health service delivery. The 2008 and 2009 JAHR reports, besides providing updates on the health system, also included in-depth analysis of the topic of health financing (2008) and health human resources (2009) in Vietnam. The 2010 JAHR report concentrated on a comprehensive update of all components of the health system, in order to support development of the Five-year health sector plan for the period 2011 - 2015.

The 2011 JAHR was developed in the first year of implementing the Five-year health sector plan for the period 2011 - 2015 and provided an update of the new orientation that had been determined in the Eleventh National Party Congress, and in the Five-year socio-economic development plan, to support development of the 2012 annual plan and promote implementation of the overall Five-year health sector plan. The JAHR reports between 2012 and 2015 had the task of supporting development of annual plans of the health sector, through providing an update on new policies, and assessing implementation of tasks in the six health system building blocks. These reports also analyzed various topics in depth including, quality of health services, orientation towards universal health coverage, control of non-communicable diseases (NCDs), and strengthening quality of the grassroots health system towards universal health care.

The 2016 JAHR was developed in the first year of the Five-year health sector plan for the period 2016-2020, which corresponds to the starting year for implementing sustainable development goals spearheaded by the United Nations. This year’s JAHR has the following tasks: (i) provide information to support development of solutions for implementing the Five-year health sector plan 2016 - 2020; and (ii) support development of policies to ensure healthy aging in Vietnam.

This year’s JAHR report contains two main parts with 8 chapters as follows:

PART ONE. Update on the health system

The six components of the health system have been updated in three chapters grouped in the following way: (1) Health system governance and health information system; (2) Inputs to
health care; (3) Health service delivery.

Chapter I: Health system governance and health information system. Update on implementation of the Five-year health sector plan 2016 - 2020 and results of implementation of tasks assigned for 2016 related to health system governance and the health information system.

Chapter II: Inputs to health services. Update on implementing the Five-year health sector plan 2016 - 2020 and results of implementing the targets for 2016 tasks related to inputs to health care including human resources, health financing, pharmaceuticals and medical equipment and infrastructure.

Chapter III: Health service delivery. Update on implementation of the Five-year health sector plan 2016 - 2020 and results of implementing the targets for 2016 tasks in the area of service delivery including preventive services, curative care, traditional medicine, population and family planning, reproductive health care and maternal and child health.

PART TWO. In-depth analysis on the topic “Towards healthy aging in Vietnam” with the following contents:

Introduction: International perspectives about aging and the WHO strategic framework for interventions; Vietnam’s policies on older persons and the Vietnamese organizations involved in protecting rights of older people, providing health and personal care interventions or activities to strengthen the social environment for older persons.

Chapter IV: Population aging and health status of older persons in Vietnam. This chapter analyzes the features of population aging in Vietnam; the health status of older persons in Vietnam; identifies priority issues to be resolved; and proposes various solutions to strive for healthy aging in Vietnam.

Chapter V: Health care to meet the needs of older persons in Vietnam. This chapter updates us on the policies about health care for older persons and the status of the healthcare network serving older persons, including human resources, health financing and health care service delivery.

Chapter VI: Long-term care of older persons in Vietnam. This chapter analyzes the need for long-term care among older people in Vietnam, assesses the various community-based and institutional long-term care options for older persons in Vietnam at present, and reviews the human resources and health financing issues related to long-term care in Vietnam.

Chapter VII: Social environment to support healthy aging in Vietnam. This chapter provides an analysis and evaluation of the social environment to meet the physical and spiritual needs of older persons.

Chapter VIII: Priority issues and recommendations for solutions towards healthy aging in Vietnam. This Chapter compiles the priority issues and recommendations aimed at the goal of healthy aging from Chapters IV through VII.

The Appendix provides a revised table of monitoring and evaluation indicators linked to various tasks and goals of the Five-year health sector plan 2016 - 2020 and Sustainable Development Goals (SDGs), and trends for the period 2011 to 2015.

Implementation methods

The process of developing the JAHR 2016 report relied on specific methodological approaches and general requirements, including the following:

- Consideration of the socio-economic context and specific attributes of the Vietnamese health system at its current stage of reform and development. Assessment of performance, progress, difficulties and shortcomings with relation to the health system goals of equity
and efficiency, and specifically the tasks that have been set out in health sector plans, and from there to propose appropriate solutions.

- Understand and apply appropriate theoretical frameworks for each component of the health system, and for the focal topic chosen for a specific year, to ensure scientific objectivity in the perspectives and approaches, appropriate with the ongoing modernization.

- Discussions with government officials and experts in relevant departments and administrations of the Ministry of Health (MOH), in order to clarify priorities for focusing attention to ensure progress in implementing Five-year health sector plan tasks that have been assigned to each department and administration. Exchange of information and timely dissemination of the draft report to the planning team in the Department of Planning and Finance. The MOH bears responsibility for coordination of the development of the JAHR report.

**Specific methods** used to develop the report include: (i) Synthesize available references, including policy documents, laws, research and surveys and (ii) Gather and process comments from stakeholders, particularly management officials, health sector experts, relevant ministries and sectors, and international experts.

_Synthesizing available references_ includes documents of the Communist Party, National Assembly, Government, MOH, Ministry of Labor, Invalids and Social Affairs (MOLISA), and other ministries, research studies and surveys; reports of ministries and sectoral agencies and of international agencies and experts. The coordinators search for and regularly provide relevant references and statistical data to supplement the information sources available to national experts.

Gathering and responding to feedback from stakeholders for the JAHR 2016 was implemented as follows:

- Organized one workshop and four roundtable discussions with national experts including representatives of the HPG.

- Sent draft chapters to individual experts, MOH administrations, departments and other units and other relevant ministries for feedback and comments.

**Organization and implementation**

Similar to previous years, the JAHR 2016 was developed under the coordination and leadership of the MOH and the HPG. The organizational structure for running the report compilation process included the following:

Steering committee, chaired by the Minister of Health, with the participation of Vice Minister Pham Le Tuan, with leaders of MOH departments and administrations as focal points and national and international coordinators with the responsibility to determine the report topic, develop the plan, recruit experts, approve the outline and check the JAHR report for approval each year.

_Coordinators_ consists of representatives of the MOH, an international coordinator, a national coordinator and support staff, with responsibility to resolve the daily operational issues and manage administrative issues; organize workshops, roundtable discussions; gather feedback from interested parties; ensure that the process of writing the report involves the active participation of many stakeholders; and edit and finalize the report.

_National experts_ include national experts of the MOH, MOLISA and some non-governmental agencies. All experts have substantial knowledge and experience related to the relevant component of the health system or support and care of older persons, and were tasked with drafting chapters of the report, gathering feedback from stakeholders and completing their chapters by responding to each comment and source of feedback.
PART ONE. UPDATE ON THE HEALTH SYSTEM

Part one of the JAHR 2016 report aims to provide an update on new policies and activities, including an assessment of activities to implement the tasks assigned to the health sector by the Government in Resolution 01/NQ-CP in 2016. The basic analytic framework for the health system is shown in Figure 1.

Figure 1. Framework of health system components
Chapter I. Health system governance and health information system

This Chapter aims to: (i) review key tasks relating to health system governance and the health information system in 2016 and the period 2016 - 2020; (ii) update preparations for the implementation of the Five-year health sector plan for 2016 - 2020; (iii) evaluate the performance of health system governance and the health information system in 2016; and (iv) identify priority issues for action and make recommendations to respond to those issues for 2017 and the period 2017 - 2020.

1. Key tasks relating to health system governance and the health information system in the period 2016 - 2020 and in 2016

On 1 March 2016, the Minister of Health signed Plan No. 139/KH-BYT issuing the Plan for People’s Health Protection, Care and Improvement in the period 2016 - 2020 (hereafter called the Five-year health sector plan 2016 - 2020), identifying nine key tasks of the health sector in the next five years, of which two are directly related to health system governance and the health information system. These two key tasks can be divided into six specific sub-tasks as follows:

- Reform and improve health system organization;
- Continue refining the system of legal documents on health;
- Promote administrative procedure reform and application of information technology;
- Enhance inspection and examination;
- Strengthen cooperation, be proactive in international integration in the health sector;
- Consolidate and strengthen the health information system.

Resolution No. 01/NQ-CP dated 7 January 2016 and the Program of Action (Program No. 135/CTr-BYT dated 29 February 2016) for implementing this Resolution have defined key tasks of the health sector in 2016, of which the following are related to health system governance:

- Complete the Master plan of Vietnam’s health system development to 2025 with a vision to 2035 to submit to the Government for promulgation, then to disseminate the approved Master plan; to consistently apply nationwide the model of commune health stations (CHSs) directly managed by district health centers (DHCs), which do not necessarily have permanent medical doctors, but can operate through doctor rotations from DHCs.
- Draft and assess potential impact of laws to be submitted to the National Assembly (i.e. Alcohol Control Law, Law on Blood and Stem Cells, Population Law) and projects to be submitted to the Government; complete the development of circulars as stipulated in the plans for legislation and policy development.
- Develop, guide and direct the implementation of the public administrative reform plan of the health sector in 2016 and the period 2016 - 2020; enhance information and communication technology application in activities of MOH agencies/units; examine, evaluate and determine the public administrative reform index of MOH departments, administrations, cabinet and inspectorate.
- Develop and effectively implement the 2016 Inspection Plan, focusing on: state management of food safety; household insecticides and other chemical products; sale and use of nutritional products for infants; comprehensive inspection of some public service providers; implementation of health insurance policies and laws; implementation of policies and laws on social mobilization in the health sector; state management in the field of pharmacy; competitive tendering for procurement of drugs, drug prices and drug use; implementation of budget collection/spending, anti-corruption, promotion of thrift and combat against waste.

- Continue applying information technology in the implementation of level-4 public administrative services, the ASEAN single-window mechanism project and the national single-window customs mechanism in MOH agencies.

For the health information system, priorities in 2016 include:

- Establish an information management system which is strong and effective enough to help managers and policymakers have enough quality information in a systematic, regular and timely manner.

- Assess implementation of the health-related Millennium Development Goals (MDGs); Develop a program of action and specific indicators for implementing United Nations Sustainable Development Goals (SDGs) in the health sector.

Based on the objectives and tasks set out above, the remaining part of this chapter will focus on evaluating achievements and difficulties as well as shortcomings, in order to determine priority areas for action in 2017 and the period to 2020.

2. Performance of health system governance and information systems in 2016

Task 1. Renew and refine health system organization

According to the Five-year health sector plan 2016-2020, the first governance-related task is “to reform and refine the organizational structure of the health system from central to local levels after the Master Plan for Vietnam’s Health System Development to 2025 is approved. The orientation is towards reducing the number of focal points and bringing the plan into line with international trends in order to utilize resources efficiently at all levels”. Three specific activities mentioned in the Master plan consist of: (i) merging district hospitals and DHCs into dual-function DHCs responsible for preventive and curative services as well as management of CHSs; (ii) gradually merging provincial centers/units in charge of preventive medicine into provincial centers for disease control (CDC) and shifting their curative functions to hospitals; (iii) merging separate quality control testing units for drugs, cosmetics, vaccines, biologicals, medical products, food safety and medical equipment into food and drug testing and quality control units and establishing a number of regional testing centers.

Implementation results

Health system at the central level

The MOH has evaluated the implementation of Government Decree No. 63/2012/ND-CP dated 31 August 2012 stipulating the functions, tasks, authority and organizational structure of the MOH. On that basis, on 20 June 2017, the Government issued Decree No. 75/2017/ND-
Chapter I. Health system governance and health information system

CP stipulating the functions, tasks, authority and organizational structure of the MOH during the 2016-2021 term of the 14th Government. It basically has the same contents as Decree 63, according to which the MOH is the Government agency responsible for state management in the area of health, including the following fields: preventive medicine, medical examination and treatment, rehabilitation; medical assessment, forensic examination, forensic psychiatry, traditional medicine; reproductive health care, medical equipment, pharmaceuticals and cosmetics, food safety, health insurance, population, and state management of public health-related services. Some detailed provisions were modified and updated according to recently issued policy documents.

Health system at local level

The MOH and Ministry of Home Affairs have issued Joint Circular No. 51/2014/TTLT-BYT-BNV dated 11 December 2015 guiding the functions, tasks, authority and organizational structure of provincial departments of health (DOHs) and district health offices. The MOH has also developed and enacted Circular No. 37/2016/TT-BYT dated 25 October 2016 on the functions, tasks, authority and organizational structure of DHCs and Circular No. 59/2015/TT-BYT dated 31 December 2015 on the functions, tasks, authority and organizational structure of provincial health centers. These are important legal documents to ensure a lean and effective local health system and guarantee coordinated and continuous health service delivery.

At the provincial level: according to Circular No. 51 “… implement the CDC model at provincial level through merging centers with the same functions, merging specialized centers and centers with inpatient beds into provincial hospitals, or establishing specialized hospitals if necessary and when resources are available” (Figure 2). This is a breakthrough in the organization of the preventive medicine system. By October 2016, 23 provinces and municipalities¹ have had a decision issued by the Provincial People’s Committee stipulating the functions, tasks, powers and organizational structure of the DOH, of which 17 are allowed to implement the CDC model at the provincial level. The organization of the local health system of other provinces is still under the review and approval process of the provincial people’s committee.

At the district level: Circular No. 51 stipulates “… DHCs should be organized consistently at the district level, performing the following functions: preventive medicine, medical examination and treatment, and rehabilitation; regional polyclinics, maternity facilities (if any) and CHSs in a district are under the management of the DHC…”; “… a separate General hospital will only be established at district level when it is really necessary and resources are available, and must meet criteria for grade-2 or higher-grade hospitals………” (Figure 2). By October 2016, 18 provinces have issued regulations on DHCs having dual-functions of preventive and curative care (of which 14 merged the DHC into the district hospital, 4 already applied the model of dual-function DHC). The application of dual-function DHCs is suitable for the actual situation. It avoids scattered investment and consolidates human resources so that health workers can be mobilized, rotated and allocated flexibly between levels. It also increases the connection between preventive and curative care, and ensures consistent direction and guidance between district and commune levels.

At the commune level: the MOH has issued Circular No. 33/2015/TT-BYT guiding the functions and tasks of CHSs. Earlier, the Government had promulgated Decree No. 117/2014/ND-CP on commune health. So far 62 out of 63 provinces have regulations stipulating that CHSs are health facilities under DHCs.

¹ In this report, hereafter the term ‘province’ will be used to refer to provinces and municipalities.
Difficulties and shortcomings

While a series of decrees and circulars related to the local health system have been enacted, the health system development master plan has not yet been approved. A plan providing detailed guidance on the arrangement and organization of departments/divisions in local health facilities is needed. Policy documents on the functions, tasks and activities of provincial CDCs were issued after a long delay (Circular 26/2017/TT-BYT was issued on 26 June 2017).

Reform of health system organization needs to be accompanied by detailed regulations on re-organization and re-arrangement of physical facilities, health human resources (recruitment and use of officials, civil servants, public employees, contracted staff), and operational and financial mechanisms (Figure 3). However, there are no specific guidelines on these contents; for example, regarding human resources, provisions on staffing stipulated in Joint Circular No. 08/2007/TTLT-BYT-BNV guiding the staffing in state-owned health facilities are no longer suitable to the organization and operation of health facilities.

Task 2. Continue developing the system of legal documents on health

The second task in the Five-year health sector plan for 2016 - 2020 is to complete the system of legislation and policy documents on health, with 3 specific activities: (i) increase the capacity in policy making and advocacy, (ii) strengthen evidence-based policy development, (iii) engage social-political organizations, social-professional organizations and the people.
Implementation results

The system of legal documents on health continues to be developed and refined. The National Assembly has passed the new Pharmaceutical Law No. 105/2016/QH13 dated 6 April 2016, with several new provisions such as pharmaceutical development policy (e.g. to prioritize research on and production of pharmaceutical ingredients from medicinal herbs available in Vietnam and to prioritize domestically produced drugs), policies on drug price control, drug registration, clinical pharmacology, pharmacy practice certificate, etc. Other laws (i.e. Alcohol Control Law, Law on Blood and Stem Cells, Population Law and Law on Transsexualism) have been drafted in detail and will be submitted soon for promulgation (Table 1).

Table 1. Development of legal documents in the health and related sectors

<table>
<thead>
<tr>
<th>Year</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Law on People’s Health Protection</td>
</tr>
<tr>
<td>2005</td>
<td>Pharmaceutical Law</td>
</tr>
<tr>
<td>2006</td>
<td>Law on HIV/AIDS Prevention and Control</td>
</tr>
<tr>
<td>2006</td>
<td>Law on Donation, Removal and Transplantation of Human Tissues and Organs, and Donation and Use of cadavers</td>
</tr>
<tr>
<td>2007</td>
<td>Law on Prevention and Control of Infectious Diseases</td>
</tr>
<tr>
<td>2007</td>
<td>Law on Prevention and Control of Domestic Violence</td>
</tr>
<tr>
<td>2008</td>
<td>Health Insurance Law</td>
</tr>
<tr>
<td>2009</td>
<td>Law on Medical Examination and Treatment</td>
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<tr>
<td>2009</td>
<td>Law on the Elderly</td>
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<tr>
<td>2010</td>
<td>Food Safety Law</td>
</tr>
<tr>
<td>2010</td>
<td>Law on People with Disabilities</td>
</tr>
<tr>
<td>2012</td>
<td>Tobacco Control Law</td>
</tr>
<tr>
<td>2014</td>
<td>Health Insurance Law (amended)</td>
</tr>
<tr>
<td>2016</td>
<td>Pharmaceutical Law (new)</td>
</tr>
<tr>
<td>2016</td>
<td>Child Law</td>
</tr>
<tr>
<td>2019</td>
<td>Alcohol Control Law (planned)</td>
</tr>
<tr>
<td>2018</td>
<td>Law on Blood and Stem Cells (planned)</td>
</tr>
<tr>
<td>2018</td>
<td>Population Law (planned)</td>
</tr>
<tr>
<td>2019 - 2020</td>
<td>Law on Transexualism (planned)</td>
</tr>
</tbody>
</table>

The MOH has also developed 11 decrees stipulating conditions required for businesses registered to work in the field of health, which were submitted to the Government for promulgation. The MOH has developed and submitted to the Government for promulgation Decree No. 36/2016/ND-CP, the first decree on management of medical equipment, stipulating the classification of medical equipment in accordance with regulations on international integration, the management of medical equipment by product life cycle, change of management methods, and application of a common form of registration for medical equipment in circulation. The MOH has issued 17 circulars and one joint circular on medical examination and treatment, traditional medicine, pharmaceuticals, competitive tendering for procurement of drugs, and health environment [1].

Progress has been achieved in capacity building for policy making and advocacy, strengthening of evidence-informed policy development with the engagement of socio-political organizations, socio-professional organizations and the people. Draft laws, decrees and circulars developed by the MOH are in line with provisions of the Law on Promulgation of Legal documents (Box 1).
Box 1. Illustration of steps to develop the 2016 Pharmaceutical Law

1. Reviewed 10 years of implementation of the Pharmaceutical Law 2005 as an important scientific and practical basis for the development of the new Pharmaceutical Law.
2. Systematically reviewed legal documents on pharmaceuticals; translated and reviewed pharmaceutical laws of selected countries.
3. Organized study tours to learn about international experience in formulating and implementing legal documents on pharmaceuticals.
4. Organized workshops to consult managers, scientists and experts about contents of the draft law.
5. During the drafting process, organized meetings of the Drafting Committee and Editorial Team for comments on contents of the draft law.
6. Collected comments in writing and through workshops disseminating the draft law to ministries, sectoral agencies, DOHs, pharmaceutical quality control facilities, health facilities, and pharmaceutical enterprises.
7. Posted the draft law on the electronic portal of the Government and the MoH to consult widely with stakeholders potentially affected by the draft law and others in society.
8. Developed a regulatory impact assessment report and detailed explanatory notes on the draft law, a report on impact assessment of administrative procedures and a report on mainstreaming gender equality in the draft law.
9. Requested the Ministry of Justice to appraise the draft law.
10. Submitted the final draft law to the Government for review and then to the National Assembly for promulgation of the new Pharmaceutical Law (2016).

The use of information for evidence-informed policy making received a high level of attention in development of draft laws, research and assessments, workshops, and policy advocacy.

The MOH has actively collected feedback from health service users to develop its reform programs. In 2016 the MOH issued Decision No. 4939/QD-BYT approving the plan for implementing the Project on measurement of patient satisfaction with public health services in the period 2016 - 2020; at the same time, it established inspection teams to inspect the implementation of the Project on improvement of health worker attitude and service style to achieve patient satisfaction in 63 provinces.

Difficulties and shortcomings

During the health policy development process, although various information/comment collection methods were used, certain methods were found to be ineffective. For example, the number of comments collected through websites was very small. The engagement of stakeholders involved in policy implementation (e.g. DOHs, health facilities) was limited, thus a number of enacted policies do not fully reflect reality.

Feedback from legal document/policy drafting agencies to those providing comments has been inadequate; no official response to comments was issued to indicate which ideas were incorporated and which were not used and to provide a justification. This fails to meet the information needs of stakeholders.

Regulatory impact assessment was not carried out uniformly, so policies and regulations that were issued face problems with feasibility in practice. For example, the regulation on supervised practice at health facilities after graduation as a prerequisite to receiving a medical practice certificate lacked detailed guidance for implementation and has not been effectively applied.
Monitoring of implementation of health sector policies and legislation is limited, while some policies are not updated and/or amended in a timely fashion. According to a Government report, from January to October 2016, the MOH was assigned 105 tasks by the Government and the Prime Minister, of which 19 were completed (on time: 10 tasks, late: 9 tasks), 86 are not yet completed (79 are on-going and 7 are overdue) [2].

**Task 3. Promote administrative procedure reform and information technology application**

The third task in the Five-year health sector plan for 2016 - 2020 is to speed up the reform of administrative procedures, to enhance application of information technology in health system management, medical examination and treatment, health insurance payment and delivery of online public services.

**Implementation results**

All 100% of MOH departments/administration/general offices have announced conformity with standards of the quality management system ISO 9001:2008. In May 2016, the MOH system of electronic document sending/receipt was connected to that of the Government Office. All legislation, policy documents and guiding documents are uploaded on the MOH electronic portal while information on incoming/outgoing documents handled by the Ministry is posted at the MOH headquarters [3].

The MOH has completed simplification of 221/225 administrative procedures (98.2%); 100% of its public administrative procedures are provided at level 2 on the MOH internet portal. The Ministry has developed 37 online public services at level 4, continuously updated results of the handling of level-4 public services on the MOH internet portal, applied digital signatures in all level-4 online public service software to return results online to businesses.

In implementation of Resolution No. 36a/NQ-CP dated 14 October 2015 on e-government and the Government’s direction on computerization of health insurance, the MOH in collaboration with the Vietnam Social Security (VSS) agency has promoted the application of information technology in the management of health care and health insurance payments. The Ministry has issued Decision No. 5004/QD-BYT dated 19 September 2016 approving the enterprise architecture of the health insurance information system and begun to connect health care information systems of health facilities since 30 June 2016 to improve efficiency and transparency in health claims review and payment.

Regarding administrative reform, the Public Administration Reform (PAR) Index is a new management tool in the implementation of the overall program on state administrative reform for the period 2011 - 2020. For the MOH between 2014 and 2015, the PAR Index has improved from 73.55 to 86.58 points (Table 2); this is the largest increase compared to other ministries. The rank of MOH among all sectoral agencies has also improved from 17th to 8th place. This affirms MOH efforts in leadership and administration. In addition, people’s feedback on health service quality and health workers’ attitude have improved over time.

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2 According to Government Decree No. 43/2011/ND-CP on the provision of online information and public services on websites or web portals of state agencies, there are 4 levels of online public services, in which level-4 service allows users to make online payment of fees (if any), results may be notified to users online, directly or by post (http://www.chinhphu.vn/portal/page/portal/chinhphu/hethongvanban?mode=detail&document_id=101050).
### Table 2. PAR index of the MOH, 2012 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>PAR Index</th>
<th>MOH rank</th>
</tr>
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<tbody>
<tr>
<td>2012</td>
<td>64.78</td>
<td>19/19</td>
</tr>
<tr>
<td>2013</td>
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<td>19/19</td>
</tr>
<tr>
<td>2014</td>
<td>73.55</td>
<td>17/19</td>
</tr>
<tr>
<td>2015</td>
<td>86.58</td>
<td>8/19</td>
</tr>
</tbody>
</table>


### Difficulties and shortcomings

Information technology applications in health care and health insurance payment are facing difficulties and obstacles because some health facilities do not use information technology devices or use diverse systems provided by different partners on different platforms. Infrastructure is not yet available to link the health network and a data integration center for storage and connection of patient databases and electronic medical records among health facilities throughout the country. Shared code lists have been developed but are not stable to ensure coherence and consistency during the updating process.

### Task 4. Enhance inspection and examination

The fourth task in the Five-year health sector plan for 2016 - 2020 is to strengthen supervision, inspection and strictly deal with organizations and individuals violating laws and regulations on people’s health protection, care and promotion.

### Implementation results

The MOH has issued Plan No. 25/KH-BYT dated 14 January 2016 on implementation of the health inspection capacity building project to 2020 (Prime Ministerial Decision No. 2176/QD-TTg in 2014). Processes of inspection on food safety, medical equipment and accountability for implementing the law on the settlement of complaints in the health sector have been developed. The Ministry has issued Decision No. 4988/QD-BYT dated 16 September 2016 promulgating four food safety inspection procedures.

The MOH issued Decision 869/QD-BYT in 2017 approving the basic competencies for health inspectors. The MOH has also actively provided technical training for MOH and provincial inspectors for general health inspection and specialized inspection in the fields of preventive medicine, health environment and food safety. The MOH has organized two training courses for disseminating legal documents and 17 training courses on the inspection tasks and penalties for administrative violations in the field of health for 2056 people in different units and localities.

The MOH and provincial DOHs have established inspection teams to perform inspection in preventive medicine, medical examination and treatment, pharmaceuticals, cosmetics, medical equipment, population-family planning, administration and anti-corruption activities. Among those teams, the MOH has organized 51 inspection teams and issued 49 penalty decisions; Provincial DOHs have implemented inspection and verification of 345 106 facilities, detecting 56 978 facilities with food safety violations (16.5%). The inspections have helped detect and handle shortcomings in a timely manner, e.g. shortcomings in food safety (e.g. products which are of unknown origin and unsafe, violation of regulations on archiving of conformity
Chapter I. Health system governance and health information system

announcement dossiers; certification of food safety knowledge, etc.), medical examination and treatment (e.g. health facilities using staff without a medical practice certificate, advertising services outside the scope of their operating license), etc.

**Difficulties and shortcomings**

The scope of fields to be inspected by the health sector and the number of facilities/units to be inspected are large, while the number of specialized inspectors does not meet the demand. At the local level, inspectors are not in stable positions and the turnover of health inspectors is high.

The engagement of authorities in some localities is not timely. Intersectoral collaboration in inspection is weak in some places.

**Task 5. Strengthen cooperation; pro-actively implement international integration in the health sector**

The next task in the area of health system governance focuses on international cooperation, with 4 specific activities: (i) strengthen international cooperation and integration in the health sector; (ii) continue mobilizing financial resources, technical assistance and experience from foreign countries and organizations; (iii) collaborate with neighboring countries in the prevention and control of communicable disease such as HIV/AIDS, malaria, dangerous and emerging epidemics; (iv) employ appropriate solutions to actively respond to negative impact of globalization and international integration.

**Implementation results**

The MOH is managing 34 ODA programs and projects, including 17 grant aid projects and 17 loan projects. The total funding of ongoing programs/projects is equivalent to 1.53 billion USD. External aid projects are being implemented effectively, contributing significantly to the operation of the health sector, e.g. construction and upgrading of many training institutions and health facilities, procurement of equipment, training and capacity building for health workers, support to the development and implementation of policies, technical assistance, technology transfer and scientific research.

The Ministry has attended many important international events, conferences and forums, e.g. Tokyo Meeting of Asian Health Ministers on Antimicrobial Resistance (16 April 2016) in Japan, World Health Assembly (23 - 28 May 2016), the 139th Session of the Executive Board of the World Health Organization (30 - 31 May 2016), etc. Vietnam has actively participated in discussion of global health issues, contributed to the development of global and regional health policies in multilateral forums such as WHO, APEC, ASEAN, etc. and has held important international positions such as member of the Executive Board of the World Health Organization (2016 - 2019) and Chair of the ASEAN Health Ministers Meeting (2016 - 2017).

**Difficulties and shortcomings**

- Implementation progress of some ODA projects is slow with low disbursement because of inconsistent administrative procedures, guidelines and regulations between the government and donors, and/or between donors.

- Technical Working Groups under the Health Partnership Group (HPG) meet infrequently and are not sufficiently active so information sharing and coordination of resources are limited.
Task 6. Consolidate and strengthen the health information system

The sixth task in the Five-year health sector plan 2016 - 2020 is to develop health information systems, with two specific activities: (i) consolidate and strengthen the HIS through promoting the implementation of the Health Information System Development Strategic Plan during 2016 - 2020 with a vision to 2030, (ii) establish an information management system which is strong and effective enough to provide managers and policymakers with sufficient quality information in a systematic, regular and timely manner.

Implementation results

The National Assembly enacted the Statistics Law No. 89/2015/QH13 dated 23 November 2015 with some new provisions, e.g. additional statistical information collection methods, use of administrative data (in addition to statistical surveys and statistical reports) in government statistical activities, application of advanced statistical methods and information and communications technology in statistical activities, analysis and forecasting of statistics, etc. This is an important legal basis to promote statistical work in the health sector.

Information has been disseminated in the form of publication such as the Health Statistics Yearbook, JAHR, etc. The Health Statistics Yearbooks 2013 and 2014 are available in electronic format on the MOH website to facilitate user access. Some localities and units have websites to disseminate legal documents and health statistics.

The MOH has actively carried out the tasks assigned by the Government in Resolution No. 36a/2015/NQ-CP dated 15 October 2015 on e-government and Decision No.1819/QD-TTg dated 26 October 2015 approving the national program on application of information technology in state agencies through issuing the Action Plan No. 1212/KH-BYT dated 31 December 2015 and Decision No. 445/QD-BYT dated 5 February 2016 approving the plan for information technology application and development in health care for 2016 - 2020.

Difficulties and shortcomings

There are many indicators for monitoring different health sector issues. However, there is a lack of consensus on definitions of some indicators, lack of reliable information sources for some indicators, and delays in reporting or inadequate dissemination of data to allow for active use of the health management information system to improve health system performance.

Health sector activities in other sectors, particularly the extensive primary care service delivery in industrial zones and social protection facilities under MOLISA management and the private sector, are not adequately included in the health statistics system.

Most statistical indicators are collected from routine reports while the reporting is often delayed, incomplete and inaccurate, creating difficulties in synthesis and compilation of the Health Statistics Yearbook. In 2016, only 73% of provinces submitted the full set of completed statistical reporting forms stipulated by the relevant Circular. Statistics from administrative records have been exploited, but to a limited extent.

Most information products are still simple, mainly tables, graphs and charts and are presented in the form of traditional publications, such as books, pamphlets and reports. There are not many products analyzing and forecasting factors affecting health activities or the health status of people.

3 MOH statistics website: http://moh.gov.vn/province/Pages/ThongKeYTe.aspx
Information technology applications in reporting and health statistics have been promoted, however there are no regulations on replacing paper-based reports with electronic ones. Health facilities still comply with MOH Decision No. 4069/QD-BYT dated 28 September 2001 issuing the paper medical record templates. Some health facilities have deployed the Picture Archiving and Communication System (PACS), allowing them to replace hard copies of medical images (traditional films, photos) with electronic images on the computer, however there is no guidance stipulating that health facilities are allowed to skip film printing.

Data collection, processing, storage, transmission and dissemination are still done manually. Health data and information remain fragmented, each health unit deploys its own software, leading to low interoperability and inability to extract reports as requested by the MOH, leading to some work duplication and difficulties in data monitoring and management.

3. Priority issues

3.1. On reorganization of the health system

The Master plan for development of the health system for the period after 2010 has not yet been issued to serve as the basis for provinces to develop their plans; there are no detailed guidelines on arrangements and reforms of organizations and activities of health care facilities, particularly the provincial level CDC.

3.2. Policy formulation and refinement

The participatory role of important stakeholders in policy formulation remains unclear; the mechanism to respond to comments suffers from delays and lack of transparency; regulatory impact assessments incompletely evaluate the effects of policies as they are implemented.

3.3. Administrative procedure reforms and information technology

There is still no unified platform for information technology, nor is there a stable and scientific set of uniform code lists to serve as the basis for integrating all databases needed for management of medical services, and to contribute to effective use of health insurance payment for medical services.

3.4. Inspections and checking

The scope of inspections is very broad, the number of units requiring inspections is large, while the number and capacity of specialized inspectors does not yet meet requirements to perform the necessary tasks; intersectoral collaboration in inspections is not yet tight or effective.

3.5. International cooperation

Impediments in regulations and administrative procedures adversely affect the pace of implementing ODA projects. Technical working groups meet irregularly and infrequently, negatively affecting effectiveness in information sharing and resource coordination.

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4 PACS: a system to facilitate electronic imaging and provide economical storage and rapid recovery of captured images from multiple modalities.
3.6. Health information systems

The monitoring of progress towards health system goals faces problems due to lack of consensus on the appropriate set of indicators and lack of data sources for some key indicators related to 5-year plan goals and SDGs. Gathering and processing data is still done manually leading to delays in updating and inaccuracies; databases are fragmented and lack interlinkages making it difficult to synthesize information, particularly health service provision activities of sectors other than the government health sector. There are not yet any regulations on use of electronic reporting to replace paper-based reporting, nor on which administrative information can be disseminated for statistical analysis purposes.

4. Recommendations

4.1. Health system organization reforms

- The MOH should promptly issue guidelines on the CDC model and on regulations for permanent staff requirements in medical facilities.
- Develop a national Master plan for development of the health sector after 2010 to guide provinces in arranging and reorganizing health sector units, ensure consistency and coherence between policy documents and the master plan for development of the health system.

4.2. Policy formulation and refinement

- Stipulate a mechanism for contributing feedback and comments on policies, and ensure transparency for all stakeholders.
- Implement comprehensive regulatory impact assessments independently and objectively to improve the quality of health policy and legislation development.

4.3. Reform public administrative procedures and apply information technology

- Continue to reform and simplify public administrative procedures in the health sector, increase the number of public services that can be implemented online at level 4 (highest level).
- Issue common code lists (for drugs, consumables, technical services, etc.) which are complete and avoid duplication and can be updated systemically in order to promote application of information technology in the management of health care and health insurance payment, improving efficiency of the use of budget from the health insurance fund.

4.4. Inspection and checking

- Promote communication, dissemination and education about legislation to raise awareness about health sector inspections among health sector units, civil servants and government employees in the health sector.
- Strengthen collaboration with the Government’s Inspectorate, ministries/sectors and training institutions in the country and abroad in training and capacity building for inspectors, specialized health inspectors and health inspection collaborators.
- Organize routine and ad-hoc inspection and checking to detect and handle strictly any violations; publicize lists of facilities where violations were detected.
4.5. International cooperation

- Strengthen the monitoring and surveillance of international cooperation project activities; detect and resolve in a timely fashion impediments that arise in the process of implementing ODA programs and projects; make recommendations to the MOH, donors and relevant organizations to collaborate to remove barriers and resolve problems.

- Review terms of reference of technical working groups; promote cooperation and collaboration mechanisms between MOH departments/administrations and development partners.

4.6. Health information system

- Establish a technical working group to come to a consensus on an appropriate set of JAHR and SDG monitoring indicators, with participation of relevant technical experts in various specialist areas of the health system and ensures reliable sources of information for all indicators.

- Improve collaboration between the MOH statistical division and the statistical divisions of other ministries to ensure more comprehensive coverage of all health system activities, including those outside of the MOH jurisdiction.

- Develop and issue a concrete plan to implement the Statistics Law and statistical censuses in 2017, particularly measures regarding private sector reporting and use of administrative data.

- Promptly promulgate regulations on the use of electronic reports and data to replace paper-based reports.

- Develop the MOH centralized data integration electronic portal for health data collection, aggregation, processing and extraction to ensure accuracy, timeliness and reliability.

5. Overview of implementation of health-related SDGs

The JAHR statistical appendix at the end of this report provides a compilation of monitoring indicators aimed at monitoring the SDGs and the Five-year health sector plan targets for 2020. There is substantial alignment in these two sets of indicators in the Vietnamese health sector. The SDG indicators or proxy indicators in the statistical appendix are indicated in grey color.
Chapter II. Inputs to health services

This Chapter aims to: (i) review key tasks relating to inputs to health services in the period 2016 - 2020 and in 2016; (ii) provide an update on preparedness for implementation of the Five-year health sector plan 2016 - 2020; (iii) evaluate the performance on health service delivery tasks in 2016; and (iv) propose a set of priorities for 2017 and the period 2018 - 2020.

1. Key tasks relating to inputs to health service delivery in the period 2016 - 2020 and in 2016

The Five-year health sector plan 2016 - 2020 (Ministry of Health Plan No. 139/KH-BYT) laid out several objectives related to inputs to health services. For 2016, Government Resolution 01/NQ-CP (2016) and the MOH Program for implementing this Resolution (Document No. 135/CTr-BYT) focus attention on tasks to be implemented in 2016. These focal tasks are presented below.

1.1. Health Human resources

- **Five-year plan goal**: Ensuring an appropriate balance in distribution and use of health human resources across regions and levels in the system and between training and deployment of health human resources.

- **Five-year plan tasks**: Develop health human resources. Implement effectively the code of conduct and improve professional ethics

- **Government Resolution 01 for 2016**: Reform health human resources training to meet requirements for standardized competencies and the needs of the health system. Reform the service attitude and style of government health workers towards improving patient satisfaction.

1.2. Health financing

- **Five-year plan goal**: Rapidly increase the share of public spending for health, develop universal health insurance, and increase effectiveness in allocation and use of the state budget. Support the poor and various entitlement groups to obtain medical services.

- **Five-year plan task**: Continue to reform the health financing mechanism and implement universal health insurance coverage

- **Government Resolution 01 for 2016**: Expand population coverage for health insurance; find appropriate solutions to implement health insurance by households; Promote implementation of public health service facility autonomy; Gradually implement the roadmap for new medical service prices on the principle of accurate and complete estimation of the costs of providing medical services, and at the same time providing appropriate support for poor people and entitlement groups.

1.3. Pharmaceuticals

- **Five-year plan goal**: Ensure adequate supply of pharmaceuticals, vaccines, biologicals, blood, blood products of good quality and appropriate prices to meet the needs for disease prevention and treatment for the people. Use pharmaceuticals rationally, safely and effectively.

- **Five-year plan task**: Reform the model for organization and management of pharmaceuticals, vaccines, biologicals and medical equipment.
Government resolution 01 for 2016: Strengthen management of drugs, vaccines, biologicals to ensure safety, quality, reasonable price and availability; Review and issue regulations on competitive tendering and price negotiation for pharmaceutical procurement.

1.4. Medical equipment and infrastructure

- **Five-year plan goal**: Ensure adequate supply of quality medical equipment with appropriate prices. Use medical equipment rationally, safely and effectively. Develop health infrastructure; develop health services in poor, mountainous, remote and isolated areas.

- **Five-year plan task**: Develop the grassroots healthcare network

- **Government resolution 01 for 2016**: Strengthen management of medical equipment; Consolidate and improve effectiveness of activities of the grassroots health network, paying special attention to mountainous, border and maritime areas.

2. Performance on tasks related to inputs to health services in 2016

**Task 1. Strengthen quality of training and improve health worker service style and attitude**

**New legal documents and policies**

MOH Decision No. 1568/QD-BYT (2016) approved the plan for scaling up and developing the family doctor clinic model in Vietnam for the period 2016 - 2020, including plans for training of family doctors).

MOH Decision No. 2151/QD-BYT dated 4 June 2015 approved the plan for implementing “Reforms in the service provision style and attitude of government health workers to increase satisfaction of patients” including 7 main contents: (i) training in communication skills for government health workers; (ii) implementing social work tasks in hospitals (“client care”); (iii) regulating government health worker uniforms; (iv) continuing to implement hotlines; (v) maintaining and consolidating feedback boxes; (vi) implementing the project on contact with patients in hospitals; (vii) formulating a service style and attitude that is civilized, friendly and avoids improprieties.

**Implementation results**

*Implement basic comprehensive reforms in training for development of health human resources to satisfy society’s need for development and international integration*

Develop a reform model for training human resources for health towards an approach following training models from advanced countries in the world, reform some key training programs with an orientation towards developing competencies to ensure health human resources that satisfy needs of society and fit with actual conditions in Vietnam, and links training with use of health human resources. Medical training in Vietnam allows two training systems, (i) a research-based system managed by the Ministry of Education and Training (MOET); and (ii) a medical practice-based system managed by the MOH. The MOH has gathered in-depth feedback to refine the model of training reforms for health human resources through organization of meetings of the Council of Deans from medical and pharmaceutical universities, organized scientific workshops with the participation of international experts on medical education reforms.

The MOH has researched and proposed a model of health workforce training reforms and the Prime Minister has approved this in the Framework for national education system.
structure and Vietnam’s National Framework on qualifications, within which, medical training includes general and specialist doctors, with general doctors considered to have master’s level qualifications, while specialists are considered to have PhD level qualifications.

The Health Professionals Education and Training for Health Systems Reforms Project (HPET) of the World Bank has contributed financial and technical assistance aimed at reforming pre-service training for doctors and nurses.

**Develop standards to ensure quality of health worker training; strengthen management of training quality**

In 2016, the MOH completed development and issued basic competency standards for dental doctors, and continues to develop basic competency standards for other professions including public health officer, pharmacist and nutritionist.

The quality of continuing medical education (CME) has received special attention. Currently the CME network for health workers has been adequately developed to implement CME to update and strengthen professional qualifications of health workers. This diverse network consists of CME providers including schools specializing in medical and pharmaceutical training (105 establishments), hospitals, central level research institutes, professional associations, provincial health departments and units directly under them. Standardization of materials and instructors is a key step to ensure quality of CME. The MOH has appraised 25 CME training programs and materials of units under its direct management. Training of trainer courses at provincial health departments and related units have been organized. A pilot CME quality accreditation is being implemented in Nam Dinh province and Ho Chi Minh City DoHs.

To improve quality of practical training for health workers, the MOH has completed a draft decree stipulating the organization of practice training in the health sciences for the Government to review. The MOH has developed the school-hospital mechanism to strengthen collaboration between training establishments and practice facilities in medical worker training.

Activities to monitor training of health workers have been strengthened, focusing on training to upgrade qualifications, training through linkages with other schools, training of currently practicing professionals to upgrade to higher qualifications, direct recruitment of medical workers in disadvantaged areas to upgrade their qualifications, or training of people who commit to working in a specific facility upon graduation. Solutions to ensure quality of post-university training with the specific features of the health sector and appraise the curriculum for first-and second-degree specialist and medical resident training materials have been implemented.

The MOH has actively coordinated with the MOET in management of training quality for the health workforce. Both ministries have collaborated in developing criteria for the teaching faculty and standards for practical training inside and outside of the school. Some regulations on health worker training at secondary level have been adjusted to standardize the professions of nurse, midwife and medical and pharmaceutical technicians, requiring that they have qualifications of junior college or higher (Circular 26).

**Develop a health workforce with adequate size, appropriate structure, sufficient competency and qualifications to implement assigned tasks, which have been made concrete in the Project on work positions of each unit.**

Implementation of the Project on work positions has standardized health workers according to the concrete tasks that take place in health sector provider units, under the

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5 On 18 October 2016, the Prime Minister issued Decision No. 1981/QD-TTg approving the Framework for the national education system structure and Decision No. 1982/QD-TTg approving the Framework for Vietnam’s national qualifications.
leadership, guidance and tight supervision of the Department of Organization and Personnel of the MOH. The MOH has also developed regulations to standardize appointments, and promotions of health sector leaders and government workers.

In efforts to boost the skill levels of the Vietnamese health workforce, Circular 26/2015/TTLT-BYT-BNV issued new professional standards and scope of work for nurses, midwives and technicians. By 2021, according to this policy, no new government health workers will be recruited if they have less than junior college training. By 2025, government staff who have secondary or lower education will have to have upgraded their qualifications to junior college level or higher, or will no longer be allowed to work in their profession.

Reform the service style and attitude of health workers towards increasing satisfaction of patients has created the start of a transformation in medical facilities

The MOH has organized verification teams led by leaders of the ministry in hospitals under direct MOH management, as well as in some localities. At the same time, the MOH has also directed the Health Strategy and Policy Institute (HSPI) to implement an independent evaluation of the results of implementing this plan in units that were inspected. Results of the independent evaluation\(^6\) indicate that some positive developments are occurring in areas of awareness and commitment of hospital leadership to implement the reforms; 71% of patients commented that health workers have a friendlier attitude towards them; over 61% of patients indicated that information posted about the medical care process has improved, waiting times have fallen, physical facilities in the medical examination clinic, environmental sanitation conditions and patient room sanitation have improved. Some 87.7% of patients have indicated a satisfied attitude towards medical services in 10 hospitals that were surveyed. Thus, the hospital satisfaction index has achieved requirements of public administrative reforms (> 80% by 2020).

In 2016, out of a total of 19,104 phone calls to the MOH hotline, the proportion of calls related to attitude, and responsibility of medical workers and doctors reached 15.6%.

**Difficulties and shortcomings**

- The quality of medical worker training does not yet meet the actual needs nor the process of regional and international integration: The contents of medical education quality accreditation has not yet been implemented. Standard outputs of new training curricula have only recently been issued, and are not yet widely used to manage training quality.

- A training policy that considers the special nature of health workers has not yet been strengthened or amended: The remuneration for government health workers remains unreasonable, with the starting salary incommensurate with the long period of training. Medical practitioners are not yet benefitting from the professional seniority salary allowance. There is not yet a sustainable policy to attract practitioners with high level qualifications and expertise to work long-term in remote, disadvantaged and isolated regions.

- Distribution of health workers suffers shortcomings: quality of health workers is not even across regions and levels of facilities.

- Quality of health workforce remains limited, particularly at the grassroots level.

- The capacity to upgrade training of a very large share of nurses, midwives and technicians from secondary to junior college or higher by 2025 remains limited, making it difficult

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\(^6\) A rapid independent evaluation using cross-section data to measure effects of implementing Decision No. 2151/QD-BYT is being undertaken by the Health Strategy and Policy Institute in collaboration with localities and units that had implemented the policy in July 2016 in 10 public medical service provider units at central, provincial and district levels.
to implement Circular 26/2015/TTLT-BYT-BNV, and creating a high risk that by 2025, there will be shortages in supply of qualified nurses, midwives and technicians.

- Implementation of regulations that transfer all junior college and secondary medical schools to MOLISA management is creating substantial disruption for both training establishments and students.
- Collaboration between the MOET and the MOH to better take into account the special features of health workers in guiding health worker training has not yet achieve high effectiveness.

Task 2. Reform the policy on medical service prices, financial autonomy and implementation of the universal health insurance roadmap

New major legal documents and policies

*Formulate the Health Financing Strategy for the period 2016 - 2025*

The MOH is collaborating with the WHO to formulate Vietnam’s Health Financing Strategy 2016 - 2025. A draft Strategy has set out clearly the objectives, targets that should be achieved by the health financing system as well as coherent and effective solutions. The MOH has also developed a plan for implementing the Health Financing Strategy. This plan helps the MOH to effectively implement the Strategy, and at the same time serves as a basis for the Ministry to mobilize resources from international and domestic partners to support implementation of health financing policies that were laid out in the Strategy.

*Medical service prices and financing mechanism*

Implementation results

*Implementing the roadmap for new medical service prices*

According to Joint Circular No. 37/2015/TTLT-BYT-BTC, the roadmap for adjusting administratively set medical service prices is to take place in two phases:

- **Phase 1**: The prices should include direct costs and special salary allowances starting from 1 March 2016.

- **Phase 2**: The prices should include direct costs, special salary allowances and salary to be implemented starting 1 July 2016. The specific timing of implementation for each unit and locality should be considered and decided by the MOH.

Medical facilities that have been classified by relevant authorities as facilities able to cover all recurrent costs from revenues and those able to cover all recurrent and capital costs from revenues should apply the Phase 2 prices starting 1 March 2016.

However, implementation of the price adjustments must be balanced with the objective of controlling consumer price inflation below 5% according to National Assembly Resolution, and the requirement to balance the health insurance fund in 2016, thus, the Government has directed the prolongation of implementation as follows:

- **First round**, from 1 March 2016, adjust prices to include direct costs and special salary allowances (on-call duty, surgical supplement) to be applied to all medical service units paid by health insurance, approximately 1400 units. This is expected to increase medical service price levels by about 30%.
• **Second round**, from 1 August 2016, price adjustments to include salary of health workers, applied in 16 provinces with health insurance coverage exceeding 85%. The price levels are expected to increase about 50%.

• **Third round**, from 12 October 2016, continue to extend the price increases to 16 more provinces, increasing the total number of provinces that have increased prices to 32 provinces.

As a result, after 3 rounds of medical service price adjustments, 32 provinces, 36 fully autonomous hospitals and 441 private medical facilities have incorporated direct costs and payroll costs into medical service prices. In 2017, the policy continued to be extended to the second phase levels (including salaries) in all localities and price adjustments applied also to uninsured patients. By 2018, administrative costs and by 2020 all costs, including depreciation, will be included in medical service prices. Through price adjustments that incorporate salary, supply-side subsidies have been eliminated, and state budget support has shifted from support to hospitals towards support directly to service users through the health insurance fund, contributing to increasing the proportion of the population covered by health insurance. In 2016, the state budget allocated approximately 20 trillion VND to fully or partially subsidize the health insurance premiums for entitled groups, accounting for approximately 27% of recurrent spending from the state budget for the health sector. Price adjustments have generally not adversely affected poor people and social policy beneficiaries, and have achieved the objective of controlling inflation, and stabilizing the macro economy.

**Strengthening implementation of autonomy of public medical service providers**

The MOH has completed and submitted to the government a draft Decree stipulating the autonomy mechanism for public service provider units in the health sector to replace Decree No. 85/2012/ND-CP. One of the important contents in this draft decree is related to proposing a model of hospital management board. The MOH has sought advice from international experts (WHO, World Bank) and organized study tours to find out more about state enterprise management models of Vietnam Posts and Telecommunication corporation, the management model for VINMEC private hospital, the pilot model for equitizing the Transport hospital and the model for managing hospitals in Singapore.

**Implementing the universal health insurance coverage roadmap**

By December 2016, health insurance coverage had reached 81.7%, exceeding the target set by the National Assembly (76%) by 5.7 percentage points and exceeding the target set by the Prime Minister (79%) by 2.7 percentage points, and has exceeded the threshold of 80% of population participating in health insurance by 2020. The total number of medical care contacts nationally in 2016 is estimated at 148 million, an increase of 14% compared to 2015. Total spending on medical services is estimated at 69 410 trillion, an increase of 41.6% compared to health insurance reimbursements in 2015. After many years of continuously achieving a surplus in the health insurance fund, in 2016, a deficit of 5 trillion VND occurred. The increase in medical care costs was predicted due to adjustments in medical service prices and the elimination of a gatekeeping system from commune to district levels in 2016.

In 2016, implementation of some contents stipulated in the revised Health Insurance Law 2014 had a positive effect to ensure and improve benefits for people with health insurance. These contents are related to implementing health insurance reimbursement at the commune and district levels, stipulations about reimbursing costs of medical care for TB and development of a basic medical service package.

Implementation of the revised Health Insurance Law includes a new measure effective 1 January 2016 in which the insured can seek medical services in any district hospital, regional
polyclinic or CHS anywhere in the province, and any district level facility nationwide. After 1 year of implementation, both positive and negative effects have been found on the insured, medical facilities and the health insurance fund. The clearest positive effect is on the insured, who now have free choice to choose the best and most convenient facility at the district and lower level within their province or any district hospital nationally. Data on national medical services provided to the insured shows a trend towards increasing number of medical service contacts at the district level and reduction in the number of visits at the commune level. The number of medical service contacts per insured individual at the district level increased 14.8% compared to 2015. However, the number of contacts per insured individual at the CHS has fallen 12.9% compared to 2015. On the other hand, average costs per insured contact at the commune and district level have both increased with growth rates of 51.4% (commune) and 34.2% (district). These growth rates exceed growth rates in costs per contact at province and central levels (Figure 4). The regulations eliminating gatekeeping at the commune or district levels have also created incentives for medical facilities to reform their service style and improve quality of medical services to attract more patients. The elimination of this gatekeeping system has increased people’s trust, leading to active participation in health insurance, and has contributed to universal health insurance goals.

In the context of Vietnam, a lower middle income country, external financial and technical assistance for health care has been cut, with substantial adverse effects in some areas like HIV/ AIDS and TB. Over 90% of funds to ensure ARV treatment for people living with HIV was supported by international assistance. The solution proposed to resolve the gap in financing when donors pull out is to use the health insurance fund. The MOH issued Circular 15/2015/TT-BYT stipulating insured medical services for people living with HIV and in 2016 issued Circular No. 04/2016/TT-BYT dated 26 February 2016 stipulating medical services and health insurance reimbursement related to treatment of people with TB. In addition, on 15 November 2016, the Prime Minister issued Decision No. 2188/QD-TTg providing for payment of centrally procured antiretroviral drugs (ARV) by the health insurance fund and support for ARV users. According to this Decision, payment of ARV will follow regulations on payment and settlement of insured health service expenditures between health facilities and the VSS. At the same time, the Decision also stipulates the responsibility of provincial people’s committees in allocating funds to buy health insurance for 100% of people living with HIV. Earlier, the MOH had also issued Official Letter No. 6741/BYT-AIDS on expansion of health insurance for people living with HIV and Circular No. 04/2016/TT-BYT on delivery and payment of TB-related insured health services.

Figure 4. Health insurance payment per medical care contact, 2015 - 2016

![](image.png)

Source: Vietnam Social Security Agency.
During 2016, the MOH has been actively developing a basic health insurance benefit package according to stipulations in the revised Health Insurance Law. Development of the basic medical services benefit package is oriented towards primary health care (PHC) and medical services at the commune level, which is the level closest to the people, easiest to access, allows for continuity of care over time and is the least costly to the people, all features of which are appropriate with the goal of universal health coverage. The basic medical services benefit package is considered as a basic competency standard for commune level health facilities, and the basis for determining need for and implementation of investments in strengthening capacity of the grassroots health facilities, ensuring all medical facilities have adequate capacity to provide the basic service package in an effective way. Circular 39/2017/TT-BYT on the basic medical services benefit package after many rounds of feedback and comments from stakeholders in multiple workshops was issued in October 2017.

In 2016, the MOH focused on developing a draft Decree stipulating details and guiding implementation of articles of the revised Health Insurance Law to replace Decree 105/2014/ND-CP. It is expected that this decree will be issued in 2018.

Raise effectiveness in use of health financing resources

Limited effectiveness in use of health financing resources is one of three priority issues in health financing that was identified in the JAHR 2015 report [5]. Many solutions aimed at improving effectiveness in use of health financing resources, particularly public financial resources, have been proposed in the JAHR 2015. A review of performance in health financing in 2016 shows that some important solutions have been implemented.

First, is the development and issuing of Circular No. 35/2016/TT-BYT dated 28 September 2016 issuing the list, rate and conditions for reimbursement of technical medical services covered by health insurance. The contents of this circular stipulate 3 groups of medical services including (i) technical medical services for which conditions and rates and price levels for reimbursement have been stipulated concretely; (ii) technical medical services for which concrete reimbursement conditions have been stipulated; (iii) technical medical services that are designated temporarily as not being reimbursable by the health insurance fund. The stipulation of tighter conditions for reimbursement are mainly related to specific clinical indications and are considered a measure to control unnecessary provision of technical services that lead to waste in use of the health insurance fund, increase costs and may be harmful to health of patients. In the process of developing this circular, the drafting group has organized many working sessions, asked for comments and feedback from many clinical experts in diverse specialties and is considered as a first step in use of results of health technology assessment, to serve as a basis for determining conditions for reimbursement of technical medical services.

Reforms to the provider payment mechanism is another important content aimed at the objective of improving effectiveness in use of financing resources through a mechanism of appropriate incentives. In 2016, the MOH has actively collaborated with relevant stakeholders and international advisors in the European Union project to complete a draft circular on the capitation payment mechanism. The model of capitation payment was proposed based on technical advice of experts hired by the European Union, experience drawn from Project 5380 piloting capitation payments in 4 provinces in 2014 and adjustments to actual conditions in Vietnam, particularly in the context of elimination of the gatekeeper system at commune and district levels starting 1 January 2016. According to the draft model proposed to be included in the revised Decree 105, the nature of the provider payment mechanism is to grant a global budget for outpatient care determined on a per capita basis based on the number of insurance cards that used medical services at the facility, including cards registered there and people using services there but registered elsewhere. Thus, in Vietnam’s conditions, the revised model for capitation payments is an adjustment towards combining capitation and capped fee-for-service payments.
In 2016, the MOH continued to implement Decision No. 488/2015/QD-BYT on implementing the pilot DRG provider payment mechanism for medical services for the period 2015 - 2020. The plan for activities in 2016 was approved and is being implemented, including a focus on preparation for the pilot to gather and standardize data for trial estimation in Ninh Binh province, train in coding and disease classification, and develop monitoring and supervision instruments.

Prime Ministerial Decision No. 1387/QD-TTg dated 13 July 2016 issued the list of public services to be paid from the state budget in the population and health sectors. This document clarifies which health spending is the responsibility of the state and which is the responsibility of health insurance or other financing sources.

**Strengthen social mobilization in the health sector and encourage public private partnership**

The year 2016 marks 10 years of implementing the Communist Party policy on social mobilization for medical services according to Resolution No. 46 of the Politburo in 2005 and the Xth Party Congress Resolution in 2006. The MOH has drafted a report to review performance in implementing this policy over the decade 2006 - 2016. In the health sector, the social mobilization policy was concretized in the following forms: (i) Collecting partial user fees; (ii) development of health insurance; (iii) implementing higher amenity services for higher prices in public facilities; (iv) developing the private sector; (v) mobilizing private resources to develop public medical facilities including joint ventures, partnerships to invest in medical equipment, mobilization of capital from health workers in the facility, borrowing from credit organizations, and investing in public private partnerships. In this section, we will focus on updating the situation related to encouraging development of public private partnerships prioritized for action in 2016 (Government Resolution No. 01).

In the context that public service provider units are being pushed to implement financial autonomy, state budget financial resources for these units have been reduced, and in some cases, have even been eliminated, forcing facilities to pay more attention to mobilizing resources from the private sector for their development. To implement the Communist Party’s social mobilization policy for health sector activities, public medical service providers have mobilized capital from their staff, borrowed money from credit organizations, and formed joint ventures or partnerships with investment organizations or individual investors to invest in and install medical equipment with profit-sharing arrangements. The MOH, after implementing a survey to evaluate implementation of Decree 43/2006/ND-CP in public hospitals nationwide, has given instructions to encourage borrowing from credit organizations and at the same time to discourage mobilization of capital from hospital staff. The MOH has approved some investment projects using capital from the state budget (about 30%) and loans (about 70%). Under this arrangement the medical service provider units are responsible for paying the principal and interest on loans. So far, 9 units have signed contracts for loans amounting to 1.9448 trillion VND. Units borrowing capital for investments are allowed to charge full cost recovery service fees. They are required to implement the decision on price declaration following legal regulations on prices. Implementation of Resolution 93/NQ-CP dated 15 December 2014 on some medical development policy mechanisms has been strengthened, including the signing of cooperation arrangements with Vietnamese joint stock commercial banks for investment development and Vietnamese joint stock banks for industry and commerce to implement concessional credit packages to support investment in development of the health sector. Up till now, public hospitals nationally have registered to borrow tens of trillions of VND to invest in infrastructure, procure equipment and satisfy demand for medical services of the population. The MOH is preparing to organize a conference to call for investors to implement some projects in the form of public private partnership in the health sector.
Joint ventures and partnerships for investing in equipment and developing higher amenity services in public medical facilities are meeting the demand of different population groups. The MOH has issued Circular No. 15/2007/TT-BYT dated 12 December 2007 guiding joint ventures and partnerships for medical equipment investment. Through synthesis of reports of 22 provincial health departments and 16 central hospitals, up till the present the health sector has implemented about 810 joint venture or partnership projects with a total capital of 3.882 trillion VND. According to data from these reports, social mobilization projects are primarily focused on 3 areas including diagnostic imaging equipment, laboratory equipment and medical examination equipment (Figure 5).

**Figure 5. Purpose of socially mobilized investments by 2016**

![Figure 5](image)

Source: Department of Planning and Finance, MoH

An examination of the sources of funds mobilized through social mobilization in the health sector finds that the dominant source of socially mobilized funds is investments from outside the hospital (83%), followed by contributions of hospital staff (15%) (Figure 6). Most social mobilization of funds was implemented at central and provincial hospitals.

**Figure 6. Source of socially mobilized funds for investment in the health sector by 2016**

![Figure 6](image)

Source: Data from Department of Planning and Finance, MoH
Joint ventures or partnerships for investment in medical equipment and provision of medical services with more amenities at prices higher than administratively set prices\(^7\) has contributed to substantial upgrading of medical equipment, including investment in very costly equipment, and implementation of high technology in the situation where state budget investment in public facilities was very limited.

In 2016, the MOH developed a draft circular guiding the organization of activities and service prices for these higher amenity medical services in public medical facilities in order to strengthen state management for this activity. The draft circular stipulates conditions for organization, medical service provision standards, structure of service prices and maximum prices. The draft circular is in the process of deliberation.

**Improve the information system on health financing**

In 2016, development and consolidation of the medical service information system and health insurance reimbursement information system has received special attention from the Government, MOH and VSS. The overall architecture of the health insurance and medical service information systems follows Government Resolution 36a/NQ-CP dated 14 October 2015. The MOH has issued database output criteria for the management software at medical facilities and a fourth version of uniform set of codes, including 8 lists: list of technical services; modern drugs; traditional medicines; medical consumables; traditional medicine services; blood and blood products; ICD-10 disease codes; and medical service facilities. These uniform sets of codes will continue to be supplemented and refined as an important prerequisite for interoperability of databases between medical facilities and VSS, in order to manage more comprehensively and accurately patient information, and to increase convenience of health insurance reimbursements. Linking of databases between medical facilities transmitting data to request health insurance reimbursement from the data receiving portal of the health insurance claims processing system of VSS has been implemented since 1 July 2016. When this is operating effectively, the database portal will be an effective instrument to help manage medical service and health insurance reimbursement data, and at the same time will aide in compiling, analyzing and producing statistical data for medical services nationally.

The system of national health accounts is a useful instrument for monitoring, analyzing and evaluating sources of financing related to use of medical goods and services on a national level through analysis of a system of health financing indicators. In Vietnam, the MOH has produced national health accounts from 1998 to 2012, with technical and financial support from WHO. In 2015, the MOH approved the plan for developing Vietnam health accounts for the period 2015 - 2020, with technical and financial support from the Health Financing and Governance (HFG) project of USAID. In 2016, the report “Vietnam 2013 General Health Accounts and Disease Expenditures with Sub-Analysis of 2013 HIV/AIDS Expenditure” was disseminated to provide an update on health financing flows using a new analysis instrument. In addition to the national health accounts system, the MOH has directed the development of provincial health accounts. The health sector is in the process of completing the operational mechanism and organizational structure to implement development of the national health accounts system and the provincial health accounts, including training and development of provincial health account pilots in 5 provinces.

**Difficulties and shortcomings**

- Inability to maintain the rate of increase of state budget spending on health due to decline in state budget spending on national target programs (NTPs), inadequate fund allocation for grassroots health care and for increasing the amount health insurance premium subsidies.

\(^7\) In Vietnamese, this is often referred to as “on request” services.
• Difficulties in continuing to expand health insurance coverage to the informal sector.

• Implementation shortcomings of strategic health service purchasing by the social health insurance fund in the areas of effective use of contracting, quality control, determining an appropriate health insurance benefit package, applying appropriate provider payment mechanisms and negotiating optimal prices.

• Difficulties in controlling cost escalation: provider habits of prescribing unnecessary services and insured users demand for excess services remain problematic.

• Continued reliance on the fee-for-service provider payment mechanism.

• Slow adoption of new public hospital management model in the context of full hospital autonomy.

• High total health spending compared to GDP, but relatively stable out-of-pocket spending relative to national income.

**Task 3. Complete the legal framework for implementing the 2016 Pharmaceutical Law**

**Major new legal documents and policies**

The Pharmaceutical Law 2016 was approved by the 13th session of the XIIIth National Assembly on 6 April 2016, and came into effect on 1 January 2017, replacing the Pharmaceutical Law of 2005. Some new contents in the Law include regulations on development of the pharmaceutical industry, traditional medicine, clinical pharmacy activities and mechanisms for drug price management. After issuing the Law, the Government has issued two decrees guiding the Law. These are Decree No. 54/2017/ND-CP guiding the Pharmaceutical Law and Decree No. 65/2017/ND-CP on the special policy on seed stock, capital and technology in development of the cultivation of pharmaceutical ingredients. The guiding circulars are being developed and have not yet been issued.

**Implementation results**

**Ensuring adequate pharmaceutical supply**

Domestic pharmaceutical manufacturing capacity has been improved, accounting for 36% of total value of pharmaceuticals and 74% of total volume (the highest in ASEAN). The number of GMP-standard factories has increased rapidly, along with strengthened cooperation and technology transfer. Generic drug production is growing strongly. Domestic pharmaceutical factories are capable of producing almost all types of formulations.

The number of drugs registered for import into Vietnam is on par with the number of domestically produced drugs registered by the Drug Administration of Vietnam, however imported drugs account for about double the number of active ingredients of domestically produced drugs. The more complex and special formulations are still mainly imported.

**Drug price management: strengthening competitive tendering for pharmaceutical procurement at hospitals**

The Law on Competitive Tendering 2013 and Decree 63 dated 26 June 2014 include regulations on competitive tendering specifically for pharmaceuticals, such as collective tendering, drug price negotiation, and priority to domestically produced drugs.
The MOH has developed two circulars guiding pharmaceutical competitive tendering. The first is Circular 09/2016/TT-BYT dated 5 May 2016 issuing the lists of drugs for normal competitive tendering, for collective tendering, and for price negotiation. Second is Circular No. 10/2016/TT-BYT dated 5 May 2016 issuing the list of domestically produced drugs that meet requirements for treatment effectiveness, drug price and capacity to supply adequate volume.

The Government has issued a Resolution (112/NQ-CP in 2016) to establish a national centralized procurement center directly managed by the MOH to serve as the basis for organizing centralized competitive tendering and drug price negotiation.

**Implement drug quality management solutions**

- Verify and provide certification of good practice: The number of factories meeting GMP standards has increased rapidly, reaching 133 pharmaceutical manufacturers.

- Manufacturing and formulation technologies continue to be improved, through cooperation and technology transfer arrangements.

- Strengthen pharmaceutical quality control: Vietnam now does quality assurance testing on samples taken from 100% of imported drug shipments from foreign production facilities that have ever violated quality standards, and has issued the third-round list of foreign drug producers with quality violations.

- Vietnam has now introduced controls over quality of pharmaceutical ingredients.

**Safe and rational use of drugs**

- Manage prescription drugs: Vietnam has issued a revised list of over-the-counter drugs and has strengthened efforts to control sales of prescription antibiotics.

- Vietnam continues to strengthen monitoring of ADRs and drug information activities for patients.

- IEC has been strengthened about the dangers of antibiotic resistance.

**Ensure vaccine safety**

The Drug Administration of Vietnam has implemented verification to issue certification and supervision of vaccine production activities of domestic vaccine producers. The Drug Administration of Vietnam has issued official letters on temporarily halting use or withdrawal of vaccines that do not meet quality standards.

Vietnam has successfully produced a vaccine that combines measles and rubella and cheer intends to incorporate this into the EPI program in 2018. Vietnam continues to research domestic production of pentavalent or hexavalent vaccine for children, to replace imports of this vaccine and eventually for export.

**Difficulties and shortcomings**

- No mechanism for regular and effective surveillance of drug prices is in place. The GSO Medical services and pharmaceutical consumer price index is inadequate for this purpose.

- The potential for Vietnamese pharmaceutical distribution enterprises remains weak; this activity continues to be controlled by a few large foreign pharmaceutical companies.

- Rational and safe use of drugs is not yet guaranteed: Sales of prescription drugs without prescriptions remain widespread. Antibiotics are overprescribed. The proportion of
patients using antibiotics remains high contributing to high rates of antibiotic resistance; shortcomings persist in capacity and effectiveness of a mechanism for comprehensive and high compliance reporting and management of adverse drug reactions and errors in medicine use.

- Management of western medicines, traditional medicines, biologicals and blood services are not yet uniform, consistent and coherent.

- The organization of state management of pharmaceuticals, medical equipment and devices is being reformed, but faces substantial difficulties in merging the various elements of a fragmented system. This issue is addressed in the Governance section.

**Task 4. Reform management of medical equipment, investment in health sector infrastructure at the grassroots level**

**Major new legal documents and policies**

The Government has issued two important decrees that achieve specific tasks listed in the Five-year health sector plan 2016 - 2020. The first is Decree No. 36/2016/ND-CP dated 15 May 2016 on management of medical equipment. The second is Decree No. 103/2016/ND-CP dated 1 July 2016 stipulating biological safety assurance standards in laboratories.

**Implementation results**

*Continue to invest in developing infrastructure: Concentrate on central and tertiary hospitals, reduce overcrowding of hospitals (develop new facilities outside of the central areas of cities, build taller structures)*

Implementation of investment projects to construct 5 central and tertiary hospitals according to decision 125/QD-TTg continues. Many large hospitals have been opened and put into operation including Soc Trang provincial general hospital (700 beds), Bac Kan provincial general hospital (500 beds) and Yen Bai provincial general hospital (500 beds).

Prime Ministerial Decision No. 2348/QD-TTg dated 5 December 2016 approved the Project for building and developing the grassroots health network in the new situation to serve as an important basis for consolidating and reforming the organizational structure, operational and financial mechanism, development of human resources to improve capacity to provide quality services at the grassroots level, improve effectiveness in activities of the CHS, implement monitoring, management of health of each individual. Work is underway to mobilize funding through the World Bank and Asian Development Bank to make the physical investments, and implement innovations to achieve the goals of the project.

*Put medical waste management systems into operation*

Approximately 54.4% of all hospitals have waste water treatment systems. Currently over 95% of hospitals implement daily sorting and gathering of hazardous medical solid waste.

**Management of medical equipment**

Decree No. 36/2016/ND-CP dated 15 May 2016 on management of medical equipment was issued, creating the basis for improving state management of equipment to ensure availability, quality, maintenance and use. The MOH is currently developing circulars to implement this decree.
Development of health technology assessment.

The health sector, together with the Vietnam Health Economics Association, is beginning to undertake health economic assessments of pharmaceuticals to create an evidence base for introducing new drugs into the health insurance drug formulary. The HSPI has begun assessment of magnetic resonance imaging as part of an effort to assess the investment and use of high cost diagnostic imaging services.

Strengthen maintenance, quality control and calibration of medical equipment

Work continues to strengthen the operations of the regional medical equipment calibration and quality assurance centers. They are playing an important role in training in areas such as biological safety in laboratories, standard operating procedures in laboratories, and medical equipment quality assurance. This is the foundation for improved internal quality control in medical laboratories, as well as external quality control.

Difficulties and shortcomings

- Lack of funds for investing in infrastructure for CHSs, regional polyclinics, DHCs (combined hospital and health center model).
- Shortcomings in management of medical waste: Some medical facilities continue to be major polluters. Besides investments in medical waste treatment infrastructure, there is a need for a budget to cover recurrent expenditures for their operation, and surveillance on compliance with standards.
- Safety and quality assurance of medical equipment is not yet achieved.
- Management of medical equipment has limitations: Lists of necessary equipment and technical standards for health facility buildings for various types of health facilities are outdated since they were issued prior to 2010. There is not yet a database on existing medical equipment and facilities and their capacities to use for planning purposes. The basis for existing lists is not the case mix of diseases treated at a facility and the equipment required to perform services according to treatment protocols for those diseases.
- Application of health technology assessment to assess cost-effectiveness in use of high tech medical equipment for diagnosis and treatment of specific conditions remains extremely limited.

3. Priority issues

3.1. Health human resources

- Quality of human resources training does not yet meet need. Health worker competencies have limitations, particularly at the grassroots level.
- Circular 26 requiring nurses, midwives and technicians to attain junior college qualifications by 2025 will have strong adverse effects on supply of registered health workers at the grassroots level unless measures are put in place to soften requirements or rapidly expand capacity for upgrade training.
- The remuneration policy for health workers is not achieving health sector objectives, it does not encourage highly qualified medical workers to work long-term in disadvantaged areas. Current incentives reward over servicing, rather than performance in keeping patients healthy.
Chapter II. Inputs to health services

3.2. Health financing
- Increasing state budget investment in health and expanding health insurance coverage to the informal sector are proving difficult to achieve; household out-of-pocket spending remains high.
- Shortcomings in implementation of strategic purchasing, control cost escalation and implement new provider payment mechanisms in the health insurance mechanism.
- A model for managing public hospitals that allows for control over medical care cost escalation in the context of hospital financial autonomy has not yet been determined.

3.3. Pharmaceuticals, biologicals
- There is still no effective routine pharmaceutical price monitoring mechanism.
- Rational and safe use of drugs is not yet guaranteed, particularly regarding antibiotic sales without a prescription and self-medication with antibiotics in the community.

3.4. Medical equipment and infrastructure
- Shortage of capital to invest in infrastructure and equipment at the grassroots level.
- Management of medical waste is still facing some difficulties in both infrastructure investments, operating budget and quality surveillance.
- Management of investments and use of medical equipment as well as quality assurance remain limited.

4. Recommendations

4.1. Health human resources
- Promote reforms in content of training combined with application of quality accreditation for medical education and standardization of outputs (i.e. graduates) in management of medical worker training quality.
- Strengthen CME and training in place for health workers at the grassroots level, appropriate with need, case mix and nature of the work.
- Implement reforms in medical worker training following the framework for the national education system structure and the Framework for Vietnam’s national qualifications to go along with remuneration commensurate with the training required for health workers. Study to develop financial mechanism to attract and motivate health workers at the grassroots level.

4.2. Health financing
- Strengthen IEC, simplify administrative procedures to participate in health insurance. Combine with expansion of benefits for insured individuals related to increasing prices of medical services following the roadmap.
- Develop a project on implementing strategic purchasing by the health insurance fund; strengthen application of IT to ensure transparency in management of medical services and health insurance reimbursement. Control abuses in medical care costs paid by health
insurance on both provider and consumer sides. Expand implementation of capitation and DRG payments.

- Promptly issue the Decree on autonomy of public service provider units in the field of medical services to replace Decree No. 85/2012/ND-CP. Implement a pilot and draw lessons from experience of a model for a hospital management board in fully autonomous hospitals.

### 4.3. Pharmaceuticals, biologicals

- Continue to review and issue regulations on competitive tendering and price negotiation and collective purchasing. Develop procurement centers and implement collective pharmaceutical procurement at the central and local levels to limit large variation in drug prices across medical facilities.

- Strengthen IEC, combine with strengthening of inspection and checking on prescribing, selling prescription drugs and use of antibiotics at medical facilities as well as in the community. Promote reporting activities and management of adverse drug reactions and errors in use of medicines.

### 4.4. Medical equipment and infrastructure

- Increase investment of state budget in building infrastructure at the grassroots level; strengthen social mobilization for investment in physical infrastructure, equipment for hospitals at the provincial and central levels.

- Continue to control medical waste treatment; particularly in polluting health facilities; supervise design and implementation of medical waste treatment options in new medical facilities being built.

- Strengthen management of medical equipment according to Decree 36/2016/ND-CP, implement health technology assessment when deciding on investments in high cost high tech medical equipment. Impose controls on use and monitor quality and safety in the process of using medical equipment.
Chapter III. Health service delivery

This Chapter aims to: (i) review key tasks relating to health service delivery in the period 2016 - 2020 and in 2016; (ii) update on preparedness for implementation of the Five-year plan 2016 - 2020; (iii) evaluate the performance on health service delivery tasks in 2016; and (iv) propose priorities for action in 2017 and the period 2018 - 2020.

1. Key tasks relating to health service delivery in the period 2016 - 2020 and in 2016

On 1 March 2016, the Minister of Health signed the Five-year health sector plan 2016 - 2020 (MOH Plan No. 139/KH-BYT), identifying nine key tasks of the health sector in the next five years, of which four are directly related to health service delivery, including:

- Reduce hospital overcrowding, improve the quality of health care and rehabilitation services;
- Develop the grassroots health care network, focus on preventive health and health promotion;
- Promote maternal and child health care, population and family planning;
- Renew the model for organization and management of food safety, pharmaceuticals, vaccines, biological products and medical equipment;
- Strengthen and improve the effectiveness of health communication and education.

On 7 January 2016, the Government issued Resolution No. 01/NQ-CP on key tasks and solutions to direct and administer the implementation of the socio-economic development plan and state budget estimates for 2016. Promoting social mobilization in the health sector is a key general task related to health service delivery mentioned in this Resolution. In addition, there are several specific tasks for each group of health services as follows.

- **Preventive Medicine**: Remain proactive in epidemic prevention and treatment; strengthen health environment management; enhance the implementation of policies and laws on quality control and food safety in accordance with Resolution No. 34/2009/NQ-QH12 dated 19 June 2009 of the National Assembly and the Food Safety Law 2010.

- **Primary health care (PHC)**: Strengthen and improve the performance of the grassroots health care network, with focus placed on health development in mountainous, border and maritime areas.

- **Medical examination, treatment and rehabilitation**: Improve health care quality; continue the implementation of measures to reduce hospital overcrowding; gradually reform the health care referral system; encourage the utilization of health services at the right level; encourage the development of non-public health sector and public-private partnership (PPP); and develop universal health services towards universal health coverage in combination with specialized and high-tech health services.

- **Traditional medicine**: Modernize and develop traditional medicine; combine traditional and modern medicine.

- **Population and family planning and maternal and child health**: Based on performance of the NTP on population and family planning over the past years and the current situation, determine goals and measures for sustainable population development; maintain replacement-level fertility and improve quality of the population.
Based on objectives and tasks set out in Resolution No. 01/NQ-CP dated 29 February 2016, the MOH has developed a plan of action (Document No. 135/CTR-BYT) with 18 groups of solutions for accomplishing the objectives and tasks assigned to the health sector in 2016.

2. Review and update of some recently issued policies related to health service delivery

To implement key tasks for achieving the objectives of the 2016 health sector plan and the Five-year health sector plan 2016 - 2020, many legal documents and new policies were issued in late 2015 and early 2016. This section only summarizes legal documents and general policies related to health service delivery, while legal documents and specific policies for each service area will be introduced in the section entitled Performance on health service delivery tasks.

The most noticeable new policy relating to health service delivery is the regulation on re-arrangement of the service delivery organization system towards lean staffing, effectiveness, collaboration and continuity. The provincial preventive medicine network is being re-organized into a CDC model through merging centers with similar functions, and merging centers with inpatient beds into provincial hospitals as stipulated in Joint Circular No. 51/2014/TTLT-BYT-BNV and Circular No. 59/2015/TT-BYT (See Chapter I).

The MOH has also issued Circular No. 37/2016/TT-BYT dated 25 October 2016 stipulating functions, tasks, powers and organizational structure of DHCs with both preventive and curative care functions and responsibility for managing CHSSs. Regarding commune level, the MOH has also issued Circular No. 33/2015/TT-BYT stipulating functions and tasks of CHSSs, which assigns CHSSs an additional task of managing public health and strengthening the connection between preventive and curative care. Currently, 62/63 provinces (except for Quang Binh) follow the model of DHCs managing CHSSs.

3. Performance on health service delivery tasks in 2016

This section will update significant changes and results of some key activities in implementation of the tasks set out by Resolution No. 01/NQ-CP relating to health service delivery and actions taken to realize short-term recommendations of JAHR 2015. Health service delivery is organized around 5 key areas: (1) preventive medicine; (2) PHC; (3) medical examination, treatment and rehabilitation; (4) traditional medicine and (5) population and family planning and maternal and child health care.

Task 1. Delivery of preventive medicine services

1. Prevention and control of infectious disease epidemics

New legal documents and policies

To institutionalize the surveillance of infectious disease epidemics, on 28 January 2016 the Prime Minister enacted Decision No. 02/2016/QD-TTg stipulating conditions for announcing infectious disease epidemics and the end of epidemics. The MOH also developed an infectious disease prevention and control plan in 2016 (Decision 827/ QD-BYT). In addition, it issued many documents including plans, programs of action, professional guidelines on prevention and control (including surveillance, diagnosis and treatment) of epidemics, especially those caused by Zika virus, Middle East respiratory syndrome-related coronavirus (MERS-CoV) and dengue fever. To increase responsibility of local authorities in prevention and control of infectious disease epidemics, the MOH issued Letter No. 6606/BYT-DP requesting provinces to
apply administrative penalties to cases where local epidemic prevention and control measures are deliberately not deployed.

**Implementation results**

The health sector has *enhanced surveillance activities, proactive prevention and control of infectious disease epidemics* on a large scale, especially dengue fever and Zika virus disease; increased surveillance, prevention and control of dengue fever in hot spots in the Central Highlands; implemented activities in response to ASEAN Dengue Day in 2016; held a ceremony to launch implementation of the campaign “People voluntarily kill mosquitoes and larva to prevent Zika virus disease and dengue fever” in 55 high-risk provinces [3].

_Epidemics were prevented, detected and controlled in time_; no major epidemics occurred. Morbidity and mortality from endemic infectious diseases decreased compared to 2015 (typhoid prevalence down by 27.8%, viral encephalitis prevalence down by 11.2%, hand-foot-mouth disease prevalence down by 16.8%, mortality from dengue fever down by 28% and mortality from hand-foot-mouth disease down by 80%). The country recorded 152 cases of Zika virus disease in nine provinces out of 4299 samples tested for Zika virus, including one case of microcephaly which is most likely related to this virus [3].

Some infectious disease outbreaks in Bao Lam district (Cao Bang province) including a bacillary _dysentery epidemic_ with 196 infected cases and 1 death and a Coxsackie epidemic with 27 infected cases and 7 deaths, have been controlled in a timely fashion.

**Difficulties and shortcomings**

- Endemic infectious diseases such as dengue fever and hand-foot-mouth diseases still have high prevalence and are very likely to develop into epidemics due to impact of environmental changes, people’s limited awareness and subjective thinking, leading to poor practice of epidemic prevention measures, while specific preventive measures are missing. In 2016, the country recorded 106.3 thousand cases of dengue fever in 56 provinces, an increase of 6.5% compared to 2015 [3]. Dengue vaccine Dengvaxia is expensive (up to 150 USD/three doses) while it is not very effective, especially for type-2 dengue, so it has not been allowed to be tested for import into the country.

- Emerging diseases are likely to penetrate and develop into epidemics in the context of globalization and increased exchanges. Meanwhile, prevention measures from a distance, such as controlling people arriving through border gates, monitoring high-risk people and public health communication for visitors and local people are non-specific and implementation is facing many difficulties. In particular, Zika virus disease is spreading in Asian countries (e.g. Singapore) and has been detected in Vietnam, while MERS-CoV has been recognized in many countries outside the Middle East and is related to tourism (e.g. China, Thailand, etc.).

2. Expanded program on immunization (EPI)

**New legal documents and policies**

In 2016, the MOH approved the plan on maintenance of polio eradication results for 2016-2020 (Decision No. 1358/QD-BYT). A plan on using injectable polio vaccine and measles-rubella vaccine in the EPI was also approved in 2015 (Decision No. 2144/QD-BYT and Decision No. 1637/QD-BYT). Regarding vaccination safety, the Government issued Decree No. 104/2016/ND-CP stipulating immunization safety and compensation related to the use of vaccines.

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8 HCMC (131), Binh Duong (7), Ba Ria Vung Tau (2), Dak Lak (2), Khanh Hoa (6), Phu Yen (01), Long An (1), Tay Ninh (1), Dong Nai (1)
Implementation results

Full vaccination for infants, pregnant women and women of reproductive age has continued to be maintained at a high rate (over 90%). Type-2 polio vaccine (bOPV) has been put into use since May 2016, as recommended by WHO. A supplementary vaccination campaign against measles-rubella was completed for 1.8 million beneficiaries aged 16 - 17 years (94.9%); oral polio vaccine was successfully provided to 95.3% of children under age 5 in 120 high-risk districts of 19 provinces. Over 96% of health facilities were evaluated and certified to be eligible for performing vaccination. Monitoring, registering and reporting complications after vaccination have improved. In 2016, the country recorded only 34 cases of measles, a 442-fold decline compared to 2014 and 8-fold decline compared to 2015 [6]. A diphtheria epidemic in Binh Phuoc and pertussis epidemic in Cao Bang were controlled in a timely manner [3].

Difficulties and shortcomings

The implementation of EPI continues to face some difficulties. Full vaccination coverage was less than 50% in many districts and communes in the northern mountainous area, or even less than 30% in a number of communes [7]. Regarding hepatitis B vaccine, according to a report of the EPI, 13 provinces had less than 50% vaccination coverage among infants within the first 24 hours after birth, while nationwide the average was just short of 70%. An example was Yen Bai province where the hepatitis B vaccination coverage among infants within the first 24 hours after birth was less than 40% [8]. An emerging issue is stock-outs leading to delayed and/or incomplete immunization at increasingly used paid immunization services, with consequent increased risk of diseases and epidemic outbreaks, especially measles and pertussis.

In that context, infectious diseases in the EPI (e.g. measles, diphtheria, pertussis, hepatitis B) are still not sustainably eliminated, due to continued exposure of the population that has been insufficiently vaccinated. Last year, a pertussis epidemic occurred in Duc Hanh commune (Bao Lam district, Cao Bang province) from 22 July to 11 August 2016 with 49 cases with clinical signs of pertussis and 4 testing positive. A diphtheria epidemic also occurred in 4 communes of Dong Phu district (Binh Phuoc province) in June-July 2016 with 65 suspected cases being monitored, 11 cases confirmed, 5 cases tested positive and 3 deaths. Another diphtheria outbreak was also reported in Tay Giang district (Quang Nam province) in late 2016 and early 2017 with 2 deaths [6].

3. Prevention and control of HIV, tuberculosis (TB) and malaria

New legal documents and policies

Direction and administration: the MOH has issued documents guiding the implementation of the HIV/AIDS prevention and control plan (Document No. 862/BYT-UB50) and the peak month of prevention of mother-to-child transmission (PMTCT) of HIV in 2016 (Document No. 2720/BYT-UBQG50). The Plan on provision of HIV viral load testing to serve HIV/AIDS treatment monitoring for 2016-2017 and the Plan on sentinel surveillance of HIV, sexually-transmitted infection, HIV linked behavior in provinces for 2016 have also been approved by the MOH (Decision No. 3111/QD-BYT and Decision 1955/QD-BYT respectively).

Technical documents: The Prime Minister promulgated Decree No. 75/2016/ND-CP dated 1 July 2016 providing for HIV testing and Decree No. 90/2016/ND-CP on treatment of opioid addiction with alternative drugs. The MOH also issued training guidelines on treatment of opioid addiction with methadone (Decision No. 159/QD-BYT), guidelines on methadone maintenance therapy (MMT) in drug detoxification facilities (Decision No. 493/2016/QD-BYT), guidelines on malaria surveillance, prevention and control (Decision No. 741/QD-

Resource mobilization and financial mechanisms: The Prime Minister has approved the list of projects to be funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) under Decision No. 227/QD-TTg. On 15 November 2016, the Prime Minister issued Decision No. 2188/QD-TTg providing for payment of centrally procured ARV by the health insurance fund and support for ARV users (discussed in Chapter II).

Implementation results

The results include expansion of the network and geographical areas, improvement of service delivery capacity and increase in the number of people getting access to services like HIV testing and counseling, harm reduction, MMT, antiretroviral therapy (ART) and PMTCT. Regarding testing and counseling, 5 more laboratories have been permitted to perform confirmatory HIV tests, bringing the total number of licensed laboratories in the countries (i.e. 63 provinces, with two new provinces being Bac Kan and Dak Nong) to 110, of which nine are located at district level. The community-based HIV testing and counseling model was piloted in the four provinces of Thanh Hoa, Thai Nguyen, Dien Bien, Nghe An and HCMC, detecting approximately 10% of new infections in these localities. In the first 6 months of 2016, HIV testing and counseling were provided for more than 985 000 people with 9200 cases found to have HIV infections (0.9%) [3]. Regarding MMT, there has been 275 establishments in 63 provinces/cities managing and providing MMT for 50,800 patients (an increase of 8 provinces, 58 establishments and 15 600 patients compared to the end of 2015). Regarding ART, there 73 additional treatment facilities and 7900 new patients receiving ART, bringing the total number of treatment facilities to 385 and the number of patients to nearly 111 700 in 63 provinces, shortening treatment initiation time. Regarding PMTCT of HIV: a peak month for PMTCT of HIV was launched from 1 June to 30 June 2016. In the first 6 months of 2016, 618 500 pregnant women received HIV testing (similar to the same period in 2015) with 563 cases detected to be positive, 873 HIV infected pregnant women received ART, 764 live births from HIV infected mothers received ARV prophylaxis and 425 infants received co-trimoxazole prophylaxis within two months after birth [3].

Support for people living with HIV through health insurance: communication was strengthened to encourage people living with HIV to participate in the health insurance scheme, and to ensure they know their rights under health insurance. A workshop to launch the implementation of Prime Minister’s Decision No. 2188/QD-TTg has been organized. Preparation for payment of ARV by health insurance was completed. So far 35% of hospitals/health centers have a contract addendum on provision of insured services for people living with HIV [3].

Up till the present, 231.6 thousand people are living with HIV, including 87.8 thousand AIDS patients. In recent years, HIV prevalence per 100,000 people has been falling gradually each year, remaining below 0.3% according to the targets. The proportion of people living with HIV eligible for ARV treatment reached 76.73% in 2015, and it is feasible to reach the target of 80% by 2020 [3].

Prevention and control of TB and malaria: TB screening and diagnosis was performed on HIV/AIDS patients in most ARV treatment facilities, patients co-infected with HIV and TB were managed and provided with INH prophylaxis. Activities in response to “World Malaria Day” were organized; malaria surveillance, prevention and control were strengthened [3].
Difficulties and shortcomings

- The reduction of HIV transmission/infection is not yet stable or substantial, the epidemic pattern and risk behaviors are becoming more complex and interventions more difficult to implement. Knowledge of HIV/AIDS and HIV prevention and control in many localities is low. HIV transmission behaviors among intervention groups remain common, the epidemic is spreading to low-risk groups, HIV/AIDS infection is increasing in some key localities.

- Access to HIV/AIDS prevention and control services is limited in terms of quantity (e.g. among men having sex with men (MSM) the proportion accessing MMT, ARV treatment and harm reduction interventions remains low) and quality (e.g. late ARV initiation).

- It is challenging to sustain the supply and use of HIV prevention and control services due to reduced funding from donors and state budget for the NTP. Meanwhile, the proportion insured among people living with HIV reached only 40% due to their difficult economic conditions leading to failure to buy health insurance cards. Many people living with HIV are homeless, with no household registration book and no stable residence address, thus they cannot enjoy health insurance support policies of the State. Some are afraid of being stigmatized and discriminated against if they participate in the health insurance scheme for people living with HIV.

- Integration and collaboration between HIV/AIDS prevention/control and TB prevention/control, as well as reproductive health care, are limited, resulting in reduced effectiveness in the context of limited resources.

- The rate of HIV transmission from mother to child is 2.96%, higher than the target of 2% set for 2016. The proportion of women aged 15 - 49 years of age with comprehensive knowledge about HIV/AIDS is not regularly assessed although in 2014, this proportion reached 43.4% [9] compared to the target of 80% by 2020.

- The monitoring of treatment adherence, control of ARV resistance, and TB and malaria treatment remain difficult due to poor treatment adherence and lack of an effective monitoring system.

4. Prevention and control of non-communicable diseases (NCDs)

New legal documents and policies

Prevention and control of NCD risk factors: the functions, tasks, powers and organizational structures of the Office, divisions and units directly under the Executive Body of the Tobacco Control Fund have been defined by Decision 1776 QD-BYT. The MOH also issued the operating regulations of the National Steering Committee for Control of Alcohol, Beer and Other Alcoholic Beverages (Decision No. 5431/QD-BYT) and Directive No. 04/CT-BYT on accelerating the implementation of national health sector policies on controlling the abuse of alcoholic beverages to 2020. Two projects have been developed to implement the National NCD Prevention and Control Strategy; the draft Alcohol Control Law continues to be developed in a consultative way. In addition, the Prime Minister also issued Decision No. 1284/QD-TTg approving a policy on investment in 3 sports facility construction projects for physical exercise and sports in school.

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9 This estimate is calculated based on the number of children monitored after birth and using PCR testing to diagnose HIV. However, for international reporting on the national response to HIV/AIDS (VAAC), estimates of HIV infection are used instead of reported, and the transmission rate is substantially higher, 18 in 2013 and 12.5 in 2014.
Detection, diagnosis, treatment and management of NCDs: the MOH has approved projects on communication and social mobilization (Decision No. 4299/QD-BYT), proactive prevention, early detection, diagnosis, treatment and management of cancer, cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD), asthma and other NCDs in the period 2016 - 2020 (Decision No. 2866/QD-BYT). Many cancer drugs produced domestically and overseas have been permitted for sale and use in Vietnam.

Implementation results

Media campaigns and press conferences focusing on diabetes prevention and control have been organized. A national survey on NCD risk factors was conducted; data were collected and analyzed for producing a survey report, thanks to which a database of NDC risk factors was established for the first time. Training materials on NCD prevention and management in the community were developed, draft NCD statistical reporting forms were completed. The report on implementation results of the national policy on alcohol control was updated; the draft Alcohol Control Law is under development.

Difficulties and shortcomings

- Investment in NCD prevention and control is not commensurate with the burden of the diseases and health care needs.
- Capacity of the health system for NCD screening, early detection, treatment and management, especially at the grassroots level, is limited.
- Regarding organizational structure and operation, there is a lack of coherence between preventive and curative care and among levels of facilities that hinder continuous and comprehensive care for NCD patients.
- The control of NCD behavioral risk factors is not effective due to people’s limited awareness, lack of prevention guidelines leading to difficulties in implementation, low compliance with legal regulations, non-strict financial penalties, and poor intersectoral collaboration.

5. Other preventive medicine activities

New legal documents and policies

Regarding food safety, the Prime Minister has promulgated Directive No. 13/CT-TTg on strengthening state management for food safety. The government also enacted Decree No. 67/2016/ND-CP prescribing conditions for production and trade of foods subject to MOH management and Decree No. 09/2016/ND-CP on fortification of foods with micronutrients. In addition, the MOH issued guidelines on implementation of the program on encouraging and monitoring food safety in the period 2016 - 2020 under Decision No. 2358/QD-BYT.

Regarding sanitation, the MOH has developed a plan for the sanitation component to be integrated in the NTP on building a new countryside for 2016 - 2020. The MOH also joined the Ministry of Natural Resources and Environment in issuing Joint Circular No. 58/2015/TTLT-BYT-BTNMT on medical waste management; moreover, it issued Official Letter No. 7979/ BYT-MT on strengthened direction of medical waste management.

Regarding occupational safety and health, the Government has issued Decrees No. 37, 39 and 44 with provisions relating to the implementation of the Law on Occupational Safety and Hygiene, technical inspection, occupational safety and health training, compensation for victims of occupational accidents and occupational diseases.
Regarding school health, the MOH in collaboration with the MOET has issued Joint Circular No. 13/2016/TTLT-BYT-BGDDT to strengthen school health work.

Regarding natural disaster prevention/control and rescue, the MOH issued Decision No. 3459/QD-BYT approving the health sector’s plan to cope with strong storms, super typhoons and Directive No. 07/CT-BYT on natural disaster prevention/mitigation and rescue for 2016 - 2020.

Regarding injury prevention and control for children, the Prime Minister issued Decision No. 234/QD-TTg approving the program on injury prevention and control for children for 2016 - 2020 and Directive No.17/CT-TTg on strengthened direction and implementation of the prevention/control of injuries and drowning for students and children.

Implementation results

Food Safety

Communication and education on food safety were delivered to target groups. Technical training in food safety management and control was organized for local staff. The Month of Action for Food Safety Quality was maintained. Capacity building for and a pilot of the model of specialized food safety inspectors was implemented in some localities.

Food safety inspection and checking was strengthened; supervision and prevention were accelerated; facilities with risk of food safety failure were given timely warnings; urgent issues and incidents related to food safety were resolved quickly and effectively; food poisoning was controlled. Through inspection and checking at the central level, many products not meeting food safety standards have been detected and destroyed. A typical example is the MOH inspection and administrative punishment for 3 companies (URC, Coca Cola and Minh Thai Loc) with fines amounting to 6.5 billion VND, while more than 11 tons of beverages and food additives were confiscated and destroyed. At the local level, 461,218 establishments were inspected and checked, leading to detection of food safety violations in 81,346 establishments (17.64%), 11,703 establishments were sanctioned with the total amount of fines equal to 31.6 billion VND. In addition, other forms of sanction were also applied such as suspension of operation, suspension of product sales and destruction of products. In 2016, the country had 174 food poisoning cases with 4,554 people poisoned and 12 deaths, a 2.8% decrease in the number of cases, an 18% decrease in the number of people poisoned and 47.8% decrease in the number of deaths compared to 2015 [10].

Intersectoral collaboration in food safety was enhanced in accordance with Directive No. 13/CT-TTg. The effective operation of the Intersectoral Steering Committee for food hygiene and safety was maintained and promoted. The MOH in collaboration with other ministries has established delegates to visit provinces and work with local authorities on handling of food safety issues; developed and implemented collaboration plans on monitoring, control, sampling, testing and assessment of the safety of aquatic products in central provinces which had incidents relating to the marine environment. Online briefings were organized to evaluate intersectoral collaboration in food safety.

Sanitation

The results include: strengthened inspection and supervision, assessment of environmental monitoring plans of 4 central institutes in 2016, organization of impact surveys, planning and implementation of responses to health problems related to drought and saline intrusion in 8 provinces in the Central Highlands and Southwest area and in 10 key provinces in 2016 - 2017, participation in the survey, investigation and monitoring of the environment in response to the massive death of fish and marine animals in the coastal areas of four central provinces and in some rivers/lakes in Hoa Binh and Thanh Hoa provinces [3].
Inspection and supervision of the management of medical waste in health facilities, chemicals, disinfectants and insecticides used in households and medical activities continued to be strengthened. The “Journey of ten million clean hands” media campaign and “Washing your hands with soap for a healthy Vietnam” project in response to the “Patriotic hygiene for improving people’s health” movement were implemented successfully. Health environmental impact assessment of hospital construction, renovation and upgrading projects was carried out [3].

**Occupational Safety and Hygiene and other preventive medicine programs**

The results include: development of national regulations, communication, training, occupational health inspection and supervision, prevention and control of occupational diseases.

**Difficulties and shortcomings**

- Food safety violations in the production, processing and trade of foods continue to occur due to poor attitude towards compliance with legal provisions, making food safety failure very likely.
- Capacity of the food safety network is limited, lacking professional staff, qualifications and experience, financial sanctions are not strong enough, intersectoral collaboration in food safety continues to face difficulties, limiting effectiveness.
- While the food poisoning situation has been controlled, there remains a very high risk of food poisoning incidents in industrial zones, export processing zones and collective kitchens (like cafeterias or canteens).
- Environmental pollution risks are high due to industrialization and urbanization while the health environment management system and personnel in localities were insufficient in quantity and quality. Marine environment incidents in central provinces have left burdens and challenges in the collaboration for environment monitoring, management and remediation in the following years.
- Awareness and consciousness of the community, as well as interest and investment of localities in sanitation, waste management, prevention of occupational diseases and injuries have been limited.
- The impact of climate change, particularly drought, saline intrusion and flash floods, is becoming increasingly severe and unpredictable while investment to mitigate these problems is insufficient.

**Task 2. Health care at grassroots level, PHC and health target programs**

1. New legal documents and policies

**Health care at the grassroots level and PHC**

The MOH has issued Decision No. 1568/QD-BYT approving the plan on replication and development of the family doctor clinic model in Vietnam for 2016 - 2020. On 5 December 2016, the Government issued Decision No. 2348/QD-TTg approving the project on building and development of the grassroots health care network in the new context, which sets out specific objectives, tasks and measures to improve capacity of the grassroots health care network in the period 2016 - 2025.

**National target programs**

On the basis of Resolution No. 100/2015/QH13 of the 13th National Assembly and Decision No. 398/QD-TTg of the Government dated 26 August 2016, the Prime Minister issued
Resolution No. 73/NQ CP approving the policy on investment in 21 target programs in the period 2016 - 2020, according to which the four previous health NTPs were consolidated into two target programs: (1) Target program on health and population, including 8 projects with a total implementation budget of 20.413 trillion VND and (2) Target program on local health development project, including 3 projects with a total implementation budget of 22.5 trillion VND.\textsuperscript{10} Regarding the collaboration between military and civilian medicine, the MOH has issued Directive No. 03/CT-BYT on national defense and security of the health sector in 2016.

2. Implementation results

**Capacity building for the grassroots health care network**

Integration of family medicine principles in PHC at CHS and regional polyclinics: by June 2016, 336 family doctor clinics have been established in eight provinces. By the end of December 2015, 195,245 health records have been established, 500,919 people have received screening, 246,049 disease cases have been detected and 3600 cases have been referred. Electronic medical records and patient management software are beginning to be used. Household health records are being established.

Rotation of doctors in the CHS: the rotation of doctors from the district hospitals and DHC to work in the CHS for 1 - 2 days/week is being promoted; at the same time, CHS doctors are being assigned to work in district hospitals/DHCs, which contributes to improving capacity of the grassroots health care network.

Promotion of health communication and education: the collaboration program between the MOH and Vietnam Farmer’s Union on communication for and encouragement of farmers to protect, care for and improve public health in the period 2015 - 2020 (Program No. 479/CTr-BYT-HNDVN) continues to be implemented.

**Collaboration between military and civilian medicine**

The MOH in collaboration with the Ministry of National Defense has successfully organized the Fifth National Conference on Military-Civilian Medicine (for the period 2005 - 2015); directed provincial military-civilian medicine committees to strengthen health care at the grassroots level, improve professional capacity of military-civilian health facilities, provide free-of-charge medical examination and treatment, medicine and gifts for social policy beneficiaries in central provinces, Central Highlands and remote areas. The sector has collaborated with the Ministry of National Defense in deploying military activities, delivering education in national defense and security in the health sector and has collaborated with the Ministry of Public Security in organizing counter-terrorism training and drills for hospitals in 2016 [3].

**Development of maritime health**

The results include: continued strengthening of the maritime health network, review of 4-year implementation of the maritime health development project by 2020 approved by Prime Minister’s Decision No. 317/QD-TTg, completion of the medium-term investment policy (for 2016-2020), direction on the implementation and completion of the Telemedicine system connecting the military-civilian health center of Bach Long Vi island district and the Maritime Medicine Institute as well as Viet Tiep hospital (Hai Phong municipality), establishment of the National Steering Committee for Maritime Health, preparations for organization of a conference of this Steering Committee in Ba Ria Vung Tau province [3].

\textsuperscript{10} Resolution No. 73/NQ-CP (2016) approving the policy on investment in 21 target programs in the period 2016 - 2020.
3. Difficulties and shortcomings

- The allocation of resources to the project on building and development of the grassroots health care network and health target programs in general, as well to military-civilian medicine activities and maritime health development, is facing many difficulties and does not yet meet requirements.

- Service delivery capacity and quality at grassroots level remain limited, especially in health management, detection and management of common diseases and health problems in mountainous, upland, border and island areas.

- There is a lack of mechanisms and policies (i.e. service package, medicines and equipment, financing mechanisms, technical guidelines, standard model for each type of health facility) to support the work of family doctors, e.g. household health management, and home-based health care.

Task 3. Delivery of medical examination, treatment and rehabilitation

1. New legal documents and policies

Solutions to reduce hospital overcrowding

The Prime Minister has issued Directive No. 08/CT-TTg on enhancing solutions to reduce hospital overcrowding and expand satellite hospitals. On that basis, the MOH approved the addition of prioritized specialties and the list of hospitals engaged in the satellite hospital project in 2016 - 2020 phase 2 (Decision No. 1303/QD-BYT).

Improvement of health service quality

Several projects and plans to improve service quality have been approved, e.g. the National Program of Action on improving the capacity of medical service quality management from now to 2025 (Decision No. 4276/QD-BYT), the National Action Plan on infection control in health facilities in the period 2016 - 2020 (Decision No. 1426/QD-BYT), the project on capacity building for the medical testing quality management system in the period 2016 - 2025 (Decision No. 316/QD-TTg).

Many professional and technical guidelines have been issued, e.g. anesthetic technical procedures (Decision No. 782/QD-BYT), surgical technical procedures, cardiovascular and thoracic surgical technical procedures (Decision No. 4423/QD-BYT), guidelines on management of antibiotic use in hospitals (Decision No. 772/QD-BYT), guidelines on blood transfusion safety for preventing Zika virus infection (Decision No. 1414/QD-BYT), regulations on the organization and operation of the microbiology department in hospitals (Circular No. 33/TB-BYT), etc. On 29 July 2016, the MOH issued Decision No. 4068/QD-BYT guiding the compilation of technical procedures in medical examination and treatment and approving technical procedures for 26 common diseases.

After 3 years of piloting hospital quality evaluation criteria, on 18 November 2016, the MOH has promulgated them as official tools to evaluate the quality of hospitals (Decision No. 6858/QD-BYT).

Regarding management of practitioners and practicing facilities, the MOH has issued Decision No. 922/QD-BYT to correct Circular No. 41/2015/TT-BYT amending and supplementing some articles of Circular No. 41/2011/TT-BYT guiding the granting of practice certificates to medical practitioners and operating licenses to health facilities.
Referral mechanism and health insurance payment

In 2015, the revised Health Insurance Law 2014 officially came into effect. The MOH has issued Official Letter No. 978/BYT-BH guiding the implementation of Circular No. 40/2015/TT-BYT on enrollment at gatekeeper facility and referrals between health facilities covered by health insurance, Decision No. 1122/QD-BYT on the list of shared codes applied in medical examination and treatment and in health insurance payment. The list of technical health services equivalent in terms of techniques and costs (Series 1-5) have also been issued in 2016. In the field of rehabilitation, the MOH has issued Circular No. 18/2016/TT-BYT defining the list of techniques and medical supplies to be used in rehabilitation and stipulating that payment for outpatient rehabilitation charges will be covered by the health insurance fund.

Related legal documents and policies

In 2016, the MOH issued some other legal documents related to medical examination and treatment, including: Joint Circular No. 16/2016/TTLT-BYT-BQP on health check-up for people subject to military obligations, Circular No. 19/2016/TT-BYT amending Circular No. 07/2010/TT-BYT guiding the assessment of the reduction of work ability of compulsory social insurance participants, Joint Circular No. 20/2016/TT-BYT-BLDBXH amending and supplementing Circular No. 41/2013/TTLT-BYT-BLDTBXH guiding the assessment of diseases, disabilities, and deformities related to chemical exposure among people fighting in the war and their children.

2. Implementation results

Improvement of service delivery capacity, reduced overcrowding at higher-level hospitals

Expansion of the satellite hospital network and increased technology transfer in overcrowding reduction projects: the satellite hospital network is operating in 63 provinces with 22 hub hospitals and 98 satellite hospitals. Professional mentoring and rotation of health workers, information technology application in training, counselling and technology transfer have been implemented effectively. Some 386 training courses have been organized, 791 techniques have been transferred from hub hospitals to 7051 staff of satellite hospitals, contributing to reducing doubling up in hospital beds, increasing the implementation of transferred techniques and reducing the referral rate in supported specialties by 73 - 99% in 37.5% of satellite hospitals (the referral reduction rates vary depending on the specialty) [3].

Continued investment in infrastructure for improving health care service delivery capacity: investment in and procurement of medical equipment for 5 central hospitals and tertiary referral hospitals were accelerated (in accordance with Decision No. 125/QD-TTg), new hospitals at different levels were constructed and put into operation such as Bac Kan provincial general hospital with 500 beds, An Giang general hospital with 600 beds, Yen Bai provincial general hospital with 500 beds, Soc Trang provincial general hospital with 700 beds, etc. In the period 2012 - 2016, in total there were 119 new hospitals constructed, 1839 hospital departments and divisions constructed or renovated with an additional of 5129 consultation rooms/tables [11].

The number of patient beds and services has increased. The number of beds/10 000 populations reached 25.0 versus the target of 24.5, in which the figure from non-state health facilities reached 1.5 beds/10 000 populations. Implementation results of general indicators on health and rehabilitation service delivery - e.g. number of outpatient visits, number of people receiving outpatient/inpatient treatment, length of outpatient/inpatient treatment, number of surgeries/procedures - were improved compared to 2015 [3].
Overcrowding has been reduced in both outpatient and inpatient sectors. In the outpatient sector, medical examination procedures have been simplified from 12 - 14 steps to 4 - 8 steps depending on the type of examination; consultation time was reduced by 48.5 minutes per visit, saving an average of 27.2 million VND working days per year for the society. In the inpatient sector, since 2012 reduction in the share of hospital wards experiencing bedsharing has been acknowledged in 58% of central hospitals and 47% of provincial hospitals where previously patients had to share beds [11].

Improvement of health service quality

Improvement of service delivery process: hospitals continued to improve procedures, upgrade the outpatient waiting and consultation area, extend working hours, and reform the procedures of hospital fee collection and health insurance payment to improve quality of care. Hospital performance was evaluated using the 83 hospital quality evaluation criteria (issued by Decision No. 6858/QD-BYT). Evaluation results at the end of 2015 and beginning of 2016 showed that there were improvements in hospital quality in comparison with 2013 and 2014 with the average score of 2.8/5 points (3.5 for central hospitals, 2.8 for provincial hospitals, 2.6 for district hospitals and 2.9 for non-public hospitals). In addition, 1273 hospitals at all levels (98.6%) have performed self-evaluation, scoring and reporting of evaluation results online with an average score of 3.1 out of 5 points [11].

Improved service attitude and style: Evaluation of the implementation of Decision No. 2151/QD-BYT by HSPI showed that there have been positive changes in the service attitude and style of health workers. At 10 evaluated hospitals of different levels, 71% of patients commented that health workers had more friendly attitudes and behaviors; over 61% of patients said posted instructions on medical examination and treatment procedures were improved, waiting time was shorter, facilities of the outpatient area and sanitation in the hospital and in patient rooms were improved; 87.7% of patients indicated satisfaction with hospital medical examination and treatment services [11].

Improved quality of testing services. The MOH is drafting a circular providing guidance on medical testing quality evaluation criteria, internal quality control and external quality assessment in testing. Capacity of the 3 national quality control centers has also been strengthened through the development and completion of management processes and technical procedures meeting international quality management standards. Technical support has been provided for 5 central and provincial hospitals to be accredited with ISO standards. A network of reference laboratories has been established nationwide in leading hospitals. Training was organized for over 2000 health workers in testing quality management from basic to advanced levels. External quality assessment was promoted with the participation of 3839 laboratories, double the number in 2014 and a 10-fold increase compared to 2010 [11].

Management of practitioners and practicing facilities: so far 45 975 (94.7%) health facilities have been granted with an operating license and 309 768 (96.17%) practitioners have been granted with a practice certificate. Inspection and examination of medical practice were enhanced in terms of number of inspection trips (5707), number of health facilities inspected (11 354), application of administrative penalties (712 facilities), warnings (297 facilities), fines (of nearly 11.7 billion VND), suspension of operation (42 facilities) and revoking of operating licenses (359 facilities) [11].

Establishment and improvement of mechanisms for referral and health insurance payment

The implementation of Circular No. 40/2015/TB-BYT on registration of PHC facility, self-referral and referrals between health facilities covered by health insurance helped patients have more choices in accessing health care services. Information technology was applied in
health care management and payment of insured health services. The architecture of the health information system was defined and criteria for data outputs of health facility management software were developed with a list of shared codes to comprehensively and accurately manage patient information and facilitate health insurance payment. Currently, approximately 99.5% of health facilities across the country are connected to the claim review system of VSS. In addition, the health sector also collaborated with VSS to supervise the use and payment of insured health services to avoid abuse of the health insurance fund.

**Encouragement of non-public health sector development**

Over the last few years, the MOH has issued policies to facilitate non-public health sector development in the form of social mobilization or PPP. The Ministry has established a PPP Technical Working Group and is currently preparing for the establishment of a PPP Steering Committee, as well as drafting a Circular guiding PPP implementation in the health sector. Through this mechanism, hospitals acquire better infrastructure, facilities, modern medical equipment and new techniques. Some hospitals have been modernized through rebuilding. Professional knowledge of health workers has improved. Many projects have received investments and are operating successfully thanks to social mobilization, e.g. Phu Tho provincial general hospital (1300 patients beds of which 500 received private investment), Dong Nai general hospital (1000 patient beds of which 500 received private investment), and the high-tech building of Viet Duc hospital. [12].

**Development of medical specialties and application of high technology in health care**

Many advanced medical techniques and technologies such as organ transplant, stem cell therapy, laparoscopic surgery, robotic endoscopy, molecular biology and nuclear medicine have been studied and applied successfully, contributing to accurate diagnosis and effective treatment of many serious/complicated diseases. By September 2016, the country has successfully undertaken 1281 kidney transplants, 54 liver transplants and 16 heart transplants. In 2016, the second robotic surgical system was licensed and operated successfully in Binh Dan hospital, allowing surgery on multiple organs with minimal invasion, high accuracy and safety, reducing the risk of complications and helping patients recover quickly. Also in the last year, the application of advanced technologies and techniques in health care has brought the health sector 3 Ho Chi Minh awards, 1 State award on Science and Technology and 3 Vietnamese Talent awards.

**3. Difficulties and shortcomings**

- The organization and operational mechanism of health facilities does not facilitate the delivery of comprehensive, continuous, quality and patient-centered services due to the lack of continuity of care among levels and failure to meet health care needs in the context of changing disease patterns.

- Overcrowding in upper-level hospitals, especially central specialized hospitals and tertiary referral hospitals like Bach Mai hospital, Cho Ray hospital, National Oncology hospital, Pediatrics Hospitals No. 1 and 2, etc. and in specialties like cardiology, oncology, trauma orthopedics, obstetrics, pediatrics, pulmonology, hematology, endocrinology, etc. has not been addressed thoroughly. It is because service quality at lower levels has not yet improved significantly, leading to lack of trust among the people, while people’s health care seeking behavior is irrational and most people still want to go to higher levels. Additionally, the management mechanism, financial autonomy mechanism and the downside of the market also affect hospital effort to reduce hospital overcrowding.
Chapter III. Health service delivery

- The quality management system has been established, but is inconsistent and lacks mechanisms, regulations, and guidance to support and encourage the provision of quality services in a comprehensive manner (i.e. independent evaluation, grant of time-limited practicing certificates, standard clinical guidelines, etc.). Medical examination and treatment results are not accepted/acknowledged among different health facilities, causing a waste of resources for people and society.

- Health care quality needs to be improved in many aspects, e.g. the organization of service delivery, administrative procedures, professional quality, etc.

- The development of the private health network is not commensurate with its potential, quality management in private health facilities faces many challenges.

- The organizational structure of the network and capacity of health workers, especially at the grassroots level, do not meet health care needs of older persons in the context of rapid population aging.

- Rehabilitation services have not been deployed widely in comparison with their potential and strengths.

Task 4. Delivery of traditional medicine service

1. New legal documents and policies

   In recent years, the MOH has issued policy documents related to trade traditional medicinal materials (Circular No. 03/2016/TT-BYT), prescription of traditional medicines or a combination of traditional and modern medicines in health facilities (Circular No. 01/2016/TT-BYT), and health insurance payment for traditional health care (Decision No. 122/QD-BYT).

2. Implementation results

   In implementation of the Government’s Action Plan on traditional medicine development in Vietnam until 2020, to date 57/63 provincial people’s committees have approved local traditional medicine development plans. In addition, to implement the project on construction and upgrading of traditional medicine hospitals nationwide in the period 2014 - 2025 under Decision No. 362/QD-TTg, 41 hospitals have registered medium-term investment projects in the period 2016 - 2020, of which 8 have been reviewed and received funding for consideration by the Ministry of Planning and Investment.

   The state management apparatus was strengthened and completed; the network of traditional medicine facilities was expanded with 63 public traditional medicine hospitals (of which 58 are provincial hospitals) and 3 non-public traditional medicine hospitals; 92.7% of general hospitals had traditional medicine departments/divisions (an increase of 2.7% compared to 2015); 84.8% of CHSs provide traditional health care (an increase of 10.5% compared to 2015) [3].

   The percentage of patients treated with traditional medicine at all levels has increased, reaching 4.1% at central level, 11.7% at provincial level, 13.4% at district level and 28.5% at commune level [3]. The quality of health services using traditional medicine or a combination of traditional and modern medicine has gradually been improved. The management of traditional medical practices and advertisement of traditional health care has become more effective. The quality of traditional herbs is gradually being controlled, especially in traditional medicine facilities.
3. Difficulties and shortcomings

- Traditional medicinal ingredients are mainly imported from other countries. Testing capacity is limited, the quality of traditional herbs and traditional medicines has not been strictly controlled.

- Personnel practicing traditional medicine in public health facilities are insufficient in quantity and quality. The use of traditional health care in health facilities is low, while there is not much research on application of traditional medicine ingredients in treatment.

- The management of private traditional medical practices has many shortcomings, there are no regulations on the scope of professional activities of traditional medical practitioners, leading to the abuse of traditional medicine for illegal practice, meanwhile a lot of valuable folk experience has not been well exploited.

- The system of legal documents and technical guidelines in the traditional medicine field is not consistent and often issued late, which does not really encourage and support the development of traditional medicine.

- Implementation progress of the project on construction and upgrading of traditional medicine hospitals nationwide in the period 2014 - 2025 (Decision No. 362/QD-TTg) and the master plan on development of medicinal herbs to 2020 with a vision to 2030 (Decision No. 1976/QD-TTg) is slow compared to demand.

Task 5. Population, family planning, mother and child health care services

1. New legal documents and policies

Population and family planning

The Prime Minister has promulgated Decision No. 468/QD-TTg approving the project on control of imbalanced sex ratio at birth in the period 2016 - 2025. On that basis, the MOH issued Directive No. 04/CT-BYT, Decision No. 1472/QD-BYT and Official Letter No. 4111/BYT-TCDs approving the project and guiding the implementation of Decision No. 468/QD-TTg. The Ministry has also approved the list of contraceptives, and reproductive health commodities in the Population and family planning program (Decision No. 1223/QD-BYT), and projects to develop and pilot the model of social mobilization of contraceptive and family planning/reproductive health care service delivery for 2016 - 2020 (Decisions No. 2350/QD-BYT and No. 2351/QD-BYT); jointly issued Circular No. 2016/TTLT-BTC-BYT-BLDTBXH guiding the implementation of Decree No. 39/2015/ND-CP on supporting poor ethnic minority women to bear children in line with population policies. In addition, the Ministry also enacted Decision No. 18/QD-TCDS temporarily prescribing primary registers and information sheet templates to be used by population collaborators. The MOH issued Official Letter No. 1728/BYT-KCB on delivery of health care and periodic health examination for the elderly in 2016.

Reproductive health care and maternal and child health care

The MOH has issued Decision No. 1223/QD-BYT temporarily guiding care for pregnant women in the context of epidemics caused by Zika virus, Decision No. 2295/QD-BYT guiding the integration of reproductive health care, prevention and control of reproductive tract infections, HIV and PMTCT services, and Decision No. 7538/QD-BYT guiding the implementation of assisted reproductive services and surrogacy according to Decree No. 10/2015/ND-CP and Decree No. 98/2016/ND-CP. Regarding technical documents, the MOH issued national guidelines on reproductive health care services, diagnosis and management of obstetric emergencies; and continues to develop and refine the draft Population Law.
2. Implementation results

Population and family planning services

The results include: continued implementation of projects on population quality improvement, for example: the project on prenatal and neonatal diagnosis and screening in 9547 communes of 634 districts of 63 provinces, an intervention project to reduce Thalassemia prevalence in 261 communes of 29 districts of six provinces; a model of pre-marital health check-up and counselling in 1461 communes of 63 provinces; preparation of conditions for implementing the project on control of imbalanced sex ratio at birth in 2016 - 2025; maintenance of community-based counselling and health care for the elderly in 390 communes of 151 districts of 32 provinces; development of a cooperation program with WHO on care for the elderly; development of a project on care for the elderly in the period 2017 - 2025 [3].

In addition, the following activities have been conducted: implementing effectively behavior change communication on population and family planning; focusing on communication and direct counseling in the community; counseling and engaging target groups; producing, duplicating and providing communication products or communication products examples; ensuring logistics and providing family planning services with diverse forms of contraception, promotion of social marketing of contraceptives and expansion of models of contraceptive, reproductive health care and family planning service delivery; increasing inspection, examination and supervision in order to detect violations relating to dissemination of methods to conceive a child of a specific sex or ultrasound services for sex selection; continuing to complete the electronic population and family planning database, maintaining and upgrading specialized management software, updating changes and refining the data warehouse at all levels.

Most population and family planning targets have been attained or exceeded. The total fertility rate was estimated to be 2.09 children per woman, thus maintaining the replacement-level fertility rate. The crude birth rate was 15.74‰, crude death rate was 6.83‰. The average life expectancy reached 73.4 years (70.8 years for men and 76.1 years for women). The sex ratio at birth was 112.2 boys per 100 girls, lower than the same period of 2015 (112.6) and exceeding the target (113). The proportion of married women aged 15 - 49 using contraception was 77.6%, an increase of 0.9% compared to 2015 [3].

Reproductive health care and mother and child health services

Several actions were undertaken including: Implementation of the Action Plan on prevention and control of cervical cancer; development of a project proposal on screening of cervical cancer by DNA tests to detect Human papilloma virus; guidance and collaboration in the implementation of Zika epidemic prevention measures for pregnant women; and supervision, training, prenatal screening and early detection of microcephaly.

The health sector has continued to strengthen direction, inspection and supervision during implementation of solutions to minimize obstetric complications in gynecological, obstetric and pediatric health facilities (including private ones) and implementation of surveys, review and audits to find the causes of maternal deaths in 2014 - 2015.

Health workers at all levels have received training to improve capacity in the implementation of professional duties on health care and nutrition care for mothers, newborns and children, reproductive health care for adolescents, women of childbearing age, menopausal women and men.
Implementation of assisted reproductive services and surrogacy for humanitarian purpose has received guidance and supervision to ensure compliance with regulations: currently, there are 3 health facilities allowed to perform surrogacy: Central Obstetrics hospital, Tu Du hospital (HCMC) and Hue Central hospital. Nationwide, nearly 200 surrogacy application dossiers have been approved, of which more than 30 cases already have babies.

Many maternal and child health targets set for 2016 were achieved: the underweight proportion in children under age 5 dropped by 13.7%; the proportion of women receiving at least 3 antenatal care visits was over 90%; the proportion of deliveries attended by trained health workers was 98%; the proportion of mothers and infants receiving care within the first week after birth was 81%; infant mortality rate (IMR) per 1000 live births was 14.52‰ [3].

3. Difficulties and shortcomings

- The project on screening before, during and after birth to improve quality of the population is only implemented on a small scale.
- The risk of imbalanced sex ratio at birth remains high.
- Investment and capacity of the health system to provide health care for the elderly are not commensurate with needs.
- Vietnam’s average population in 2016 is estimated at 92.7 million, an increase of 987.8 thousand people. This indicates failure to contain population at or below the target of 92.4 million. The proportion of women aged 15 - 49 having three children or more is 16.3%, an increase of 0.5% compared to 2015.
- Accessibility to services is low, unmet need for services remains high in mountainous, upland, and ethnic minority areas and among adolescents, youth, workers in industrial zones, and migrants.
- Facilities, equipment and human resources at district hospitals in many localities do not meet the needs for care and treatment, or obstetric and neonatal emergencies.
- The maternal mortality ratio (MMR) and IMR are still high and declining slowly, especially in mountainous and midland areas. Causes of maternal deaths vary among regions, with indirect causes (cardiovascular, respiratory, endocrine) increasing their share in urban areas, and direct causes remaining high in rural areas, requiring varied strategies and solutions for each region. Reduction of the under-five mortality rate (U5MR) is challenging, because causes are not always related to the scope of actions of the health sector (e.g. injuries, drowning, etc.), so close intersectoral collaboration is necessary.
- The stunting rate in children remains high, especially in rural areas of the Central Highlands, and Northern midlands and mountainous areas, while overweight and obesity rates in children are increasing in urban areas.
- The statistical reporting system for population and family planning and maternal and child health fails to provide accurate, timely and complete data for effective planning, policy formulation and design of interventions.
4. Priority issues

4.1. General issues

- There is a lack of linkages and integration between preventive and curative care service provision, between levels of care, and between facilities needed to ensure continuity and comprehensiveness of care.

- Insufficient attention has been paid to preventive activities like health education and advising, management of risk factors, periodic health checkups, and disease screening.

- Professional qualifications and competencies of grassroots health workers remain limited, and inadequate attention has been paid to upgrading their skills and competencies in line with the casemix and healthcare needs of the people.

- Investment in grassroots health is facing many difficulties, including the financial mechanism, pharmaceuticals, health insurance reimbursements, etc. These have not yet motivated continuous, comprehensive, people-centered health management and care at the grassroots level.

4.2. Preventive medicine

- The burden of disease caused by infectious diseases remains high, while preventive measures are passive and there is a lack of funding. Endemic infectious diseases have high prevalence and are at high risk of developing into outbreaks; infectious diseases in health target programs are likely to return while emerging diseases are likely to occur in the context of expanded exchanges and globalization.

- Monitoring, control and promotion of changes to NCD risk behaviors are ineffective (because people’s awareness is low, prevention guidelines are difficult to implement, financial sanctions are not strict enough, and intersectoral collaboration is weak) while capacity of the health system, especially at the grassroots level, in NCD prevention, detection and treatment management is limited.

- Access to and use of HIV/AIDS prevention services are still limited among high-risk groups. These services are not sustainable in the context of reduced funding, low health insurance coverage and ineffective integration of health programs.

- Food safety violations in food production, processing and trade are still common. Food poisoning in collective kitchens of industrial parks and export processing zones, while currently controlled, remain a high risk. The recent marine environmental incidents in four central provinces continue to create challenges to the monitoring of seafood safety and environment in the coming time.

- The impact of environmental pollution and climate change are becoming increasingly serious; environment and occupational safety and health management requires intersectoral collaboration while the Environment Protection Law and the Occupational Safety and Hygiene Law have only recently been enacted with insufficient guiding documents. The organization and human resources of the health systems in charge of this work are inadequate in quality and quantity. Investment and interest of ministries/sectors/localities in this area are low.
4.3. Health care at the grassroots level, PHC and health target programs

- Investment in health care at the grassroots level, PHC and health target programs is very limited. Capacity of the health sector does not meet health care needs.
- There is a lack of coherent financial and technical mechanisms and policies to support service delivery of the family doctor model

4.4. Medical examination, treatment and rehabilitation

- Overcrowding in many specialized departments and tertiary referral hospitals has not been addressed thoroughly
- Service delivery capacity at lower levels remains limited, especially in responding to the needs for comprehensive and continuous health care because of population aging and NCD burden.
- The management and organization of service delivery and quality control remain inadequate. Service quality has gradually been improved but is not yet meeting expectations.
- The organization and working mechanisms are not encouraging and ensuring the delivery of quality services and continuum of care. Failure to accept/acknowledge test results among health facilities is still common.
- Service delivery capacity of the private health sector is limited and quality control is facing difficulties.

4.5. Traditional medicine

- The supply of raw materials in the country is limited while the management of medicinal material quality and traditional medicine practices is facing difficulty. The planning of medicinal material development has been slow.
- The study of application of traditional remedies and treatment methods in health care is slow and not practical. Traditional health care coverage in health facilities is small, especially at lower levels, which is not commensurate with the potential and needs.

4.6. Population and family planning, reproductive health care, mother and child health care

- There are major differences in health indicators, disease patterns and access to maternal and child health and reproductive health services among regions. Access to maternal and child health services in remote areas is limited leading to high and slowly-decreasing MMR and child mortality rate in mountainous and upland areas. Unmet need for population, family planning, reproductive health care and maternal and child health care services among certain target groups such as adolescents, youth, migrants and workers in industrial parks remain high.
- The risk of imbalance in the sex ratio at birth is still high; population quality improvement projects are only deployed on a small scale; population aging is happening fast which changes the population structure, requiring a change to the approach of population policies to ensure stable and sustainable development.
- Investment and capacity of the health systems in health care for the elderly are not commensurate with needs.
5. Recommendations

5.1. General solutions

- Unify the organizational structure of the health service delivery system at all levels towards enhancing the connection between preventive and curative care, and among all levels.

- Develop and complete legislation, regulatory policies and technical guidelines in each field of service delivery.

- Increase investment in health care at the grassroots level and PHC; reform the organization of health service delivery and the financial mechanisms for the commune and district levels to meet patient needs and to encourage and motivate health workers.

- Enhance training and technology transfer to improve capacity and service delivery quality at the grassroots level in health management and detection and treatment of common health problems, with focus placed on NCDs.

5.2. Preventive medicine

- Plan, monitor and forecast proactively, and detect early infectious disease outbreaks for prompt prevention and control; capture information quickly, supervise strictly and prevent epidemic infectious diseases at international border gates in a timely fashion.

- Strengthen the management of immunization, promote communication activities, ensure sufficient supply of vaccines and monitor the organization of vaccination to ensure high immunization rates and constantly improve immunization quality and safety.

- Strengthen communication to raise people’s awareness and change behaviors in prevention and control of infectious disease outbreaks, prevention of NCD risk factors, and active implementation of prevention and health improvement measures.

- Provide training, coaching and technical support to improve capacity in prevention, control and monitoring of risk factors, detection and management of the treatment of NCDs at the grassroots level.

- Strengthen surveillance, assessment and projections of the HIV/AIDS epidemic; increase the number of counseling and testing service providers, and expand ARV distribution and MMT down to the commune level; integrate counselling services and ART, MMT, TB treatment and reproductive health care services at the grassroots level.

- Promote communication, education and other measures to convince people living with HIV to buy health insurance; ensure the interests of people living with HIV/AIDS in utilization of insured health care and HIV/AIDS prevention services; develop plans to ensure the continuous supply of quality ARV at reasonable prices; gradually supply ARV reimbursable through health insurance.

- Increase monitoring of and support for adherence to ARV, TB and malaria treatment; develop preventive plans and monitor drug resistance.

- Continue implementation of the waste treatment system development project for health facilities approved by the Prime Minister; simultaneously, enhance inspection, examination and supervision of medical waste management and treatment in and out of health facilities.
Organize and guide the implementation of legislation and regulatory policies on environmental protection, occupational safety and hygiene, prevention and control of injuries; strengthen intersectoral collaboration in monitoring the implementation of regulations on environmental protection.

Develop programs, plans, and technical guidelines and organize the implementation of activities to respond to health-related issues caused by drought, saline intrusion and marine environmental incidents in the central region.

Promote intersectoral collaboration in state management of food safety, inspection, supervision and handling of food safety violations; develop models and monitor the operation of clean food production and business facilities.

Continue piloting the model of specialized food safety inspectors and study replicability; provide training and capacity building for the food safety system of the health sector in active food safety supervision, prevention, warning of risks, inspection and examination.

5.3. Primary health care

Mobilize resources from ODA, health insurance, and other sources for increased investment in PHC at the grassroots level, as well as in the implementation of the project on building and development of the grassroots health care network in the new context.

Develop mechanisms, enhance training, attract personnel, innovate, improve effectiveness of activities and integrate health target programs at the grassroots level; apply family medicine principles in PHC at CHSs, and regional poly-clinics. Refine financial mechanisms/policies and professional and technical guidelines to support the operation of the family doctor model.

Expand the model of family doctor clinics according to a roadmap based on the development and evaluation of the effectiveness of standard models for each kind of health facility with typical characteristics of each region; focus on household health management, management of chronic NCDs, maternal and child health and health care for the elderly in the community.

5.4. Medical examination, treatment and rehabilitation

Continue deploying various measures against overcrowding in hospitals: accelerate the implementation of key hospital construction projects focusing on the following specialties: cardiology, oncology, trauma, obstetrics-pediatrics, pneumonology, and neurology; expand the network of hub and satellite hospitals; continue the rotation of health workers between levels, and strengthening of training and technology transfer for lower-level hospitals; apply telemedicine.

Issue technical regulations and guidelines, establish the service quality management system at all levels and enhance the patient feedback system; develop and implement the model of independent hospital quality evaluation and scoring; modify and expand hospital quality evaluation criteria; develop financial and management mechanisms for motivating quality service providers; strengthen communication in combination with monitoring improvement of health workers attitude and service style.

Strengthen the management and control of medical laboratory test quality; at the same time, refine the mechanism for ensuring mutual recognition of test results among health facilities.
Chapter III. Health service delivery

- Reform administrative procedures in health care to facilitate people’s access to and use of health services, especially for the insured; continue implementing regulations on enrollment at a gatekeeper facility and referrals between health facilities covered by health insurance to create favorable conditions for people, especially health insurance card holders, to access and use health services.

- Develop the family doctor model in parallel with formulating mechanisms for encouraging the delivery of medical services and techniques at lower levels to facilitate patients to access quality health services close to home, especially for chronic disease management (hypertension, diabetes, asthma, etc.) in the community.

- Strengthen the management and licensing of practitioners in combination with examination, inspection and supervision to ensure the quality of private health services; develop a mechanism and a roadmap for organizing examinations for practitioner registration; grant time-limited practice certificates; link the granting of practice certificates to fulfillment of CME requirements.

- Encourage PPP implementation in the construction of health facilities; diversify types of health services, develop quality specialized health care in parallel with universal health care.

5.5. Traditional medicine

- Enhance the implementation of the traditional medicine network development project; refine the state management system for traditional medicine from central to local levels plan, invest and support the development of and create business opportunities for concentrated medicinal material cultivation zones to gradually ensure raw material sources for traditional medicine.

- Issue technical guidance, scope of practice for traditional medicine, accelerate research on applying traditional methods of curative treatment; expand the scope of traditional health care combined with modern medicine in health care; increase the proportion of patients having medical examination and treatment with traditional medicine.

- Build capacity in and promote testing, inspection, supervision of the quality of medicines, medicinal materials and professional activities of traditional medicine/medicinal material production and business establishments and traditional medicine facilities.

5.6. Population, family planning, mother and child health care

- Make efforts to sustain a reasonably low birth rate, continue to implement measures to reduce birth rate in rural, disadvantaged, remote areas and maintain a reasonably low birth rate in areas with already low birth rates; control population growth in maritime areas.

- Study and recommend the development of a new population and family planning strategy, shifting the focus of population policies from family planning to population and development to comprehensively address population issues in terms of scale, structure, and distribution improvement in the quality of the population.

- Proactively control and resolve underlying causes of the imbalance in the sex ratio at birth; promote communication combined with strengthened inspection, examination and strict handling of sex selection behaviors.
- Ensure logistics and provide adequate and quality family planning services, especially in disadvantaged areas; promote social marketing to increase the use of modern contraceptive methods.

- Develop population and family planning plans and integrate population and family planning activities into reproductive health care, maternal and child health care and HIV prevention activities at the grassroots level; promote intersectoral collaboration in prevention of childhood injuries and drowning.

- Implement effectively the project on health care for the elderly; expand and diversify health services for the elderly.

- Train skilled birth attendants and obstetric emergency response teams for hospitals, obstetric surgical teams for district hospitals; support district hospitals in disadvantaged areas to deliver comprehensive emergency obstetric care (i.e. caesarean section and blood transfusion).

- Improve statistical reporting forms in the program, determine causes of maternal mortality as a basis for recommending appropriate interventions for each area.
PART TWO. TOWARDS HEALTHY AGING IN VIETNAM
Introduction

1. International perspectives on healthy aging

1.1. General perspectives

- Population aging is a major trend in the 21st century and the increase in life expectancy marks an important achievement of human development. To ensure that people can live long and healthy lives, substantial changes to the organization and operation of the entire care delivery system are needed, particularly in the health care delivery system.

- Problems faced by older persons must be addressed in an integrated way: unfair treatment and stereotypes about older persons are one of the barriers to achieving a healthy aging society. Therefore, healthy aging requires strategic approaches to assist older persons.

- Improvement of the status, voice and contributions of older persons: it is necessary to mobilize the participation of the community of older persons in formulating healthy aging goals, raising awareness and capacity for implementation through exchange and dialogue at the national level.

- Instead of seeing older persons as an economic burden on society, managers should be made aware of long-term benefits and potential of older persons, particularly in the labor market.

1.2. WHO strategic intervention framework

According to the WHO intervention framework, the aging process across the life course extends over three phases as illustrated in Figure 7, including: (i) high and stable capacity, (ii) declining capacity; and (iii) significant loss of capacity [13]. On this basis, interventions to impact the aging process, increase intrinsic capacity and functional ability for achieving healthy aging can be divided into three categories taking place along the life course as follows:

1. **Health services**: including interventions to prevent chronic conditions or ensure early detection and control in the early phase of the aging process to reverse or slow declines in capacity in the second phase and manage advanced chronic conditions

2. **Long-term care** for older persons from around the middle of the second phase of aging (i.e. declining capacity): support capacity enhancing behaviors, ensure a dignified late life when older persons suffer from significant loss of capacity.

3. **Intervention in the cultural and social environments**: including interventions to promote capacity enhancing behaviors in the early stages of the life course, remove barriers to participation in socio-economic activities and compensate for loss of capacity in late life.

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11 Intrinsic capacity is the combination of the physical, emotional and cognitive capacity of each individual. Functional ability comprises the health related attributes that enable people to be and to do what they have reason to value. It is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interactions between the individual and these characteristics (Source: World Report on Aging and Health 2015)
Following this framework, Part Two of the JAHR 2016 report is entitled *Towards Healthy Aging in Vietnam*. It is comprised of five chapters: *Chapter IV*. Population aging and health status of older persons in Vietnam; *Chapter V*. Health care to meet the needs of older persons in Vietnam; *Chapter VI*. Long-term care of older persons in Vietnam; *Chapter VII*. Social environment to support healthy aging in Vietnam; and *Chapter VIII*. Priority issues and recommendations for solutions towards healthy aging in Vietnam.

**2. Vietnam’s policies on older persons**

**2.1. Existing legislation and policies on health care for older persons**

**2.1.1. Legislation on older persons**

The *Constitution* of the Socialist Republic of Vietnam has adopted various changes to articles relating to older persons over the years (Table 2). The 1946 Constitution had a general statement that all older persons would receive assistance. In 1980, the revised Constitution added the obligation of the State and entire society to assist older persons who lack family support. The 1992 revision to the Constitution stipulated that children of older persons shall take the primary responsibility for taking care of their parents while the State

12 In this report, we will generally use the term older persons to refer to people aged 60 and older, rather than elderly, except when there is ambiguity about the term older, and when the name of an organization or policy is known widely with the term elderly, rather than older persons.
and the entire society are responsible for taking care of older persons who lack family support. The latest revised Constitution (2013) stated that the State shall create equal opportunities for citizens to enjoy social welfare, develop the social protection system, and adopt policies to support older persons. Thus, the current Constitution does not limit the rights of older persons who lack family support, and facilitates the development of different forms of assistance for older persons.

Table 3. Constitutional provisions on the rights of older persons

<table>
<thead>
<tr>
<th>Year</th>
<th>Constitution’s provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1946</td>
<td>Aged or disabled citizens who cannot work shall get support (Article 14).</td>
</tr>
<tr>
<td>1980</td>
<td>Older persons without family support and people with disabilities shall be supported by the state and the society (Article 74).</td>
</tr>
<tr>
<td>1992</td>
<td>Children and grandchildren have the duty to respect and look after their parents and grandparents (Article 64). Older persons without family support, people with disabilities and orphans shall be supported by the State and the society (Article 67).</td>
</tr>
<tr>
<td>2013</td>
<td>The State shall create equal opportunities for citizens to enjoy social welfare, develop the social security system, and adopt policies to support older persons, people with disabilities, the poor, and other disadvantaged people (Article 59)</td>
</tr>
</tbody>
</table>

The Law on the Elderly (Law No. 39/2009/QH12 dated 23 November 2009) effective since 2010 stipulates that families shall take the prime responsibility for taking care of older persons. At the same time, the State has a policy to support poor older persons who lack family support and those aged 80 or older who have no retirement pension or do not benefit from any other social insurance or assistance payments. According to the Law, these groups of older persons are entitled to health insurance, monthly social assistance payments and payment of funeral and burial costs upon their death. Poor older persons, who lack family members to take care of them, and who lack resources to live in the community on their own, and who wish to live in a social protection establishment shall be entitled to the following additional benefits: provision of personal effects and articles for activities of daily living (ADLs),13 basic medicines, devices and equipment for functional rehabilitation. The Law also stipulates the option of authorizing other people to take care of older persons on behalf of the children or grandchildren who have this legal obligation. Articles of the Law also stipulate the policy about establishments providing care for older persons including social protection establishments, elder care counseling, elder care services and other facilities that care for older persons. The management of establishments providing care for older persons is the responsibility of MOLISA, not the MOH. Decree No. 06/2011/ND-CP and legal documents detailing and guiding the implementation of the Law’s provisions on health care and social care14 for older persons will be presented in Chapters VI and VII below.

2.1.2. Policies on care for older persons

The Vietnam National Action Program for the Elderly for the period 2012-2020 (Decision No. 1781/QD-TTg issued in 2012) aims to improve the quality of care for older persons; promote the social mobilization of care activities and promote the roles of older persons

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13 ADL—activities of daily living are self care tasks such as bathing and toilet hygiene.
14 Social care includes assistance with ADLs (like bathing, toileting, feeding), and assistance with IADLs (like going to market, cooking, managing use of medicines, financial management, etc.) and psychosocial support (like confiding, counselling, etc.)
in accordance with the potential and level of socio-economic development of the country. The Action Program has been translated into practice. Cultural and entertainment centers/facilities for older persons have been set up in provinces. At the same time, older persons participate in community activities, asserting their roles and position in the political, cultural, economic and social life of the country. Older persons have affirmed that “the aged are still capable” instead of what was previously believed, that “the aged are always incapable”.

The Health Care for the Elderly Project for the period 2017 - 2025 has been promulgated by the Minister of Health in Decision No. 7618/QD-BYT in 2017 with the objective “To meet older people’s needs for health care in accordance with population aging, contributing to the implementation of the Vietnam National Action Program for the Elderly, the Strategy for Population and Reproductive Health, the National Strategy for People’s Health Protection, Care and Promotion”. The Project is implemented nationwide through the following eight solutions:

- Enhance behavior change communication (BCC) and awareness raising, create an enabling environment for the society to participate in health care for older persons;
- Initiate and develop a “health care for older persons” campaign;
- Consolidate and complete the PHC and curative care delivery system for older persons;
- Develop and disseminate long-term care models for older persons;
- Develop human resources for health care for older persons;
- Improve the legal framework on health care for older persons, encourage and support enterprises, organizations and individuals to deliver health care to older persons;
- Perform research and boost international cooperation; and
- Consolidate and develop the system of statistical indicators on management of health care for older persons.

2.2. Major agencies and organizations assigned tasks related to care of older persons to achieve healthy aging

**Vietnam Association of the Elderly (VAE)** was established in 1994 following a Prime Ministerial decision, with the first Congress to establish the VAE organized in 1995. Chapter IV of The Law on the Elderly defines this Association as a social organization representing the aspirations, rights and legitimate interests of Vietnamese older persons. VAE is established on a voluntary basis and operates under the Constitution, the Law and VAE regulations.

VAE now has a wide network in all provinces and branches in all communes/wards throughout the country. It has actively participated in many social activities like development of policies and assistance regimes for older persons, implementation of social security policies for older persons, and establishment and development of different forms of clubs for older persons, thus contributing to improving the physical health and spiritual life of older persons. However, the quality and contents of VAE activities in several places is limited, failing to attract members and older persons to participate. Funding for VAE operations is limited [14].

**Vietnam National Committee on Aging (VNCA)** was established following Decision No. 141/2004 QD-TTg dated 5 August 2004. It is a multi-sectoral organization with the function of assisting the Prime Minister to direct and coordinate ministries, sectors, mass organizations and localities in handling matters related to older persons. In each province and district, there is a local working group on elderly affairs, responsible for studying, making proposals for
solutions and directing related organizations to deliver care for older persons.\textsuperscript{15} Members of VNCA and provincial working groups on elderly affairs work on a part-time basis and are formally assigned this responsibility in writing.

\textit{MOH} is clearly one of the ministries that plays an important role in delivering care to older persons. Specific tasks of MOH will be described in detail in Chapter V.

\textit{MOLISA} is the ministry with primary responsibility for matters related to older persons. The Social Protection Department is a unit under MOLISA, responsible for assisting the Minister in performing the state management of matters relating to older persons, people with disabilities, support to beneficiaries of social protection policies and poverty reduction in the whole country in accordance with the Law. The labor sector is also responsible for social protection establishments (residential care) and social work service centers as types of social assistance centers.

\textit{The Ministry of Culture, Sports and tourism} has an important role in helping older persons access sports, cultural, performance and tourism activities. These activities will be described in Chapter VII.

\textit{The Center for Aging Support and Community Development (CASCD)} is a humanitarian organization belonging to the Vietnam Red Cross Society, with the functions of: promoting community culture and responsibility of all organizations and individuals towards the community and society with humanitarian objectives; developing and implementing programs and projects to assist older persons and the community, with the aim of contributing to developing a humanitarian environment and strengthening the community.

\textit{HelpAge International in Vietnam (HAIV)} is the Vietnamese office of HelpAge International, a global network aimed at promoting the rights of older persons, helping older persons to have a dignified, healthy and safe life. HelpAge hopes to develop a world in which all older persons, both male and female, can confidently say that: “I have the income that I want”; “I have the highest health and quality of life possible”; “I feel safe, protected, and do not face discrimination or abuse” and “My voice is being heard.” HAIV continues to provide technical support for agencies and organizations who are concerned about population aging and older persons in Vietnam in their development of policies and models, as well as in their implementation of projects, with the primary model being the Inter-generational Self-help Club (ISHC) aimed at helping older persons to raise their incomes, improve their health, and strengthen their participation in social activities. HAIV has also piloted implementation of models for care of older persons in the community through the ISHCs, such as volunteers to provide care in the home and support care in the community.

A summary of the different roles of organizations contributing to healthy aging is presented in Table 4. The roles are categorized into health care, long-term care and social environment to correspond to Chapters V, VI and VII of Part Two of this report.

\textsuperscript{15} Ministry of Home Affairs Circular No. 08/2014/TT-BNV dated 19 September 2014 on the establishment of provincial and district working groups on elderly affairs.
Part two: Towards healthy aging in Vietnam

Table 4. Summary of the roles of organizations with contributions to healthy aging

<table>
<thead>
<tr>
<th>Organization</th>
<th>Protection of the rights of older persons</th>
<th>Healthcare/rehabilitation</th>
<th>Long-term care</th>
<th>Social environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNCA</td>
<td>Policies, coordination, supervision</td>
<td>Policies, coordination, supervision</td>
<td>Policies, coordination, supervision</td>
<td>Policies, coordination, supervision</td>
</tr>
<tr>
<td>VAE</td>
<td>Advise on policies, information, supervision</td>
<td>Collaborate with MOH on health care for older persons, physical activity to promote health through outdoor health clubs, ISHCs; Counselling and care model</td>
<td>ISHCs</td>
<td>70 000 VAE clubs, ISHCs, outdoor health clubs</td>
</tr>
<tr>
<td>MOH (including health facilities)</td>
<td>Health facilities, CHSs; IEC through Older persons help Older persons clubs</td>
<td>Volunteers of the counselling and care model, Older persons help older persons clubs</td>
<td>Older persons help older persons clubs</td>
<td></td>
</tr>
<tr>
<td>MOLISA</td>
<td></td>
<td></td>
<td>Social Protection Dept. and social assistance centers</td>
<td>Social Protection Dept., social assistance centers, Dept. of Labor and Wage</td>
</tr>
<tr>
<td>Ministry of Culture, Sports and Tourism</td>
<td>Physical exercise for improved health</td>
<td></td>
<td>Information, transport discounts, celebration of longevity</td>
<td></td>
</tr>
<tr>
<td>CASCD (under Vietnam Red Cross Society)</td>
<td></td>
<td></td>
<td>Volunteer caregivers in homes through ISHCs and paid care givers</td>
<td></td>
</tr>
<tr>
<td>Women’s Union</td>
<td>Physical exercise in ISHCs</td>
<td>Volunteer caregivers in homes through ISHCs</td>
<td>ISHCs and other clubs</td>
<td></td>
</tr>
<tr>
<td>HAIIV</td>
<td>Advice on policies, ISHCs</td>
<td>Advice on policies, ISHCs</td>
<td>Advice on policies, ISHCs</td>
<td>Advice on policies, ISHCs</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Policy advice and evaluation</td>
<td>Reproductive health of older persons</td>
<td>Volunteer caregivers in homes through ISHCs</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>Policy advice</td>
<td>International healthcare guidelines</td>
<td>ISHCs</td>
<td></td>
</tr>
<tr>
<td>Charitable and religious organizations</td>
<td></td>
<td></td>
<td>Social protection facilities</td>
<td>Spiritual life</td>
</tr>
<tr>
<td>Private care providers for older persons</td>
<td>Health facilities</td>
<td>Assisted living facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16 Previously known as RECAS.
Chapter IV. Population aging and health status of older persons in Vietnam

1. Population aging in Vietnam

1.1. Concepts

**Older persons**: according to the United Nations, older persons are individuals aged 65 years and older. In this report, older persons are defined as persons aged 60 and over as stipulated by the Vietnamese Law on the Elderly (Chapter 1, Article 2).

**Population aging stages**: there are 4 stages including “aging, aged, very aged, super-aged” depending on the proportion of older persons in the population. The division of stages is based on the definition of older persons. According to Cowgill and Holmes (1970) [15], a population is classified as “aging, aged, very aged, super-aged” when older persons (65 and over) account for 7 - 9.9%, 10 - 19.9%; 20 - 29.9% and more than 30% of the total population respectively. Some reports use 60 as a threshold for these categories. A population is classified as “aging” when persons aged 60 and over account for 10% of the total population; it is classified as “aged”, “very aged” and “super-aged” with the share of population aged 60 and over at 20%, 30% and 35% respectively [16].

**Aging process**: the number of years for the elderly share (aged 60 and older) of total population to increase from 10% to 20%, or for the elderly share (aged 65 and older) of total population to increase from 7% to 14% [17].

**The Aging index** reflects the structure of dependent population groups and is calculated as the number of persons aged 60 years old or over per hundred persons under age 15 [18].

**Dependency ratio** is the ratio of the population outside the labor force (i.e. 0 - 14 years old and 60 years of age and older) to the working age population (i.e. 15 - 59 years of age). It is usually calculated as the number of the persons outside the labor force per hundred working age population. This indicator can be decomposed into the child dependency ratio (number of children aged 0 - 14 per 100 persons aged 15 - 59) and the aged dependency ratio (number of persons aged 60 or more per 100 persons aged 15 - 59) and is often used to measure the pressure of the population on the labor force.

1.2. Characteristics of population aging in Vietnam

Over the past 50 years, thanks to improved life expectancy from 44.4 years in 1960 to 73.2 years in 2014, and reduced fertility rates from 7 children to 2.09 children per woman on average [19] the scale and age structure of the Vietnamese population have changed dramatically. In the period 1979 - 2015, the population increased from 53.7 million to 91.5 million people; at the same time, the number of older persons also increased from less than 4 million (6.9% of the total population) to 10.35 million (11.3% of the total population) respectively (Figure 8). Since 2012, Vietnam’s population is considered to be an aged population, as the number of people aged 60 and over reached 10.2% of the total population [20] and it will become a country with a very aged population in 2038 with the proportion of persons 60 years and older forecast to reach 20.1% [21]. It is projected that by 2049, older persons will account for approximately 25% of the population, i.e. one older person for every four persons in the population. It is forecast that the working age proportion of the population (15 - 59 years of age) will fall from 65% in 2015 to 57% by 2049.
Chapter IV. Population aging and health status of older persons in Vietnam

Figure 8. Vietnam’s age structure and the proportion of population aged 60 and older, 1979 - 2049

Population aging in Vietnam has similar characteristics to that occurring in other countries, at the same time it has some particularities.

Vietnam is one of the countries with the fastest pace of aging in the world

Figure 9 shows that the aging process in Vietnam will last only 26 years (2011 - 2037), similar to China - 27 years (2000 - 2027), Japan - 26 years (1970 - 1996) and much faster compared to developed countries such as France - 115 years (1865 - 1980), Sweden - 85 years (1890 - 1975), Australia - 73 years (1938 - 2012), and the United States - 68 years (1944 - 2012) [23]. The fast pace of aging reduces the time available to prepare for the challenges of population aging. Therefore, relevant and timely solutions are needed to ensure the well-being and to meet the rapidly growing needs of older persons.

Figure 9. Aging process in Vietnam, 2006 - 2049

The aging index is increasing quickly and the aged dependency ratio is increasing

The aging index of the Vietnamese population has increased 2.8 times in the period 1979 - 2015, from 17 to 47 (Figure 10). From now to 2049, the aging index will increase to 138, meaning there will be 138 persons aged 60 or over per hundred children aged under 15.

**Figure 10. Aging index, Vietnam, 1979 - 2049**

![Aging index, Vietnam, 1979 - 2049](chart)


Among ASEAN countries, Vietnam’s aging index (for the population aged 65 and over) is lower than that of only two countries, Singapore and Thailand, and is much higher than that of Laos, Cambodia and the Philippines (Figure 11) [25].

**Figure 11. Aging index (age 65+) of ASEAN nations, 2015**

![Aging index (age 65+) of ASEAN nations, 2015](chart)


The rapid increase of the aging index in recent years is mainly due to the decrease of the child dependency ratio. In the period 1979 - 2009, the aged dependency ratio remained quite
stable at around one older person per 10 working age people. However, the aged dependency ratio has begun to increase in recent years, reaching one older person for every 9 working age people in 2015 and is forecast to increase sharply in the coming time to one older person for every 6.2 working age people in 2029 and one older person for every 3.5 working age people in 2049 (Figure 12).

**Figure 12. Dependency ratio, Vietnam, 1979 - 2049**

![Dependency ratio chart]


**Aging occurs most rapidly in the oldest age group**

The changing age structure among older persons in Figure 13 shows that aging is occurring among older persons, with the most rapid aging occurring among the oldest group. The number of persons aged 80 and over has increased from 0.33 million (9% of the total elderly population) in 1979 to 1.95 million in 2015 (18.8%) and is forecast to reach 4.3 million (16% of the total elderly population) by 2049 [21].

**Figure 13. Age structure trends among older age groups in Vietnam, 1979 - 2049**

![Age structure trends chart]

Feminization of aging and increase in widowhood and older persons living alone

Feminization is occurring among older persons with a rising female proportion of the population as age increases. It is estimated that in 2014, the number of men per 100 women varied from 79 in the group aged 60 - 69 years to 63 in the group aged 70 - 79 years and only 52 in the group aged 80 and older (Figure 14). It is projected that by 2049, the number of men per 100 women will increase significantly in all age groups as the life expectancy of men will begin to increase after a long period of peace. However, the “feminization” pattern among older persons requires appropriate policies on care for older persons, since elderly women are more vulnerable to economic and social shocks [27].

Figure 14. Sex ratio by age group among older persons, 1979 - 2049

Along with feminization of aging is the high proportion of widows/widowers in the older population, especially for women. In 2011, this proportion was 36.1%, and it increases with age. The proportion widowed among women is 3.6 times higher than the proportion of widowers among men (50.7% versus 14%) (Table 5). This is mainly because the life expectancy of women is higher than that of men, hence the proportion of widows is higher than that of widowers, and because the remarriage rate among women is lower. This again focus attention on the need for policies to pay special attention to older aged women.

Table 5. Marital status of older persons, 2011

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Unit: %</th>
<th>Age group</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>60 - 69</td>
<td>70 - 79</td>
</tr>
<tr>
<td>Single</td>
<td>3.7</td>
<td>5.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Married</td>
<td>58.9</td>
<td>72.7</td>
<td>54.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>0.8</td>
<td>1.5</td>
<td>0.2</td>
</tr>
<tr>
<td>Separated</td>
<td>0.5</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>36.1</td>
<td>19.4</td>
<td>41.2</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: VNAS 2011 [28]

In this context, the proportion of older persons living alone or with an elderly spouse is increasing. Vietnamese people have a tradition of respecting older persons and living in
extended families, where older persons usually live with children and/or grandchildren and are taken care of when sick. However, the results from the Vietnam Household Living Standards Surveys (VHLSS) 2002 to 2012 show that there has been a change in the living arrangements for older persons in Vietnam (Figure 15). The proportion of older persons living with their children and/or grandchildren is decreasing as a result of the migration of younger people from rural to urban areas to study or to seek employment and a transition from extended families to nuclear families [16]. Accompanying these trends is an increase in the proportion of older persons living with their elderly spouse (from 13.6% to 21.6%) and older persons living alone (from 5.3% to 7.4%). This complicates delivery of care to older persons, requiring appropriate reorganization of health care service provision for older persons.

Figure 15. Living arrangements among older persons in Vietnam, 2002 - 2012

The Viet Nam Aging Survey 2011 indicated a significant age, gender and geographic variation in the living arrangements of older persons (Table 6). The proportion of older persons living alone increases as age increases; and is higher among women and in urban areas [19]. These older persons are more vulnerable because they do not have regular caregivers at home. Therefore, attention should be paid to the provision of social security and healthcare, which should meet the special needs of older persons living alone, especially older women in rural areas.

Table 6. Living arrangements among older people in Vietnam by age, sex and urban/rural residence, 2011

<table>
<thead>
<tr>
<th>Person(s) living with older persons</th>
<th>Total</th>
<th>Age group</th>
<th>Gender</th>
<th>Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>60 - 69</td>
<td>70 - 79</td>
<td>80+</td>
</tr>
<tr>
<td>Children</td>
<td>69.5</td>
<td>63.8</td>
<td>63.9</td>
<td>67.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>13.8</td>
<td>16.8</td>
<td>16.2</td>
<td>10.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>6.2</td>
<td>6.0</td>
<td>10.6</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandchildren</td>
<td>5.9</td>
<td>8.5</td>
<td>6.6</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other persons*</td>
<td>4.6</td>
<td>4.9</td>
<td>2.8</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *Older persons may live with other older persons, e.g. sisters/brothers, or even parents.
Source: VNAS 2011 [28]
Older persons mainly live in rural areas and this tendency increases with age

In 2015, about two thirds of older persons lived in rural areas. The population pyramids reflecting the urban and rural population (Figure 16) show that people aged 60 - 64 in urban areas account for 11.6% of the total elderly population, but in rural areas they account for 21.4%, that means this age group accounts for 33% of the total elderly population. The next age group accounted for approximately 20% of the total elderly population. The number of older people falls by half between the 60 - 64 and the 70 - 74 age groups, likewise between the 70 - 74 and the 85 and older age groups. Thus, the 85 and older age group accounts for only 8.9% of the total elderly population. While 35% of the 60 - 64 age group live in urban areas, the figure for the 85 and older age group is only 28%. The sex ratio (men per 100 women) in the 60 - 64 age group is 83 in urban areas and 85 in rural areas, while in the 85 and older age group the ratios are 53 in urban areas and 48 in rural areas. In brief, the older old are more concentrated in rural areas, where the gender gap is higher.

**Figure 16. Population pyramid for older persons by urban/rural residence, 2015**

Currently, the proportion of older persons in the population is relatively similar in urban and rural areas. However, according to population projections, by 2049 the proportion of older persons will triple in rural areas and double in urban areas compared to today, leading to an increase in the number and share of older persons living in rural areas. If we define older persons as 65 years of age or older, by 2049 the rural population will become super-aged (Figure 17).
Chapter IV. Population aging and health status of older persons in Vietnam

Figure 17. Projection of elderly share of the population by urban/rural residence compared to threshold of super-aged population, 2015 - 2049

Source: GSO-UNFPA Population Projections [21]

Older persons are more concentrated in delta regions

Figure 18 shows that there are three regions with less than 10% of the population aged 60 and older, including the Northern Midlands and Mountains, Central Highlands and Southeast. Of these, the Central Highlands and the Northern Midlands and Mountains have a lower share of older persons because they are poor regions with high fertility rate and low life expectancy. The Southeast has a low share of older persons because this region attracts many working age migrants. The remaining three delta regions, namely the Red River Delta, the North and South Central Coast and the Mekong Delta, have a higher share of older persons in the population, because the number of young out-migrants exceeds or equals the number of in-migrants. The Mekong River Delta has a particularly high net out-migration rate, resulting in an older population being left at home. There is almost no urban-rural difference currently in the elderly share of the population nationally.

Figure 18. Proportion of population aged 60 and older, 65 and older by region, 2015

Source: GSO-SPCFP 2015 [22]

A map of the aging index shows that the provinces with the highest levels of the aging index are not highly urbanized areas, but rather the out-migration areas in adjacent provinces (Figure 19). Thus, one sees that while Hanoi has an aging index towards the middle of the distribution, many of the rural Red River Delta provinces have levels of the aging index at the higher end of the distribution. This reflects the rural to urban migration of young people,
leaving older persons behind, often in skip-generation households where grandparents are caring for grandchildren. The situation is similar in Da Nang and HCMC, which all fall in the middle of the range of the aging index, and have neighboring provinces with higher levels of the aging index. The lowest level of the aging index is found in mountainous areas in the North and Central Highlands regions, where fertility is high and life expectancy is lower.

**Figure 19. Geographic variation in the aging index, 2015**

Aging Index

- 14 - 27 %
- 27 - 39 %
- 39 - 51 %
- 51 - 61 %
- Over 61 %

Source: GSO-SPCFP 2015 [22]
Chapter IV. Population aging and health status of older persons in Vietnam

2. Health status of older persons in Vietnam

2.1. Life expectancy and healthy life expectancy of older persons in Vietnam

2.1.1. Average life expectancy and average healthy life expectancy

Vietnam’s average life expectancy at birth in 2015 is 73.3 years (70.7 for men and 76.1 for women) - an increase of 0.1 years compared to 2014 as estimated by the General Statistics Office [22]. WHO estimates of healthy life expectancy (HALE) are 63.2 years for men and 70.0 years for women - an increase by 4 years for men and 5 years for women compared to 2000 [29]. According to WHO statistics, among the 10 ASEAN countries, Vietnamese men’s life expectancy ranks fifth and Vietnamese women’s life expectancy ranks second (after Singapore). HALE in Vietnam is high, for Vietnamese men it is only lower than HALE in Singapore and Brunei and for women it is lower than HALE in Singapore (Figure 20) [29]. Using WHO data, the difference between the life expectancy and HALE in Vietnam, i.e. the average number of years lived with disability, is relatively high compared to other countries. In Vietnam, the average number of years lived with disability was 11 for women and 8 for men.

Figure 20. Healthy life expectancy (HALE), average years lived with disability (YLD) and life expectancy at birth by sex among ASEAN nations, 2015

Source: WHO-GHO. [29]

2.1.2. Life expectancy and healthy life expectancy at age 60

Life expectancy (and HALE) at age 60 is the average number of years that a person at that age can expect to live (and live in good health). In 2015, life expectancy and HALE at

17 HALE = number of years of full health + number of years of illnesses x disease coefficient. Therefore, a person having a simple illness with low disease coefficient for many years may have the same number of years of full health as a person having a serious illness for a short time.
age 60 in the Vietnamese population were 19.5 years and 14.7 years respectively in men, 24.9 years and 18.4 years respectively in women [29]. The life expectancy at age 60 of Vietnamese women is the second highest, after Singapore (Figure 21). However, it includes an average of seven years of illnesses, equivalent to that of Cambodia. Life expectancy and HALE at age 60 among Vietnamese men are roughly equivalent to those of Brunei, Malaysia and Thailand. The discrepancy between life expectancy and HALE in Vietnamese men and women is relatively large. While women expect to live 25 more years from the age of 60, men expect to live only 19 more years, and both men and women have relatively many years living with disability.

Figure 21. Healthy life expectancy, average years lived with disability and life expectancy at age 60 by gender for ASEAN nations, 2015

Self-assessment of health status by older persons

Self-assessment of health status reflects subjective assessment of health. Although this indicator is not objective, it nevertheless measures an aspect of “well-being” of older persons. Results of self-assessed health among older persons have not changed much over recent years.

According to the Viet Nam Aging Survey 2011 in Vietnam,18 65.4% of older persons assessed their health status as sick or very sick, 29.8% as average and 4.8% as healthy or very healthy [28]. These results are equivalent to results from previous studies on older persons. Findings of a study conducted in 2000 in Hanoi showed that 65% of older persons assessed their health as unwell and 35% as average [30]. Another study of 1132 older persons in three provinces in 2006 revealed that 53.5% of older persons assessed themselves as being sick or very sick [31]. A study conducted in 2007 of 2878 older persons in 72 communes, in 8 provinces representing 8 socio-economic regions across the country, showed that 41.97% of older persons assessed themselves as sick, 52.71% as average health and 5.32% as healthy [32].

18 With a sample size of 2789, selected to be nationally representative of older persons.
Results of the self-assessments of health status of older persons varied by age, sex and urban/rural residence (Figure 22). Higher ages, female sex and rural residence seem to be associated with self-assessment among older persons of health status as sick or very sick more often than other groups [28].

**Figure 22. Self-assessment of health among older persons in Vietnam by demographic and geographic characteristics, 2011**

Label in figure indicates the share reporting weak and very weak health

<table>
<thead>
<tr>
<th>Category</th>
<th>Very weak</th>
<th>Weak</th>
<th>Average</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>62%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>64%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>55%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80+</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-79</td>
<td>68%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>60-69</td>
<td>58%</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: VNAS 2011 [28]

**2.3. Impairment of basic capacities and functions**

The aging process is associated with a weakening in the intrinsic capacity of older persons. During the personal aging process, many people lose basic functions such as vision, hearing, mobility, or cognition. According to results of the Population and Housing Census 2009, approximately 40% of male and 46% of female older persons reported having difficulties with at least one of these four functions, while 24% of male and 31% of female older persons indicated difficulties with two or more of these functions (Figure 23) [33]. The share of older persons with disabilities is higher among women than men, mainly because they live longer than men on average. The following section will analyze, in detail, the situation of disability in the Vietnamese elderly population.
When intrinsic capacity is weakened, older persons need care from family and society to ensure functional abilities. However, results of the Population and Housing Census 2009 show that 10% of older persons experiencing some level of disability are living alone and about 20% live with only one other person (Figure 24) [33]. However, among older persons with severe disabilities or inability to perform basic functions, the proportion living alone is nil, while the proportion living with only one other person was quite small.

Source: UNFPA 2011 [33]
2.3.1. Visual impairment

In 2009, about 28% of male and 34% of female older persons reported visual impairments, while less than 1% of male and female older persons were blind. The percentage of older persons encountering visual impairments increases with age, from 19.45% in the 60 - 69 age group to 34.8% in the 70 - 79 age group and 54.7% in the 80+ age group [24]. The Viet Nam Aging Survey 2011 found that more than 60% of older persons reported that they could not see well without prescription glasses. Results of eye examinations showed that 76.7% of older persons had poor vision without correction with prescription lenses. Poor vision increased with age, from 70.3% in the 60 - 74 age group to 93% in the 75+ age group [28]. According to a study of the burden of disease, vision loss accounted for 1.8% of the total lost DALYs of older persons, of which refraction and accommodation disorders accounted for 44%, cataracts 40% and other disorders 16% (Figure 25). Among people with vision disorders, older people account for a high share; among people with cataracts, 80% are older persons, with glaucoma 77% are older persons and macular degeneration 82% are older persons [34].

Figure 25. Structure of vision-related burden of disease (DALYs) among older persons in Vietnam, 2015

Cataracts is a common eye disease in older persons in Vietnam. According to the National Ophthalmology Hospital, up to 70% of blind people in Vietnam suffer from cataracts [27]. The National Geriatric Hospital estimates that 57.9% of older patients have cataracts (49.3% in the 60 - 74 age group and 79.6% in the 75 and older group) [35]. The Viet Nam Aging Survey 2011 found that 10.3% of older persons reported being diagnosed with cataracts with an increasing prevalence as age increases: from 5.2% in the 60 - 69 age group to 17.9% in the 80 and older age group [28]. Older persons lack knowledge about eye disorders; up to 35% of people who become blind due to cataracts do not know they have this disease or that it is curable [27].
2.3.2. Hearing impairment

A study conducted in 2009 estimated that 40.1% of older persons suffered from hearing loss [27]. According to the Population and Housing Census 2009, approximately 21% of the male and 25% of the female elderly reported difficulties in hearing. This proportion increased with age, from 10.4% in the 60 - 69 age group to 25.6% in the 70 - 79 age group and 54.5% in the 80 and older age group [16]. Similar findings were noted in the Viet Nam Aging Survey 2011, with the proportion of older persons unable to hear well without a hearing aid increasing from 19.5% in the 60 - 69 age group to 37.2% in the 70 - 79 age group and over 50% in the group aged 80 and older. The trend of visual loss and hearing loss among both elderly men and women is relatively similar [28]. According to Vietnam results in the global burden of disease study, about 3.3% of the burden of disease measured in DALY’s is caused by hearing loss due to old age; the higher the age, the higher the burden of disease associated with hearing loss [34]. However, the current health insurance benefit package in Vietnam does not cover prosthetics, eyeglasses, or hearing aids.

2.3.3. Mobility impairment

A study on health care for older persons in seven provinces in Vietnam from 2005 - 2006 showed relatively good mobility of older persons, with 90% able to walk normally around the house and 79% around the village. Those with mobility difficulties were mostly very old or in poor health [31]. Findings of the Population and Housing Census 2009 shows that mobility difficulties affected approximately 22% of male and 29% of female older persons (Figure 23 above) [33]. The Viet Nam Aging Survey 2011 uses a more complex definition of “mobility difficulties” compared to the two surveys mentioned above. According to this survey, 71.6% of older persons reported having at least one difficulty in mobility. The most difficult motor actions for older persons were standing up from a sitting position (54.2%), stepping up or down stairs (52.1%) and sitting or squatting (50.9%) [28]. The degree of difficulty increased with age (Figure 26). In general, women experience more mobility difficulties than men, probably because they have longer life expectancy on average. There was no big urban-rural difference in the degree of mobility difficulty.

Figure 26. Difficulties in mobility among older persons in Vietnam by age group, 2011

Source: VNAS 2011 [28]
2.3.4. Cognitive impairment

Memory loss is a common symptom in older persons. According to the Population and Housing Census 2009, 19% of male and 26% of female older persons had difficulties in concentrating and remembering. The Viet Nam Aging Survey 2011 found that 47.9% of older persons thought they had poor/very poor memory, 36.6% thought they had normal memory, only 15.5% thought they had good memory. The proportion of older persons reporting having poor/very poor memory was higher in women than in men (51.1% versus 42.9%), and higher among rural than urban residents (51.5% versus 39.7%) [28].

2.3.5. Impairment of ability to perform activities of daily living

The Viet Nam Aging Survey 2011 also found that 37.6% of older persons encountered at least one difficulty in activities of daily living (ADLs). This proportion was higher in women than in men (39% vs. 35%) and was up to 50% in the 80 and older age group [28]. The most prevalent difficulty for older persons was sitting up from a lying down position (30.8%), while the least prevalent difficulty was bathing/washing and dressing/undressing (12.9%). However, the degree of difficulty in daily activities increased with age (Figure 27). For example, less than 10% of persons aged 60 - 69 had difficulties in bathing, walking and toileting while the figure for persons aged 80 and older was nearly 30%. The proportion of women experiencing at least one difficulty in daily activities was higher than that of men (39% versus 35%) [28].

Figure 27. Impairment in performing ADLs among older persons in Vietnam, 2011

Source: VNAS 2011 [28]
2.4. Burden of disease

In addition to morbidity and mortality, the burden of disease is usually measured by \textit{Disability-Adjusted Life Years} (DALY). The concept, definition and calculation of DALYs is illustrated in Figure 28. Each person has the potential to live a healthy life until the average life expectancy of society. However, there are people who die before reaching average life expectancy, or suffer from illnesses or reduced functioning leading to loss of some years of full health. The sum of the years of life lost due to disability, illnesses and premature death is called DALY, and is calculated for each disease. The following analysis will primarily use this concept as a measure of the burden of disease in older persons.

\textbf{Figure 28. Explanation of concepts about DALYs}

\[
\text{DALY} = \text{YLD} + \text{YLL}
\]

Cumulative number of years lost due to ill-health, disability or early death

Years lived with disability

Years of life lost

Healthy life

Disease or disability

Early death

Expected life years

Source: Adjusted from original found in “DALY disability adjusted life year infographic.png”; CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=20278903

Causes of the burden of disease for older persons can be divided into three major groups: (i) communicable diseases and nutrition disorders; (ii) NCDs; and (iii) accidents and injuries. Figure 29 shows that the burden of disease in older persons in Vietnam is mainly caused by NCDs, accounting for 87 - 89% of DALYs and 86 - 88% of deaths, depending on the age group. The higher the age is, the greater the vulnerability to disease and death. The 60 - 69 age group has a population two times larger than that of the 70 - 79 age group, but the number of DALYs is only 1.35 times higher. Meanwhile, the 80 years and older age group has a population much smaller than that of the 70 - 79 age group, but has a higher number of DALYs and a mortality rate 2.5 times higher.

\textbf{Figure 29. Main causes of DALYS and death among older persons in Vietnam, 2015}

Source: IHME-Vietnam GBD data 2015 [34]
The number of older persons in 1989 was 4.6 million, increasing 1.35 times to 6.2 million in 1999 and rising a further 1.67 times to 10.3 million in 2015. At the same time, DALYs also increased but at a slower pace: increasing only 1.23 times in the period 1990 - 2000 and 1.19 times in the period 2000 - 2015. Figure 31 shows that the increase of DALYs in older persons is mostly due to NCDs.

**Figure 30. Trends in DALYs by main disease group among older persons aged 60 and older in Vietnam, 1990 - 2015**

When DALYs are used to calculate the burden of disease, prolonged illnesses, diseases that cause severe functional impairments and highly prevalent diseases will account for a large proportion, while acute illnesses (cured quickly) and rare diseases (including those causing functional impairments) will only account for a small proportion. Figure 31 shows that among NCDs in Vietnam, cardiovascular diseases (predominantly stroke and ischemic heart disease with hypertension as a risk factor) cause the biggest burden of disease in older persons. The burden of disease from cardiovascular conditions increases with age, accounting for 26% of all DALYs in the 60 - 69 age group, 33% in the 70 - 79 age group and 38% in the 80 and older age group. The second highest disease burden results from cancer (especially cancer in the lung and trachea, liver, stomach, and colon), with burden of disease gradually declining as age increases. Other major causes of the burden of disease include chronic lung diseases, mental disorders and neurological diseases (including Alzheimer’s disease and depression), endocrinological and urological disorders (diabetes mellitus, chronic renal failure), musculoskeletal disorders (back pain, neck pain), sense organ disorders (hearing impairment, visual impairment) and other NCDs (liver cirrhosis, digestive, gynecological, andrological, dermatologic diseases, etc.)
Figure 31. Patterns of cause of burden of disease measured in DALYS among older persons in Vietnam, 2015

Source: IHME-Vietnam GBD data 2015 [34]

Figure 32 shows the pattern of causes of death in older persons, which are slightly different from causes of DALYs because many diseases create considerable burden of disease due to functional impairment, but rarely lead to death, e.g. musculoskeletal disorders and mental disorders, while some acute diseases cause a high risk of death but do not cause long-term disabilities. The condition causing the highest mortality in all three age groups is cardiovascular disease, with mortality increasing with age. In this group of diseases, deaths are mainly related to stroke (hemorrhagic) and ischemic heart disease in the 60 - 69 age group, and stroke (ischemic) in the 80 and older age group. One third of the mortality in the 60 - 69 age group is related to cardiovascular disease, while this figure for the 80 and older age group rises to 46%. Cancer remains the second leading cause of death, especially cancer of the lung and trachea. Communicable diseases, predominantly pneumonia and tuberculosis, chronic lung diseases (mainly COPD), neurodegenerative diseases (e.g. Alzheimer’s disease), and endocrinological and urological disorders (diabetes mellitus and chronic renal failure) are common causes of death in people 80 years and older. Deaths due to injuries among older persons are generally related to falls rather than traffic accidents, and are more common among the oldest age group.
Chapter IV. Population aging and health status of older persons in Vietnam

2.5. Illnesses and diseases in older persons

2.5.1. Common symptoms/diseases of older persons in the community

Older persons in Vietnam often suffer from NCDs and multiple co-morbidities. Findings of a survey of 1305 older persons in three communes of the north, central and south regions in 2007 showed that on average an older person had 2.69 diseases with the common diseases being the following (in decreasing order): sense organ diseases, cardiovascular diseases, musculoskeletal disorders, endocrine and metabolic diseases, digestive diseases, neurological diseases, respiratory diseases, and urinary tract diseases [27]. Another study in 2015 found high rates of comorbidity among older persons, for persons aged 80 years and older, on average they had 6.9 medical conditions [36].

The Viet Nam Aging Survey 2011 found that joint pain, dizziness and headache were the most common symptoms reported by older persons, followed by cough, respiratory difficulties and chest pain with a higher prevalence in the 80 and older age group and in women [28]. The survey also found that 46% of older persons had been diagnosed with hypertension and 34% with arthritis and prevalence tended to increase with age. Others such as cardiovascular, dental diseases, bronchitis or chronic lung diseases were also common in older persons, with the prevalence approximately 20% for each of these diseases. Female older persons have higher prevalence of hypertension, arthritis and heart disease than men. Bronchial diseases and chronic lung disease are more common in the rural elderly [28]. Findings of the HSPI Household Health Survey in 2015, with a nationally representative sample, also found that the most common conditions reported by older persons were hypertension (30%); musculoskeletal diseases (10%) and respiratory diseases (7.6%) [37].
2.5.3. Disease pattern of elderly patients at health facilities

The two most common diseases in older persons visiting health facilities from commune to central levels were hypertension and acute bronchitis. These are two common diseases that require management (hypertension) or examination and treatment (acute respiratory infection). Diabetes mellitus is one of the 10 most common diseases in elderly patients visiting hospitals at district and higher levels. Other diseases which are also common in older persons visiting health facilities include duodenal gastritis, cardiovascular diseases, and musculoskeletal disorders [35,38].

In 2008 at the National Geriatric Hospital - the leading specialist health care provider for older persons - the 10 most common diseases of older persons accounted for 56.9% of the total patients visiting the hospital. Among these common diseases, only two were communicable diseases (pneumonia and bronchitis) accounting for nearly 10% of total patients. Patients with cardiovascular diseases accounted for the highest proportion, including: stroke (21.9%), hypertension (7.7%), and heart failure (2.4%). The other common diseases found were diabetes mellitus, COPD, Parkinson’s disease, vestibular syndrome and osteoporosis (Figure 33). There are significant differences in the disease patterns of male and female patients at the hospital. Endocrinological and metabolic disorders, musculoskeletal disorders and diseases of ear and mastoid process were more common in women, while respiratory disease, cancer, and urinary tract disease were more common in men [35].

Figure 33. Morbidity patterns among elderly patients treated at the National Geriatric Hospital, 2008

At the grassroots level, a survey conducted in four provinces in 2014 showed that the 10 most common diseases alone accounted for 84% of the total elderly patients at the commune level; and 52% of outpatients and 45% of inpatients at the district level (Figure 34). Some groups of disease are common in both types of facility and both types of services. The most common disease was hypertension, accounting for 49.5% of total elderly patients at the commune level, 15.4% of outpatients and 12.5% of inpatients at district hospitals. Prevalence of communicable diseases - predominantly acute respiratory infection, influenza, gastritis and duodenitis - is also high in older persons, accounting for 22.1% of total elderly patients at
the commune level, and 16.4% of outpatients and 15.4% of inpatients at district hospitals. Musculoskeletal disorders are also common, accounting for 6.1% of elderly patients at the commune level, 9.4% of outpatients and 5.0% of inpatients at district hospitals. In addition, vestibular dysfunction and other soft tissue disorders are among the 10 common diseases in older persons at the commune level; diabetes and vestibular dysfunction (in outpatients), heart failure, COPD and neuro-gastrointestinal diseases (in inpatients) were among the 10 common diseases in older persons at the district level [38].

Figure 34. Morbidity patterns among older persons seeking curative care by level of facility, 2014

Note: Data are from 4 provinces (Hoa Binh, Binh Dinh, Gia Lai and Dong Thap). Each province provided data for 2 district hospitals and 4 CHSs. Hospitals in the same group are combined.

Source: Survey of the Health Financing Governance project (HFG) on use of the health insurance fund in 6 provinces in 2014. [38]

2.5.4. Common chronic diseases in older persons

**Hypertension and cardiovascular diseases**

Hypertension is considered a disease but is also a risk factor for other diseases, especially cardiovascular diseases. Hypertension is a common health problem and prevalence tends to increase with age. At the same time, cardiovascular diseases accounted for the highest share of the disease burden of older persons in Vietnam. Globally in both developed and developing countries, the prevalence of hypertension in older persons is usually above 50%, or as high as 80%. For example, the prevalence of hypertension in people aged 60 and older in the United States in 1999 - 2004 was 67% [39]. The prevalence of hypertension among older Vietnamese
people is slightly lower than that of countries in the region but the difference is not significant, e.g. the prevalence in rural areas of Malaysia is 54.5% [40], in China is 59.4% [41] in Singapore is 74.1% [42].

Table 7 summarizes results of some studies on the prevalence of hypertension in older persons in Vietnam. The table shows that the actual prevalence of hypertension is higher than the proportion of older persons diagnosed with hypertension and those self-reporting this disease because many older persons with hypertension have not been diagnosed. However, when comparing statistics in 2001 and 2015, the proportion of older persons with known hypertension status increased substantially. Hypertension rates increase with age. Most studies on hypertension in older persons in Vietnam show that nearly 50% require daily disease management. The prevalence of hypertension among patients in the National Geriatric Hospital study is very low. There are many possible reasons for this, for example cardiovascular patients may tend to go to cardiology hospitals for medical examination and treatment instead of to geriatric hospitals; or among patients examined and treated at the geriatric hospitals many hypertension patients may be effectively managing their blood pressure through medication, so hypertension is not recorded in the diagnosis.

Table 7. Summary of study findings on hypertension in older persons in Vietnam, 2001 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>% diagnosed with hypertension</th>
<th>% reporting to have hypertension</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 - 2002</td>
<td>Age group</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>55 - 64</td>
<td>36.6%</td>
<td>35.3%</td>
<td></td>
</tr>
<tr>
<td>65 - 74</td>
<td>50.0%</td>
<td>49.2%</td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td>55.8%</td>
<td>62.3%</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>16 - 20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>7.7% (National geriatric hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>45.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>52.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>- Patients at CHSs: 49.46%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Outpatients at district hospitals: 15.36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Inpatient at district hospitals: 12.52%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>64.25%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypertensive heart disease is a specific disease in the ICD-10 classification. According to assessment of the burden of disease, the disease itself only accounts for 1 - 2% of the total DALYs of older persons in Vietnam. However, hypertension is also a risk factor for many serious diseases, such as ischemic heart disease, stroke and renal failure. As a risk factor, hypertension
is associated with 23% of burden of disease among older persons measured in DALYs [34]. Hypertension as a risk factor will be analyzed in the section on NCD risk factors.

Hypertension management aims to reduce the burden of cardiovascular disease. The burden of disease due to cardiovascular disease (predominantly ischemic heart disease and stroke) tends to increase with age (Figure 35), from approximately 25% of the burden of disease in the 60 - 64 age group to about 38% in the 80 and older age group. In the period 1990 - 2015, there was no significant change in the prevalence of cardiovascular diseases except for the 80 and older age group. In 1990, cardiovascular diseases accounted for 35% of total DALYs but by 2015 this had increased to 38%. It is estimated that the total number of deaths from cardiovascular disease in older persons aged 60 and over is 188,917, accounting for 42.8% of the total deaths in older persons [34].

Figure 35. Trends in burden of disease due to cardiovascular disease among older persons in Vietnam by age, 1990 - 2015

Note: Cardiovascular disease includes also cerebrovascular disease and coronary artery disease.

Diabetes mellitus

The prevalence of diabetes in older persons varies widely among studies so it is difficult to detect trends over time. According to studies in Vietnam, the lowest diabetes prevalence estimate in older persons is 4.15% and the highest is 14.59% (Table 8). The prevalence of diabetes in older persons falls as age increases. Prevalence is higher in women than in men, in urban residents than in rural residents, among delta residents than among midlands and mountains area residents, and in the Kinh majority than in ethnic minority people. Diabetes prevalence found in Vietnam is mostly lower than rates found in other countries [45].

19 It is estimated that 6.3 million DALYS in Vietnam are due to NCDs, of which 1.4 million DALYs have hypertension as a risk factor.
Table 8. Summary of research findings on prevalence of diabetes among older persons in Vietnam, 2004 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Diabetes prevalence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>7.8% in mountainous areas; 8.2% in delta; 7.9% in midlands and 13.4% urban areas</td>
<td>Ta Van Binh (2005) [46]</td>
</tr>
<tr>
<td>2008</td>
<td>4.15% (55+ years old)</td>
<td>Hoang Dang Mich (2008) [47]</td>
</tr>
<tr>
<td>2009</td>
<td>5.7% (60 - 74 years old) 4.2% (75+ years old)</td>
<td>Pham Thang and Do Thi Khanh Hy (2009) [27]</td>
</tr>
<tr>
<td>2011</td>
<td>General: 6.1% 6.5% (60 - 69 years old); 6.0% (70 - 79 years old) and 5.3% (80+ years old) 5.0% in men and 6.8% in women 10.1% in urban areas and 4.2% in rural areas 7.0% in the North; 3.6% in the Center; 6.5% in the South</td>
<td>Viet Nam Aging Survey 2011 [28]</td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>4.15% - 8.2% (5.8%)</td>
<td>Tran Van Long (2015) [45]</td>
</tr>
<tr>
<td>2014</td>
<td>7.91% (outpatients at district hospitals)</td>
<td>USAID-HFG, 2014. [38]</td>
</tr>
<tr>
<td>2015</td>
<td>- General: 14.59%; 16% (60 - 79 years old) and 9.05% (80+ years old) 20.69% in urban areas; 9.92% in rural areas 15.04% in Kinh ethnicity; 7.03% in ethnic minorities</td>
<td>HSPI (2016) [37]</td>
</tr>
</tbody>
</table>

Diabetes accounts for 3 - 7% of the total burden of disease in older persons in Vietnam measured in DALYs. The burden of disease caused by diabetes has increased markedly over time and is higher in the 60 - 69 age group than in the 70 and older age group (Figure 36). In 2015, an estimated 22.4 thousand Vietnamese older persons died of diabetes [34].

Figure 36. Trends in burden of disease due to diabetes among older persons in Vietnam by age group, 1990 - 2015

![Figure 36. Trends in burden of disease due to diabetes among older persons in Vietnam by age group, 1990 - 2015](image)

Source: IHME-Vietnam GBD data 1990, 2000, 2015 [34]
Chapter IV. Population aging and health status of older persons in Vietnam

**Musculoskeletal disorders**

Musculoskeletal disorders or symptoms are also common in older persons. While the proportion of older persons diagnosed with arthritis is about 34%, the proportion of older persons reporting back pain and joint pain varies from 20% to 69% (Table 9). Arthritis prevalence is higher in women than in men. There is no significant difference in the prevalence of musculoskeletal disorders/symptoms among age groups [28,37].

**Table 9. Summary of research findings on prevalence of musculoskeletal disorders in the Vietnamese elderly, 2000 - 2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Proportion of older persons reporting musculoskeletal conditions</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>53% have musculoskeletal symptoms</td>
<td>Geriatrics hospital (2000) [30]</td>
</tr>
<tr>
<td>2010</td>
<td>40.62% have musculoskeletal symptoms</td>
<td>Dam Huu Dac et al (2010) [48]</td>
</tr>
<tr>
<td>2011</td>
<td>69% have back pain; 68% have joint pain (self-reporting of health status over the last 30 days) 34.1% (40.4% of women and 24.7% of men) have arthritis</td>
<td>Viet Nam Aging Survey 2011 [28]</td>
</tr>
<tr>
<td>2015</td>
<td>19.41% musculoskeletal diseases/symptoms over the last 4 weeks</td>
<td>HSPI (2016) [37]</td>
</tr>
</tbody>
</table>

Figure 37 shows that lower back pain accounts for more than one third (36%) of the burden of disease due to musculoskeletal disorders in older persons in Viet Nam, followed by neck pain (22%), osteoarthritis (15%), rheumatoid arthritis (3%) and gout (2%).

**Figure 37. Structure of burden of disease (DALY) due to musculoskeletal disorders among older persons in Vietnam, 2015**

The burden of musculoskeletal disorders is mainly due to disability. The burden of musculoskeletal disorders is lower among older age groups. Over time, the burden of disease due to musculoskeletal disorders is increasing especially in younger old-age groups (Figure 38). In the years 1990 and 2000, musculoskeletal disorders accounted for less than 7% of the
total DALYs of older persons aged 60 - 64, in 2015 this share has increased to 8%. But the total DALYs due to osteoarthritis in the older age groups, particularly in the 80 and older age group, were slightly higher. Musculoskeletal disorders only caused a small proportion of deaths in older persons in 2015 (an estimated 354 deaths, accounting for less than 1% of the total deaths to older persons) [34].

**Figure 38. Trends in burden of disease due to musculoskeletal disorders among older persons in Vietnam by age group, 1990 - 2015**

![Figure 38](image)

Source: IHME-Vietnam GBD data 1990, 2000, 2015 [34]

**Chronic lung diseases**

Common chronic lung diseases in Vietnam include COPD and asthma. The prevalence of chronic lung diseases in older persons is relatively high, between 10% and 20% (Table 10). There is no clear trend in the prevalence of chronic lung diseases by age. One study shows that prevalence increases with age, while another finds that it falls.

**Table 10. Summary of study findings on COPD in the Vietnamese elderly, 2000 - 2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>16.6% (60+ years old); 13.2% (60 - 69); 19.9% (70 - 79); 18.4% (80+) diagnosed with acute and chronic respiratory diseases</td>
<td>Viet Nam Aging Survey 2011 [28]</td>
</tr>
<tr>
<td>2015</td>
<td>8.1% (40+)</td>
<td>Nguyen Viet Nhung et al. (2015) [49]</td>
</tr>
<tr>
<td>2015</td>
<td>14.53% (60+); 15.42% (60 - 69); 14.74% (70 - 79); 11.2% (80+) (reporting to have respiratory symptoms over the last 4 weeks)</td>
<td>HSPI (2016) [37]</td>
</tr>
</tbody>
</table>

Chronic lung diseases cause a substantial burden of disease, accounting for about 5.5% of total DALYs of people aged 60 - 64 and nearly 9% in the 80 and older age group (Figure 39). COPD accounted for 68% of the total DALYs from lung disease, asthma 24% and other
diseases 8%. In 2015, there were an estimated 35.3 thousand deaths associated with chronic lung diseases [34].

**Figure 39. Trends in burden of disease due to chronic lung disease among older persons in Vietnam by age group, 1990 - 2015**

Source: IHME-Vietnam GBD data 1990, 2000, 2015 [34]

**Cancer**

Community surveys show that about 1.1% of older persons in Vietnam suffer from cancer. This rate is higher in the 70 and older age group, in men and in urban areas compared to rates in the 60 - 69 age group, in women and in rural areas respectively [28]. The prevalence of neoplasms among elderly patients at the National Geriatric Hospital in 2008 was 6.4% [35]. Although cancers are relatively common in older persons, there are very few studies on prevalence of different types of cancer.

According to estimates of GLOBOCAN, approximately 38.6 thousand Vietnamese older persons were diagnosed with cancer of all types in 2012, with the incidence among men 1.5 times higher than among women [50].20 Figure 40 shows that lung cancer, liver cancer and stomach cancer are the three most common types of cancer in both genders, accounting for half of all cancer cases in women and nearly three quarters in men. In addition, breast cancer and cervical cancer cases account for nearly a fifth of the incidence in women. The number of deaths due to cancer in 2012 was approximately 40 000 according to GLOBOCAN statistics and about 73 000 as estimated by IHME. Since cancer in Vietnam is often detected in late stages, the pattern of cancer mortality resembles that of cancer incidence.

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20 Vietnam’s cancer incidence estimates are aggregated from the cancer registration data in Hanoi and HCMC combined with data on cancer associated mortality in rural areas and estimated incidence based on a survival analysis model.
Figure 40. Structure of cancer types among older persons in Vietnam, 2012

Cancer contributes about 20% of DALYs in older persons aged 60 - 64. This share falls in older age groups, since many other diseases affect their health. However, the burden of disease due to cancer in older persons is increasing over time in each age group (Figure 41).

Figure 41. Trends in burden of disease due to cancer among older persons in Vietnam by age group, 1990 - 2015

Source: IHME-Vietnam GBD data 1990, 2000, 2015 [34]

Neurological and mental disorders

Neurological disorders include common diseases like Alzheimer’s disease, Parkinson’s disease, epilepsy, and migraines. Mental disorders include conditions like depression, anxiety, schizophrenia and alcohol-related mental disorders. These diseases are relatively common in older people in Vietnam. Some mental disorders affected by lifestyle, such as mental decline and depression are on the rise and the proportion of older persons with these disorders is increasing with age.
Table 11 summarizes study findings on neurological diseases and mental disorders in the Vietnamese elderly population. Prevalence of depression varies from 0.5% to 2.3% depending on the study, and tends to increase with age. As for dementia, the prevalence ranges from about 3% to 10%, and clearly increases with age. Dementia prevalence is higher in women and in rural residents than in men and in urban residents. The prevalence of Parkinson’s disease is estimated to be 1.3% and the prevalence of memory loss (severe status of dementia) is 0.78%.

Table 11. Summary of study findings on prevalence of neurological diseases and mental illnesses in the Vietnamese elderly, 2000 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Disease/illness</th>
<th>Prevalence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Depression</td>
<td>1.2%</td>
<td>Pham Thang (2007) [51]</td>
</tr>
<tr>
<td>2009</td>
<td>Depression</td>
<td>0.8% (60 - 74 years old) and 2.3% (75+)</td>
<td>Pham Thang &amp; Do Thi Khanh Hy (2009) [27]</td>
</tr>
<tr>
<td>2011</td>
<td>Depression</td>
<td>0.5%</td>
<td>Viet Nam Aging Survey (2012) [28]</td>
</tr>
<tr>
<td>2000</td>
<td>Dementia</td>
<td>7.9% (Thai Nguyen)</td>
<td>Tran Viet Nghi et al. (2001) [52]</td>
</tr>
<tr>
<td>2005</td>
<td>Dementia</td>
<td>4.63%; increased by 1.78 times among age groups of 5-year difference</td>
<td>Nguyen Ngoc Hoa (2006) [53]</td>
</tr>
<tr>
<td>2007</td>
<td>Dementia</td>
<td>4.9% (60 - 74 years old) and 9.8% (75+), 3.9% (male) and 5.7% (female)</td>
<td>Pham Thang (2007) [51]</td>
</tr>
<tr>
<td>2009</td>
<td>Mental impairment</td>
<td>2.9% (60 - 74 years old) and 9.8% (75+)</td>
<td>Pham Thang &amp; Do Thi Khanh Hy (2009) [27]</td>
</tr>
<tr>
<td>2010</td>
<td>Dementia</td>
<td>5.1% (rural) and 3.2% (urban)</td>
<td>Le Van Tuan (2010) [54]</td>
</tr>
<tr>
<td>2005</td>
<td>Memory loss</td>
<td>0.78%</td>
<td>Nguyen Kim Viet (2005) [55]</td>
</tr>
<tr>
<td>2007</td>
<td>Parkinson’s disease</td>
<td>1.3%</td>
<td>Pham Thang (2007) [51]</td>
</tr>
</tbody>
</table>

Dementia can be caused by various reasons, with Alzheimer’s disease accounting for 60 - 80%, followed by brain damage due to stroke [56]. Clinical manifestations of dementia include diverse symptoms but the most prominent one is decline in memory. An important feature of dementia is that it progresses slowly, with day to day declines in functioning, and it is irreversible. Alzheimer’s disease is a disease of the brain that severely affects memory, thinking and behavior. Patients lose their cognitive and intellectual ability over a period of two to ten years. Finally, the patients lose all of their ability for independent living, become completely dependent on others, and they often die of infections [55].

The burden of neurological diseases and mental illnesses is mainly due to years of life lost due to disability, with Alzheimer’s disease (memory loss) accounting for more than half of the burden of disease from neurological and mental illness in Vietnam (Figure 42). In 2015, an estimated 23 000 people died from Alzheimer’s disease, most of them old. It is estimated that 98% of Alzheimer’s patients were 60 years and older and 78% were 80 years and older [34]. Depression disorders play the second most important role, accounting for 17% of the burden of disease. The remaining diseases/illnesses each contribute less than 5% of the burden of disease due to neurological and mental disorders, e.g. migraines, epilepsy, Parkinson’s disease, schizophrenia, and substance use disorders.
Figure 42. Disease structure of burden of disease (DALYs) due to neurological and mental disorders among older persons in Vietnam, 2015

Source: IHME-Vietnam GBD data 2015 [34]

The proportion of the burden of neurological diseases and mental illnesses in the total burden of disease is relatively stable, slightly increasing over time. However, the burden of neurological diseases (predominantly Alzheimer’s disease) increases sharply with age, while the burden of mental illnesses decreases with age (Figure 43).

Figure 43. Trends in burden of disease due to neurological and mental health disorders among older persons in Vietnam, 1990 - 2015

Source: IHME-Vietnam GBD data 1990, 2000, 2015 [34]
2.6. Burden of health risk factors in the Vietnamese elderly population

Health risk factors can be divided into three main groups: (i) metabolic; (ii) environmental; and (iii) behavioral factors. As mentioned in the above section, the burden of morbidity and mortality in older persons is mainly due to NCDs and disabilities. Most of the health risks of older persons are attributable to the accumulation of many risk factors starting at a young age such as smoking, drinking, diet, physical exercise, and the working environment. Metabolic factors tend to begin adversely affecting health from middle age if they are not detected early and managed, e.g. systolic hypertension and hyperglycemia. Although changes to behavior and the living environment and management of metabolic risk factors from age 60 may help improve the health of older persons, reduction of these risk factors at an early age is more effective for achieving healthy aging in the long run.

Analysis of the burden of disease due to health risk factors among older persons helps in development of appropriate prevention strategies. Information on the risk factors associated with the burden of morbidity and mortality in the Vietnamese elderly population is presented based on the global burden of disease study results for Vietnam, which relies on available evidence linking diseases to risk factors. However, the impact of risk factors on morbidity and mortality is complex, a risk factor can have effects on many diseases and a disease can be affected by multiple risk factors. In 2015 data for Vietnam, known risk factors can explain only about 58% of the burden of disease by DALY in older persons; the remaining 42% of the burden of disease cannot be explained by known risk factors [34].

2.6.1. Burden of disease caused by health risk factors

Of the three main groups of known risk factors for the 58% of the burden of disease measured in DALYs among older persons in Vietnam that can be explained, behavioral factors contribute the most to burden of disease (40%), followed by metabolic factors (33%) and environmental factors (14%) (Figure 44). The sum of the contribution of these three groups exceeds 58% because some risk factors affect multiple diseases. The burden of environmental risk factors does not differ much among age groups while the burden of metabolic factors increases with age and that of behavioral factors decreases with age.

Figure 44. Share of burden of disease (DALY) related to the 3 main risk factor categories by age group among older persons in Vietnam, 2015

![Figure 44. Share of burden of disease (DALY) related to the 3 main risk factor categories by age group among older persons in Vietnam, 2015](image)

Source: IHME-Vietnam GBD data 2015 [34]
More detailed analysis of the role of individual risk factors shows that the greatest contributors to the burden of disease in the Vietnamese elderly include unhealthy diet (with excessive salt, fat, red meat, and processed foods combined with inadequate fruits, vegetables and seafood), high systolic blood pressure and exposure to tobacco smoke (both active and passive smoking) (Table 12). The burden of some factors increases with age (e.g. high systolic blood pressure) while that of other factors decreases as age increases (e.g. body mass index-BMI, use of alcohol and drugs and exposure to occupational hazards).

### Table 12. Proportion of the burden of disease (DALY) related to risk factors by age group in the Vietnamese elderly, 2015

<table>
<thead>
<tr>
<th>Age group</th>
<th>60 - 64</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80+</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental factors</td>
<td>13.8%</td>
<td>14.0%</td>
<td>15.1%</td>
<td>13.4%</td>
<td>12.7%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Unsafe water sources</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.7%</td>
<td>1.1%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Air pollution</td>
<td>8.6%</td>
<td>9.5%</td>
<td>10.0%</td>
<td>9.8%</td>
<td>10.1%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Exposure to occupational hazards</td>
<td>5.1%</td>
<td>4.3%</td>
<td>5.0%</td>
<td>2.8%</td>
<td>1.1%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Metabolic factors</td>
<td>28.8%</td>
<td>30.9%</td>
<td>32.7%</td>
<td>35.4%</td>
<td>36.0%</td>
<td>32.9%</td>
</tr>
<tr>
<td>High fasting blood glucose</td>
<td>11.0%</td>
<td>12.1%</td>
<td>12.2%</td>
<td>11.9%</td>
<td>9.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Increased total cholesterol</td>
<td>5.1%</td>
<td>4.0%</td>
<td>3.7%</td>
<td>4.9%</td>
<td>6.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>High systolic blood pressure</td>
<td>17.2%</td>
<td>18.7%</td>
<td>20.1%</td>
<td>22.6%</td>
<td>22.1%</td>
<td>20.2%</td>
</tr>
<tr>
<td>High BMI</td>
<td>4.4%</td>
<td>4.5%</td>
<td>3.4%</td>
<td>2.6%</td>
<td>1.5%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Behavioral factors</td>
<td>43.8%</td>
<td>44.3%</td>
<td>43.1%</td>
<td>39.6%</td>
<td>33.8%</td>
<td>40.1%</td>
</tr>
<tr>
<td>Exposure to tobacco smoke</td>
<td>21.9%</td>
<td>21.7%</td>
<td>20.4%</td>
<td>17.2%</td>
<td>14.6%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Use of alcohol/drugs</td>
<td>6.9%</td>
<td>5.4%</td>
<td>4.4%</td>
<td>3.3%</td>
<td>1.3%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Inadequate physical activity</td>
<td>1.8%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.3%</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Unhealthy diet</td>
<td>22.3%</td>
<td>23.3%</td>
<td>23.4%</td>
<td>22.4%</td>
<td>19.3%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Total of all risk factors</td>
<td>56.6%</td>
<td>57.9%</td>
<td>59.1%</td>
<td>58.7%</td>
<td>57.0%</td>
<td>57.6%</td>
</tr>
</tbody>
</table>

Note: Exposure to tobacco smoke includes both active and passive smoking.

Source: IHME-Vietnam GBD data 2015 [34]

Among behavioral risk factors, the three most important ones are unhealthy diet, exposure to tobacco smoke (mainly active smoking), and alcohol and drug use, and these factors vary by sex. The proportion of the disease burden related to tobacco smoke and alcohol use in men is always higher than that in women of all ages (Figure 45). Meanwhile, the sex difference in the proportion of the disease burden related to unhealthy diet is small. This can be explained by the fact that eating behaviors are normally shared by the whole family, while smoking and drinking are personal behaviors. In addition, the contribution of all three behavioral risk factors in women and of the factor related to diet in men is relatively stable in all age groups, while that of smoking and drinking in men decreases as age increases.
Figure 45. Share of burden of disease (DALYs) attributed to behavioral risk factors by age and sex among older persons in Vietnam, 2015

Source: IHME-Vietnam GBD data 2015 [34]

Metabolic risk factors are intermediate risk factors and are closely related to behavioral risk factors. Figure 46 shows the contribution of metabolic risk factors to the burden of disease in older persons by age and gender. Accordingly, the burden of high systolic blood pressure increases with age while that of high BMI decreases with age in both men and women. Hyperglycemia and high BMI contribute more to the burden of disease in men than in women of all age groups. At the same time, high systolic blood pressure contributes more to the burden of disease in men than in women in the group aged under 75 years, but for the groups aged 75 and older this risk factor contributes substantially to the burden of disease with little gender difference. The effect of high total cholesterol on DALYs is almost the same for men and women.

Figure 46. Share of burden of disease (DALY) attributed to metabolic risk factors by age group and sex among older persons in Vietnam, 2015

Source: IHME-Vietnam GBD data 2015 [34]
2.6.2. Causes of death due to health risk factors

The pattern of impact of risk factors on causes of death in older persons is not much different from the pattern of impact on the burden of disease. Only about 67% of deaths in older persons can be explained by risk factors. Again, the overall impact of risk factors is not equal to 100% since some factors have overlapping impact. The risk factors with greatest impact on mortality are behavioral factors (45%), followed by metabolic factors (41%) and finally factors related to the environment (16%). The contribution to causes of deaths by factors related to the environment does not differ much among age groups, while the contribution of metabolic factors increases with age and of behavioral factors decreases as age increases. Risk factors with the greatest contribution to cause of death in the Vietnamese elderly population include high systolic blood pressure, unhealthy diet and exposure to tobacco smoke, similar to results found when using DALY as a measure of burden of disease (Table 13).

Table 13. Share of deaths attributed to known risk factors among older persons in Vietnam, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>60 - 64</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80+</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental factors</td>
<td>16.3%</td>
<td>17.4%</td>
<td>18.4%</td>
<td>16.0%</td>
<td>14.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Unsafe water sources</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>1.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Air pollution</td>
<td>11.9%</td>
<td>12.6%</td>
<td>12.8%</td>
<td>12.2%</td>
<td>12.0%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Exposure to occupational hazards</td>
<td>4.3%</td>
<td>4.8%</td>
<td>5.6%</td>
<td>2.9%</td>
<td>1.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Metabolic factors</td>
<td>35.6%</td>
<td>37.5%</td>
<td>39.2%</td>
<td>42.3%</td>
<td>42.6%</td>
<td>40.6%</td>
</tr>
<tr>
<td>High fasting blood glucose</td>
<td>12.0%</td>
<td>13.4%</td>
<td>13.5%</td>
<td>13.1%</td>
<td>11.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Increased total cholesterol</td>
<td>7.0%</td>
<td>5.3%</td>
<td>4.7%</td>
<td>6.1%</td>
<td>8.3%</td>
<td>7.2%</td>
</tr>
<tr>
<td>High systolic blood pressure</td>
<td>23.5%</td>
<td>24.5%</td>
<td>25.7%</td>
<td>28.4%</td>
<td>26.8%</td>
<td>26.0%</td>
</tr>
<tr>
<td>High BMI</td>
<td>5.3%</td>
<td>5.3%</td>
<td>4.0%</td>
<td>3.0%</td>
<td>1.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Behavioral factors</td>
<td>57.7%</td>
<td>56.7%</td>
<td>53.9%</td>
<td>48.6%</td>
<td>39.4%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Exposure to tobacco smoke</td>
<td>29.6%</td>
<td>28.2%</td>
<td>25.7%</td>
<td>21.1%</td>
<td>16.5%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Use of alcohol/drug</td>
<td>9.5%</td>
<td>7.2%</td>
<td>5.7%</td>
<td>4.2%</td>
<td>1.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Inadequate physical activity</td>
<td>2.2%</td>
<td>2.5%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Unhealthy diet</td>
<td>29.6%</td>
<td>30.2%</td>
<td>29.7%</td>
<td>28.1%</td>
<td>23.3%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Total of risk factors</td>
<td>70.1%</td>
<td>71.2%</td>
<td>71.2%</td>
<td>70.0%</td>
<td>66.4%</td>
<td>67.3%</td>
</tr>
</tbody>
</table>

Source: IHME-Vietnam GBD data 2015 [34]

Analysis by gender shows that while behavioral and environmental factors contribute more to mortality in men, metabolic risk factors affect women more—mainly related to high body mass index and fasting blood glucose (Figure 47).
Figure 47. Proportion of deaths attributed to risk factor groups among older persons by gender in Vietnam, 2015

2.7. Quality of life of older persons in Vietnam

Indicators of quality of life are important for assessing health status of the population in general, and particularly of older persons. Improving and strengthening quality of life of older persons is also an important goal of WHO in relation to health care of older persons.

Several studies have been undertaken in Vietnam on quality of life of older persons through use of different measurement instruments like WHOQOL-BREF, EQ-5D, etc. These studies all show different levels of relationship between quality of life of older persons and age, gender, location of residence, economic conditions and social relations. Some studies show that older men tend to have higher quality of life than women [57], particularly in terms of physical fitness, mental health and environment [58]. Quality of life is also higher among older persons with higher educational attainment and those with better socio-economic conditions [57,59], particularly among women [58]. Long-term living conditions have a greater effect on quality of life than short-term living conditions; the effect of economic conditions on quality of life among older persons in rural areas is also more important than in urban areas [60]. In terms of social relations, older persons in urban areas prioritize dependence on their children while older persons in rural areas focus more on community relations [60]. Quality of life is also higher among older persons who are head of household and who work until older ages [59] and older men with greater connections [58]. Age affects quality of life, primarily through reductions in physical fitness more than effects on mental health functioning [59]. There is also a relationship between sickness and quality of life in older persons, with older persons having no sickness in the past 6 months reporting higher quality of life [58].
In conclusion, with the rapid pace of population aging, the burden of disease and death among older persons is increasing, dominated by NCDs and declines in intrinsic capacity adversely affecting ability to perform ADLs and instrumental activities of daily living (IADLs). The burden of many health problems tends to increase with age, and in general is higher among women than men. To achieve the objective of healthy aging, prioritization of health problems among older persons is required to focus limited resources on their resolution. Criteria for prioritization were set based on the above situation analysis. These include: (i) preventable health problems; (ii) health problems that can be detected early and managed effectively to reduce harm; (iii) health problems that may cause major reductions in intrinsic capacity requiring action to reverse or slow progression; and (iv) advanced chronic diseases that cause major impairments and require palliative care or end-of-life care. In addition, attention should also be paid to improving quality of life of older persons. Chapter VIII will present the selected priority issues and recommendations for action.

21 IADL-instrumental activities of daily living such as housework, managing money, preparing meals, are not necessary for fundamental functioning, but they let an individual live independently in a community.
Chapter V. Health care to meet the needs of older persons in Vietnam

Healthy aging requires interventions throughout the life course for each individual (Figure 48). This includes early interventions (starting at birth) for prevention and control of risk factors, which are generally deemed the most cost-effective. The next type of intervention consists of early detection and diagnosis of NCDs, followed by treatment and effective management of NCDs and other chronic conditions. When encountering disabilities, illnesses or frailty, older persons should be assisted by the society to adapt to these conditions, and if possible, to undertake rehabilitation to return to independent living. Long-term care in the community or in residential care settings is an integrated intervention that is critical to ensure that older persons can maintain quality of life, maintenance of dignity and respect until end of life, with a primary focus on ADLs and psychosocial interventions, in addition to basic health care. At the end of life or when a person experiences serious incurable illnesses, palliative, or end-of-life care, may become necessary, particularly to ease pain. In brief, healthy aging requires not only medical interventions but also assistance for living with disabilities, long-term care and an enabling living environment that enhances and maintains functional capacity of older persons.

Figure 48. Contents of interventions aimed at the goal of healthy aging

This chapter of the report analyzes policies, activities and conditions for health care for older persons. According to WHO, health care for older persons is one of the interventions aimed at achieving healthy aging. To that end, people need effective preventive services from young age, early diagnosis and treatment of chronic diseases and rehabilitation to reverse or delay the decline of abilities during the aging process. Finally, the health system should respond to the needs for treatment of and care for advanced chronic diseases that have led to severe decline of intrinsic capacity of older persons (Figure 49).
While this chapter focuses on healthcare, healthy aging also requires long-term care and interventions in the social environment. Therefore, Chapter VI will provide analysis on long-term care and Chapter VII on social environment interventions. During the analysis, we will present relevant policies, achievements and difficulties in policy implementation in order to provide recommendations for the development and adjustment of strategies, policies and plans in the future for achieving healthy aging.

1. Key policies on health care for older persons

1.1. Some global policies relating to the right to healthcare of older persons

Article 25 (1) of the United Nations Declaration on Human Rights (1948) emphasizes “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”.

In 2002, the United Nations General Assembly endorsed the Political Declaration and Madrid International Plan of Action on Aging. Three priorities for action were identified in their recommendations: “older persons and development; advancing health and well-being into old age; and ensuring that older people benefit from enabling and supportive environments”. Several key issues were flagged in the plan. These remain relevant in 2015 and are emphasized in this report. They include: promoting health and well-being throughout life; ensuring universal and equal access to health-care services; providing appropriate services for older persons with HIV or AIDS; training care providers and health professionals; meeting the mental health needs of older persons; providing appropriate services for older persons with disability; providing care and support for caregivers; and preventing neglect and abuse of, and violence against, older people.

1.2. Vietnam’s policies on health care for older persons

Legal documents stipulate tasks related to disease prevention, NCD prevention and control, medical examination and treatment, healthcare, and rehabilitation, with specific items
targeted to older persons. The State and MOH have paid attention to the issue of population aging in Vietnam and have included health care for older persons in the sector’s strategies and plans of action, with a clear focus on PHC for older persons. The MOH Medical Services Administration plays an important role in the development and implementation of policies, standards, and guidelines for diagnosis and treatment of common diseases in older persons. The National Geriatric Hospital, the leading geriatric health facility, has advised MOH on policies on development of the geriatric care network as well as health care for older persons at all levels, with a focus on health care for older persons at the grassroots level and in the community. This section covers major policies related to health care for older persons, including preventive care, curative care and rehabilitation. Issues related to long-term care will be addressed in Chapter VI.

1.2.1. The right to health care of older persons

The Law on the Elderly stipulates the rights and obligations of older persons, including rights to health care. The Law’s provisions focus on two areas: PHC in the home and medical examination and treatment at health facilities. In addition, the Law also stipulates the right of older persons to health insurance and the responsibilities of the MOH. Older persons account for a large proportion of the population with disabilities, therefore this section also covers the right to rehabilitation stipulated in the Law on Persons with Disabilities (Law No. 51/2010/QH12).

PHC is a right of older persons specified by Article 13 of the Law on the Elderly and detailed by MOH Circular No. 35/2011/TT-BYT. CHSs are primary health facilities responsible for managing the health of older persons through health communication and education, establishment of health records of older persons, provision of health services within their level of technical service capacity and collaborating with upper-level health facilities to organize routine health checkups for older persons. For older persons lacking family support (i.e. no caregivers) with serious illnesses and unable to visit health facilities, CHSs are responsible for sending staff to the home of the older person for medical examination/treatment and commune people’s committees are responsible for bringing such older people to health facilities at the request of CHSs. In addition to CHSs, the government also encourages other organizations and individuals to provide medical examination and treatment for older persons in their home. The model of family doctor/family doctor clinics is being developed to improve the organization and implementation of PHC. In policy documents related to the development, pilot and replication of the family doctor model, one of the main tasks of family doctors is to provide health care for older persons.22

The prioritization of older persons in health care is being implemented through several measures. First, people aged 75 years and older are entitled to get medical examination and treatment before other patients.23 Second, they are to be provided with suitable beds for inpatient treatment in a geriatric department or in beds specifically designated for older persons in hospitals. Third, after the treatment of acute symptoms in a hospital setting, they are to receive rehabilitation services and guidance on how to maintain follow-up treatment and care at home. Fourth, traditional medicine should be combined with modern medicine, and older persons should be given guidance on non-drug treatment at the grassroots level.

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22 Circular No. 16/2014/TT-BYT dated 22 May 2014 guiding the pilot of the family doctor/family doctor clinic model; Decision No. 935/QD-BYT dated 22 March 2013 approving the project on building and developing the family doctor clinic model for the period 2013 - 2020; MOH Decision No. 1568/QD - BYT dated 27 April 2016 approving the plan to replicate and develop the family doctor clinic model in Vietnam for the period 2016 - 2020
23 In the Law on the Elderly, this entitlement is for people aged 80 years and older. Subsequently, however, according to MOH Document No. 2413/BYT-KCB dated 26 April 2013, the entitlement was extended to people aged 75 years and older.
1.2.2. MOH responsibilities related to health care for older persons


Firstly, the MOH is responsible for guiding and organizing health care for older persons at health facilities and in the community, and guiding the management of chronic diseases in older patients. MOH fulfills this responsibility through Circular No. 35/2011/TT-BYT, specific documents guiding the implementation of the Law on the Elderly, and the Health Care for the Elderly Project 2017 - 2025.

The main way this task is to be implemented is through the establishment of a geriatric department in various provincial health facilities. As stipulated in Circular No. 35/2011/TT-BYT, all general hospitals, specialized hospitals (excluding pediatric hospitals), and traditional medicine hospitals with 50 or more planned beds must have inpatient beds and consultation rooms in the outpatient department specifically designated for older persons. According to the Vietnam National Action Program for the Elderly, the 2020 target is for 90% of these facilities to have specially designated beds and consultation rooms. Depending on need for medical care among older persons, hospitals are encouraged to set up a geriatric department when they have adequate facilities, medical equipment and personnel. According to the Vietnam National Action Plan for the Elderly, by 2020 100% of provincial general hospitals and specialized hospitals should have a geriatric department. However, at present, there are no MOH policy documents guiding the functions, tasks and organizational structure of the geriatric department.

The Health Care for the Elderly Project 2017 - 2025 also has some specific targets that act as intermediate criteria for the accomplishment of the objective “to meet the health care needs of older persons” as shown in Table 14. The project also lays out several measures to achieve these targets. To increase the understanding of older persons, the Project will enhance communication and education to change behaviors and raise awareness as well as to create a social environment enabling health care for older persons. To help older persons access healthcare services, the Project will implement solutions with a focus on families, the community and grassroots health facilities such as: building and developing “health care for older persons” movements, consolidating and refining the PHC delivery system, providing medical examination and treatment for older persons. Finally, the Project includes the activity of developing and disseminating a model of long-term health care for older persons.
Table 14. Health and health service targets for older persons in the Health Care for the Elderly Project for the period 2017 - 2025

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Targets by 2025</th>
<th>Achieved by 2015 - 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve the health of older persons through improved knowledge, skills for self-healthcare and accessibility to PHC of older persons.</td>
<td>80% of older persons can take care of themselves, and are equipped with knowledge and skills for self-healthcare</td>
<td>9.6%</td>
</tr>
<tr>
<td></td>
<td>80% of older persons receive routine health checkups at least once a year and have health records.</td>
<td>7.7%</td>
</tr>
<tr>
<td>To meet the needs for medical examination and treatment of older persons with better quality, at reasonable costs and in proper forms (at health facilities, at home, etc.)</td>
<td>90% of older persons can get access to healthcare services when having illnesses/diseases.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of central and provincial hospitals (excluding pediatric hospitals) have a geriatric department or inpatient beds specifically dedicated to older persons; the establishment of geriatric hospitals is encouraged in municipalities.</td>
<td>42 provinces have dedicated or joint geriatric department; 1 geriatric hospital in Hanoi.</td>
</tr>
<tr>
<td></td>
<td>100% of older persons have health insurance cards.</td>
<td>75% (2014)</td>
</tr>
</tbody>
</table>

Source: Policy targets from Decision No. 7618/QD-BYT in 2016; Evidence about achievement on most indicators: Giang Thanh Long 2016 [61]. 2014 results on health insurance coverage was calculated by the JAHR team using Vietnam Living Standards Survey Data 2014.

Secondly, according to the Law on the Elderly and the Vietnam National Action Program for the Elderly, MOH is responsible for developing and implementing a program on prevention, examination and treatment of cardiovascular disease, diabetes, Alzheimer’s disease, other chronic diseases, and reproductive health related diseases for older persons. To fulfill this responsibility, MOH has developed the National Strategy for Prevention and Control of Cancer, Cardiovascular Diseases, Diabetes, COPD, Asthma and other NCDs in the period 2015 - 2025 (Decision No. 376/QD-TTg in 2015) [hereafter referred to as the National Strategy for NCD Prevention and Control], which was approved by the Prime Minister. MOH also issued a decision to approve a Project on active prevention, early detection, diagnosis, treatment and management of cancer, cardiovascular diseases, diabetes, COPD, asthma and other NCDs in the period 2016 - 2020 (Decision No. 4299/QD-BYT in 2016).

Thirdly, MOH is responsible for implementing a program on prevention of disabilities and guidance on community-based rehabilitation for people with disabilities, including older persons. In 2014, MOH approved the National Plan for Rehabilitation Development in the period 2014 - 2020 (Decision No. 4039/QD-BYT) aiming to strengthen and develop the network of rehabilitation facilities, improve the quality of rehabilitation services, enhance the prevention of disabilities, early detection, early interventions and improvement of the quality of life of people with disabilities. The Prime Minister also approved the National Blindness Prevention Strategy to 2020 with a vision to 2030 (Decision No. 2560/QD-TTg in 2016) with targets related to older persons including: reducing blindness in people aged 50 years and older, increasing the cataract surgery rate and increasing the proportion of diabetes patients receiving eye examination and monitoring of eye problems.
1.2.3. Policies on human resources providing health care for older persons

**Achievements**

MOH is responsible for training and retraining of physicians and health workers specialized in geriatrics (as stipulated in the Vietnam Law on the Elderly) and in rehabilitation (the Law on Persons with Disabilities); improving the capacity of social workers counselling and caring for older persons (the Vietnam National Action Program for the Elderly).

The National Geriatric Hospital is responsible for organizing CME and advanced training in geriatrics, collaborating with national health education institutions in developing geriatric training materials and practice guidelines (Circular No. 35/2011/TT-BYT). According to the Health Care for the Elderly Project, the National Geriatric Hospital is also responsible for direction, support and technical transfer related to health care for older persons to lower level facilities across the country.

The Vietnam National Action Program for the Elderly stipulates the integration of contents relating to health care for older persons into training and capacity building programs for social workers, collaborators and volunteers who provide counseling and care for older persons.

**Difficulties**

Currently there are no standards for the geriatric medicine specialization to help in determining the scope of practice of geriatric specialists. Vietnam has not yet developed geriatric competency standards for general doctors, family doctors, internal medicine physicians and geriatric physicians. Although there are three schools providing training in the geriatric medicine specialty, the national education system does not yet have a code for geriatric medicine in the list of postgraduate education specialties. There is no framework curriculum or standard geriatric curricula to be used in training programs of general doctors, family doctors or internal medicine physicians or for CME and geriatrics training programs.

There are no provisions on CME to improve the general knowledge of health workers on the special needs of older patients, for example drug interactions, psychology of both healthy and sick older persons, risk of falls, counseling on diet and self-management of diseases, etc. This is very important because most elderly patients with specific diseases are likely to be treated in a specialty department, rather than in a geriatric department.

Although most technical services are provided by health workers, many basic health care tasks are performed by families or paid caregivers. These individuals rarely have any kind of training or guidance in providing health services to their care receivers, such as medicines management or tube feeding. Without proper guidance from health professionals, these caregivers cannot effectively contribute to health care of older persons.

1.2.4. Health financing policy for older persons

**Achievements**

Health financial protection for older persons is implemented through the health insurance scheme and state subsidy for PHC facilities, as well as funding for the Health and Population Target Program for 2016 - 2025 in relation to NCD prevention, control and management. Chapter VI will discuss issues of long-term care insurance, which is separate from health insurance.

According to the Health Insurance Law and the Law on the Elderly, older persons have the right to health insurance (Table 15). For the group aged 80 and older, their health insurance premiums are paid either by VSS or by the state budget. For the group aged 60 - 79
years, some groups (i.e. pensioners, the poor without family members obligated to provide support, people with meritorious services, people with disabilities living on monthly social assistance payment) get their health insurance premiums paid by VSS or by the state budget, while the rest of people in that age group must pay the health insurance premium by themselves. Specifically, for poor older persons who do have family members obligated to take care of them, the insurance premiums are to be paid by the family caregivers. For older persons under age 80 entitled to survivor allowances from VSS, they are expected to pay premiums to obtain voluntary health insurance from their survivor allowance, while other groups like the non-poor, people without meritorious services, non-pensioners, people without disabilities are expected to pay health insurance premiums by themselves. These groups are likely not to participate in health insurance, or to participate in health insurance only when they have a disease, leading to adverse selection in health insurance.

Table 15. Health insurance entitlements of older persons

<table>
<thead>
<tr>
<th>Aged 60 - 79 years</th>
<th>Aged 80 years and older</th>
<th>Co-payment rate</th>
<th>Legal document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pensioner</td>
<td>Premiums paid by VSS</td>
<td>Premiums paid by VSS</td>
<td>5%</td>
</tr>
<tr>
<td>Poor older people without family support</td>
<td>Premiums paid by the state budget (but it is difficult to identify beneficiaries)</td>
<td>Premiums paid by the state budget</td>
<td>0%</td>
</tr>
<tr>
<td>Poor older people with family support</td>
<td>Premiums paid by family on a voluntary basis</td>
<td>Premiums paid by the state budget</td>
<td>20%; 0% (starting at age 80 years)</td>
</tr>
<tr>
<td>People with meritorious services; parents, spouse, children or caregivers for war invalids (beneficiaries of social policies)</td>
<td>Premiums paid by the state budget</td>
<td>Premiums paid by the state budget</td>
<td>0%</td>
</tr>
<tr>
<td>People with disabilities (living on monthly social assistance payments)</td>
<td>Premiums paid by the state budget</td>
<td>Premiums paid by the state budget</td>
<td>0%</td>
</tr>
<tr>
<td>People entitled to survivor allowances from social security agencies</td>
<td>Premiums paid on a voluntary basis</td>
<td>Premiums paid by VSS</td>
<td>20%; 0% (starting at age 80 years)</td>
</tr>
<tr>
<td>Other older people not mentioned in above groups</td>
<td>Premiums paid on a voluntary basis</td>
<td>Health insurance premiums paid by the state budget</td>
<td>20%; 0% (starting at age 80 years)</td>
</tr>
</tbody>
</table>

The benefit package of health insurance participants covers medical examination, treatment and rehabilitation (according to the Health Insurance Law and Circular No. 18/2016/TT-BYT). According to the Law, older persons participating in health insurance under most of the above-mentioned groups shall pay a co-payment rate of 20% while the remaining 80% is paid by health insurance. Older persons who are poor or social policy beneficiaries shall
get 100% health care costs covered by health insurance. Upon reaching age 80, the co-payment rate falls to 5%. However, the health insurance reimbursement rate will be reduced if older persons bypass lower level facilities to use services at higher levels without a referral. Under the Health Insurance Law, some services that are important to older persons are not covered by health insurance, for example: screening of chronic diseases such as hypertension, diabetes mellitus, and routine health checkups. If an older person has symptoms of diseases and visit a health facility, the charges will be reimbursed by health insurance; but if a healthy older person uses health checkup service for early detection of non-symptomatic NCDs, the charges are not covered by health insurance. However, in principle, CHSs are responsible for providing this service or inviting health workers from higher levels to provide this service at CHSs, and localities must allocate funding from their state budget to fulfill this obligation.

The costs for CHS-based PHC services and community-based rehabilitation for older persons with disabilities should be covered by the state budget (according to the Law on the Elderly and Law on Persons with Disabilities). Ministry of Finance Circular No. 21/2011/TT-BTC stipulates that local budget shall cover recurrent expenditures for CHSs to deliver health care for older persons, excluding payroll payments. Activities with fixed cost norms include health communication and education, printing of blank patient records, health monitoring and management logbooks for older persons, and payment for upper-level health facilities coming to CHSs to provide routine health checkups for older persons. For older persons without family support, additional funds are to be allocated to cover travel costs, medical examination fees of CHS staff delivering medical examination at the home of older patients, or costs to send them to higher-level health facilities at the request of the CHS. As for older persons being admitted to the social protection establishments, besides getting their health insurance premiums paid by the state budget, they are also provided with general medicines and rehabilitation facilities if necessary, which are not covered by health insurance.

The state also encourages social mobilization in the field of healthcare and rehabilitation for older persons. Under the Law on the Elderly, the state encourages organizations and individuals to provide free-of-charge healthcare to older persons. In the Law on Persons with Disabilities, the state encourages investments, financial aid and technical assistance to rehabilitation activities and the construction of rehabilitation facilities.

**Difficulties**

**There is a lack of financial mechanisms to encourage older persons to use services in the community.** Older patients often want to use hospital services so that the costs of their medical examination and treatment, NCD medications or rehabilitation services will be covered by health insurance reimbursement. This, is aligned with the incentives faced by CHS staff to under-provide services, because currently under the Labor Code, salaries and allowances paid to health workers only depend on seniority, position and working conditions, not on level of effort, productivity and effectiveness of health care for older persons in the community. Payment mechanisms do not respond adequately to the need for continuous healthcare and PHC at CHSs, referral to higher-level hospitals when diseases require technical capacity beyond that of the CHS, and referral downward to CHSs for NCD management or to the community for rehabilitation once the patient is stabilized. Hospitals financially benefit if they retain patients rather than referring them back to the CHS for longer term health management.

**1.2.4. Shortcomings related to policies on health care for older persons**

Despite the Law on the Elderly, the Vietnam National Action Program for the Elderly and the Health Care for the Elderly Project, some areas have unclear policies or the policies do not respond adequately to the needs of older persons.
Areas related to health care for older persons with no specific strategies/plans:

- **Mental health care for older persons**: current mental health policies focus on schizophrenia, epilepsy and depression in the community. Although neurological diseases, particularly dementia (including Alzheimer’s disease), account for a large share of burden of disease among older persons, there are not yet any policies or interventions for this disease.

- **Reproductive health care for older persons**: The Vietnam National Action Program for the Elderly has determined the responsibility for development of a reproductive health care program for older persons, but to date there are no policies for implementing it. Currently the only relevant actions seem to be the development of content related to reproductive health for older persons (e.g. menopause care) in the national reproductive health guidelines.

- **Disability Prevention Program**: currently we have the National Blindness Prevention Strategy to 2020 with a vision to 2030 focusing on visual impairment. The MOH is striving to establish timely stroke services in health facilities to reduce permanent impairment and assist rehabilitation after stroke (Circular No. 47/2016/TT-BYT). There are no prevention programs for other types of disabilities.

- **Home-based care for older persons**, is an important area because of difficulties in or loss of mobility/vision hindering access or frailty during end of life when palliative care is needed in the home. However, the existing Law on Examination and Treatment does not provide a legal basis for setting up home-based healthcare services able to provide the range of services needed by older persons in the home. Only service providers registered as family doctor clinics are allowed to provide curative care services at home.

- **End-of-life palliative care for older persons** is a very important area but is not mentioned in policies. While there are guidelines on palliative care standards for AIDS and cancer patients, there are no policies or guidelines for palliative care for older persons in general, although many of them and their families will come to the moment when they must decide whether to continue or discontinue treatment in the presence of incurable disease.

**Leadership and collaboration in health care for older persons**

- **The General Office for Population and Family Planning (GOPFP)** is assigned to take the lead in coordinating and implementing the Health Care for the Elderly Project, while the Department of Planning and Finance (DPF) and Medical Services Administration also share responsibility for Project implementation. However, the Project does not define responsibilities of the General Department of Preventive Medicine, which oversees disease prevention, especially NCD prevention. At the same time, each MOH unit assigned to Project implementation has an equal level of authority, so it is difficult for GOPFP to coordinate tasks that are assigned to other MOH units.

- The health sector has not coordinated closely with other sectors of relevance to ensure health care for older persons, such as Vietnam Sports Administration (regarding physical activity for older persons), MOLISA (regarding health care in residential long-term care facilities or elder care services provided in the home of older persons) and Vietnam Social Security (VSS) (regarding health insurance benefits for older persons).

- **There are no focal points responsible for collecting and reporting annual monitoring and evaluation data** on the implementation of the Health Care for the Elderly Project from administrative data sources or through regular surveys on health care for older persons.
2. Health care network providing services to older persons

2.1. Special needs of older persons require special healthcare services

Like all people in society, older persons also need health care; but their healthcare needs are often greater and there are some special needs due to the characteristics of aging (see details in Chapter IV).

- **Common NCDs in older persons include cardiovascular diseases** (hypertension, heart failure, coronary artery disease), stroke, diabetes mellitus, hyperlipidemia, COPD and cancer. These diseases need careful management and regular contact with medical services for a long period of time.

- **The prevalence of disability in older persons is also high**, e.g. visual impairment, hearing impairment, paralysis due to stroke, osteoarthritis, even fractures (prominently broken hip), leading to many adverse consequences for health and mobility difficulties that require home-based medical care.

- **Neurological diseases are very common among older persons**, including dementia (particularly Alzheimer’s disease), Parkinson’s disease, depression, sleep disturbance and anxiety. Diseases and disabilities have a negative impact on the mental health of older persons as they cannot manage their own life, often suffer from incontinence, and pain and have many other problems.

- **Medical treatment of a vulnerable person or a person with disabilities can lead to other medical conditions** from muscular atrophy due to restricted mobility, pressure ulcers due to prolonged bed rest, fall risks or adverse drug reactions (ADR).

- **Older persons often have multiple chronic diseases at the same time**. If an older patient is admitted to a specialist department for treatment of their main disease, it is likely that their co-morbidities will be ignored or ineffectively treated, for example by providing too many drugs at the same time, which leads to drug interaction or impairment of liver or renal function.

- **Old age is the final stage of life**. Once people becomes very weak, treatment options may not address their health problems effectively or prolong their life. In fact, treatment options may bring them discomfort caused by side effects, that makes them weaker and reduces their quality of life.

To respond to the characteristics mentioned above, health facilities and health workers delivering health care for older persons should pay attention to the following:

- **Healthcare for older persons is mainly provided by older people themselves, and their family members**, so it is necessary to increase their knowledge in many areas such as health promotion methods, prevention of disease, prevention of disabilities, early detection of symptoms or screening of diseases that need to be managed or treated early, NCD management methods, community-based rehabilitation and increasing awareness of palliative care options for older persons with incurable diseases at the end of their life.

- **Older persons should be cared for in a holistic manner**, i.e. they themselves - instead of their individual diseases - should be considered as the center of the care process. Therefore, health facilities should have mechanisms to coordinate interventions from various specialties to provide the best care for older persons.
Nurses caring for elderly patients should pay attention to higher risks among older persons, such as fall risk, ADRs and drug interactions, urinary and fecal incontinence, risks of pressure ulcers or muscular atrophy due to prolonged bed rest.

The design of the geriatric department should be suitable for older persons (with handrails along corridors, in toilets, slip-resistant floors, minimization of direct light, etc.)

In preparation for discharge of older patients, continuing treatment, rehabilitation and home-based care options should be considered. Attention should be paid to rehabilitation after inpatient treatment, helping older persons to regain their autonomy in ADLs and reintegrate into the community.

Preventive and curative care should be combined to reduce the risk of relapse and improve the health of older persons. At the same time, it is necessary to prevent complications and slow the rate of impairment experienced by older persons.

Close-to-home healthcare is very important because older persons tend to have difficulties with mobility, yet NCD management requires regular contact with health facilities. Service providers (individuals and organizations) need to keep information on the history of diseases and treatment process for older patients.

Palliative care is an important option for older persons who have incurable diseases or who are suffering from weakness/pain reducing the ability of the body to respond to treatment. Therefore, counseling for elderly patients and their families on end-of-life care and pain relief should be a key activity during the healthcare process.

Health care for older persons in Viet Nam is integrated into the current health care network (Figure 50). At central and provincial levels, the curative and preventive systems are separate and specialized, and have the function of guiding lower levels. The grassroots level includes district and commune levels, where healthcare for older persons is better integrated and has the advantage of being closer to where older persons reside, thus facilitating accessibility to health services. In addition to the government health system, private health facilities (including hospitals and clinics) also participate in providing health care to older persons, particularly the recent development of family doctor clinics. Home-based health care for older persons is provided by family doctor clinics and CHSs, however this service has not yet been fully developed to meet need-especially for palliative care, and currently the legal framework does not allow the delivery of adequate home-based care services.
In addition to health facilities, in Vietnam health care for older persons is also delivered through several models which care for and promote the roles of older persons in the community. GOPFP (MOH) has developed and guided localities to implement the Counselling and Care Model for Older Persons to increase accessibility to appropriate physical and mental health services, prevent NCD risk factors, and help older people to perform ADLs independently. The ISHC model has a wider scope of activities, including three activities directly focusing on health care for older persons. These are: monthly health checkup and monitoring, participation in physical activities and learning how to protect health in old age. Some long-term care facilities for older persons, such as nursing homes, social protection centers and home-based care services for older persons, also deliver health care services. Since these activities are linked to long-term care for older persons, they will be analyzed in Chapter VI below, although some of these models also mobilize health sector workers at all levels to engage more fully in providing health care to meet the needs of older patients. This Chapter will focus primarily on services provided directly by the health sector.

In terms of geographic development, specialized geriatric departments are being developed in many localities. The map in Figure 51 shows that about two-thirds of provinces have a geriatric specialist department. Among provinces that have developed a geriatric medicine department, it tends to be a joint department (such as internal medicine and geriatrics or cardiology and geriatrics. However, one third of the provinces still do not have a geriatric department. Note in some provinces, the geriatric department is in a central, rather than provincial hospital. Specialized hospitals including mental hospitals and traditional medicine hospitals that have developed geriatric departments are not included in this map.
Figure 51. Map of geriatric specialization development, 2017

Source: Rapid survey implemented by National Geriatric Hospital in 2016 - 2017
2.2. Healthcare utilization by older persons

When analyzing health care utilization patterns among older persons, we should keep in mind that 91% of the contacts among older persons are for outpatient care and only 9% for inpatient care (Figure 52). At the same time, more than half of health service contacts of older persons are at the grassroots level (i.e. district and commune levels), 16% in private health facilities (inpatient and outpatient) and 11% at other levels (e.g. preventive medicine centers, charity clinics), which are types of health facilities not yet encouraged to establish geriatric departments. Approximately 20% of health service contacts among older persons are at central and provincial levels, most of which are for outpatient care.

Figure 52. Structure of health service contacts among people aged 60 and older, 2012

![Pie chart showing health service contacts among older persons, with OP at CHS at 21%, OP at district hospital at 27%, OP private at 15%, OP other at 11%, IP at district hospital at 4%, IP at higher level hospital at 4%, and IP at other facilities at 1%.]

Source: GSO-Vietnam Household Living Standards Survey 2012. JAHR team calculations

Functions and tasks of the geriatric department at central and provincial levels in Vietnam are unclear and there is a lack of guiding documents from the MOH. In some countries, the geriatric department in a hospital is a unit responsible for rehabilitation, health communication and education, and plays an important role in coordinating and collaborating necessary specialty services for elderly patients, including services provided by other health facilities. In Vietnam, older persons account for a large proportion of the patients in almost all types of health facilities. Therefore, in all health facilities with or without a geriatric department, a suitable mechanism to meet the needs of older persons is needed. There is a lack of policy documents guiding health care for older persons at all levels of the health care service delivery hierarchy, to stipulate the organization, staffing, target patient groups and physical facilities of the geriatric department in general hospitals, as well as at the grassroots level. There should be more guidance on linking NCD prevention and health care for older persons.

2.2.1. At the central level

The National Geriatric Hospital is the only tertiary referral hospital specialized in medical examination and treatment, rehabilitation and health promotion for older persons. It was established in 1983 (when it was named “Institute for Protection of the Health of Aged People”). The hospital is responsible for providing health services, training and guidance in the field of geriatrics and conducting scientific research on geriatrics.
The National Geriatric Hospital is expanding its scale and scope of services. According to plans approved by the MOH, the hospital has renovated and upgraded its first campus with 350 patient beds, at the same time it is constructing the second campus in Ha Nam province with 500 patient beds and a long-term care unit for older persons. Currently, under Decision No. 284/QD-BKLK (2017), the National Geriatric Hospital has the following clinical departments: neurology and Alzheimer’s disease care, mental health, endocrinology and rheumatology, cardiovascular and respiratory disease, internal medicine, oncology and palliative treatment, cardiovascular interventions and surgery, emergency and stroke, intensive care unit, and rehabilitation, which are suitable with the morbidity pattern of older persons. The hospital also has para-clinical departments and functional divisions, e.g. nursing division. The hospital receives elderly patients (aged 50 and above) who are transferred from other hospitals as well as older persons with demand for medical examination and treatment.

The Training and Professional Mentoring Center at the National Geriatric Hospital has the role of increasing the quality of health care for older persons nationwide through its provision of training and mentoring. The hospital has actively directed, supported and transferred technology related to health care for older persons to lower levels. In addition, the hospital has conducted CME and advanced training on geriatrics and collaborated with national health education institutions in compiling geriatric training materials and practice guidelines.

Findings of scientific research on basic geriatrics, clinical geriatrics and social geriatrics are used to provide evidence to the MOH for building and developing a network to provide health care for older persons nationwide. At the same time, the hospital has carried out various applied research to develop important and specialized techniques in the field of geriatric medicine.

By 2016, a geriatric department or integrated geriatric department has been established in some general hospitals or specialized hospitals at the central level in accordance with Circular No. 35/2011/TB-YT. In the North, a geriatric department has been set up at the National Traditional Medicine Hospital and Thai Nguyen Central General Hospital. In the Central region, a geriatric department is available at Vietnam-Cuba Dong Hoi Hospital, Hue Central General Hospital, Da Nang C Hospital, Quang Nam Central General Hospital and Quy Hoa Central Leprosy and Dermatology Hospital. In the South, a geriatric department is available at HCMC Medicine and Pharmaceutical University Hospital and Can Tho Central Hospital.

2.2.2. At the provincial level

The Law on the Elderly and Circular No. 35/2011/TB-YT requires that health facilities with 50 or more planned beds must have inpatient beds designated for older persons. According to the Health Care for the Elderly Project, 100% of provincial hospitals (excluding pediatric hospitals) must have a geriatric department or certain beds designated for older persons.

By the beginning of 2017, more than 70 provincial, district or private hospitals had established a dedicated geriatric department or geriatric department integrated with some other department (predominantly internal medicine or cardiology department), or a geriatric unit. This figure is significantly higher compared to 49 hospitals in 2015 [62]. However, there are still 21 provinces with no hospitals having a geriatric department. Although not all health facilities have outpatient clinics and inpatient rooms designated exclusively for older persons, the majority of facilities have some beds available for older persons and prioritize older persons in medical examination and treatment [63]. In 2016, 37 622 inpatient beds were dedicated to older persons [64]. However, MOH has not issued any documents guiding the functions, duties

24 Eight out of 41 central hospitals, excluding pediatric hospitals and the National Geriatric Hospital, are known to have a geriatric department or geriatric integrated department.
25 Rapid survey of provincial general hospitals conducted by the National Geriatric Hospital in 2016 and 2017 and information collected from the “Organizational Structure” page of hospital websites.
and organizational structure of the hospital geriatric department. As a result, very few geriatric departments operate properly and in accordance with requirements for a geriatric department. It is quite common that hospitals simply choose a department with many elderly patients (e.g. internal medicine, cardiology) to become their geriatric department. Usually in all hospitals, elderly patients are admitted to different clinical departments for treatment of their specific diseases. The geriatric department should work in collaboration with other departments to meet the complex needs of elderly patients; to avoid neglect of co-morbidities; to pay attention to drug interactions and poor drug tolerance among frail older persons, post-discharge care planning; and providing counseling in case treatment is no longer suitable and the patient should receive palliative care instead. A few provincial general hospitals, whose geriatric department was established in consultation with the National Geriatric Hospital, have assigned appropriate responsibilities to the geriatric department.

Regarding outpatient services, 24 provincial general hospitals have clinics for older persons, 39 provincial general hospitals do not have them. According to regulations of hospitals in 57 provinces, older persons aged 75 and older are given priority for medical examinations, while the remaining 6 provinces do not implement this priority service for older persons.26

Rehabilitation service providers include rehabilitation centers, hospitals and rehabilitation department of health facilities. In addition, there are also community-based rehabilitation services organized at the commune level. Rehabilitation is the process of assisting patients and people with disabilities by medical methods, rehabilitation techniques, social and educational measures to minimize the impact of disabilities, help patients have equal opportunities to participate in social activities and integrate into the community. For older persons, rehabilitation service providers will help them recover from episodes of illness (e.g. stroke), surgeries or impairments during the aging process. There are currently 36 provincial nursing and rehabilitation hospitals and 15 nursing centers of different sectors. In addition, many hospitals have a rehabilitation department and outpatient rehabilitation rooms. At CHSs, there are many staff trained in community-based rehabilitation by the NTP on Community-based Rehabilitation in the period prior to 2016. The Health and Population Target Program to 2020 continues to ensure that people with disabilities get access to appropriate rehabilitation services.

At the provincial level, provincial preventive medicine centers and Centers for Disease Control and Prevention (CDCs) (available in some provinces) deliver preventive care to older persons. By October 2016, 17 provinces have established CDCs following Joint Circular No. 51/2014/TTLT-BYT-BNV dated 11 December 2015. Functions and duties of preventive medicine centers or CDCs engaged in health care for older persons include health promotion, prevention of risk factors affecting health, screening for early detection and management of diseases, outpatient preventive treatment of infectious diseases and NCDs. CDCs are different from preventive medicine centers since they coordinate information, education and communication (IEC) activities better, and provide screening and surveillance of diseases. However, the re-organization of the provincial preventive medicine system with the new model is still in the initial stage of development, which will take several years to be stabilized and to reach its full potential.

2.2.3. At the grassroots level

The grassroots level, including district, commune and village levels, plays an important role in controlling NCDs and managing the health of people, including older persons, in a continuous and long-term manner. According to the Law on the Elderly, all general hospitals with 50 or more planned beds must have inpatient beds and consultation rooms in the outpatient

26 Rapid survey of Geriatric Departments in provincial general hospitals conducted by the National Geriatric Hospital in December 2016.
department designated for older patients. CHSs are responsible for delivering medical examination and treatment to older persons in accordance with their abilities, functions, and duties and for providing home-based examination for the lonely elderly. The Health Care for the Elderly Project has set the objective “to invest in the development of material and technical facilities of health service providers, to establish the geriatric department at district hospitals, etc.”

**District level**: the country has 629 district hospitals accounting for 30.7% of the total inpatient beds nationwide, and 544 regional polyclinics [65]. In addition, most districts have DHCs that provide preventive services and manage CHSs. However, according to Circular No. 37/2016/TB-YT, DHCs will be merged with district hospitals and have the function of providing preventive care, curative care, rehabilitation and other health services. By October 2016, 18 provinces in the country had dual-function (preventive and curative) DHCs. This helps combine preventive and curative services in a more appropriate and effective manner for NCD prevention and control and management of health care for older persons. This model is also more convenient for people. It also helps DHCs to provide professional direction and guidance for CHSs.

According to MOH reports, district general hospitals and CHSs have organized reception area, outpatient clinics and inpatient rooms exclusively for older persons, with increased quantity and quality [62]. Some cities, like HCMC and Hanoi, have established a geriatric department or geriatric unit to provide treatment for older persons in district hospitals. However, most district hospitals of other provinces do not have outpatient clinics or inpatient units dedicated to older persons because of their small scale. Elderly patients normally obtain care in specialty departments depending on their types of disease; meanwhile, many health workers have not been trained in geriatrics so they do not focus enough on elderly patients, i.e. to look at their health problems holistically, treat co-morbidities, pay attention to drug interactions, needs for rehabilitation and the psychology of older patients [66]. In many district health facilities where the majority of patients are poor and many of them are older persons with chronic illnesses, health counseling and education play an important role but are performed in a very limited manner [67].

**Commune level**: there are 11 101 CHSs nationwide (CHSs are available in 99.5% of communes, wards and towns in the country) [65]. CHSs and regional polyclinics are intended to provide basic PHC services to local people, including first aid, medical examination and treatment, and rehabilitation (within their level of technical service delivery and scope of operation specified in law), health management of older persons, NCDs, chronic diseases, health communication and education, and collaboration with higher levels in planning and carrying out routine health checkups for older persons. In brief, CHSs are assigned responsibility for delivering minimum essential healthcare services to older persons and managing some NCDs. NCDs are prevalent among older persons and many CHSs have begun to participate in NCD prevention to some extent, mainly related to prevention of diabetes and hypertension. Currently, CHS and regional polyclinics are being reoriented towards implementing primary health care service delivery following family medicine principles. Nevertheless, this orientation has only begun to be implemented, so it is not yet applied widely and will require some time to assess its effectiveness.

Although a new policy orientation is in place, CHS staff still have limited ability to perform the assigned tasks due to lack of training or supervision. The management of and

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27 Including government and private facilities, excluding CHSs, nursing centers, maternity homes and outpatient clinics.
28 MOH Circular No. 33/2015/TB-YT dated 27 October 2015 guiding functions and duties of CHSs.
counselling on health care for older persons in remote, isolated and ethnic minority areas are facing many difficulties [68]. CHSs are not yet providing home-based treatment and care for older persons in need following family medicine principles.

2.2.4. Preventive medicine system

The preventive health system, which has responsibility for NCDs common among older persons, has strengths such as wide coverage to villages/hamlets, detailed and updated treatment regimens, and effective implementation of some NCD prevention and control programs. However, this system is assessed as having poor capacity for NCD prevention and control. It has no specialized unit or system for NCD monitoring, and so far has not been heavily involved in NCD prevention and control. The existing organization of the health system results in the separation of the preventive system from the curative one, leading to a quantitative deficiency in each system [69]. By 2014, 81% of provincial preventive medicine centers have participated in NCD prevention and control but on different scales and to different degrees. Most provincial preventive medicine centers participate in prevention and control of diabetes mellitus (65.0%) and hypertension (55.6%), mainly through screening/early detection and counseling for patients. They are not yet involved in cancer and COPD prevention and control, and only a few are active in prevention and control of risk factors. Most of them have limited human resources and funding, and must depend on programs/projects from the central level. In addition, their organizational structure is inappropriate. [70].

2.2.5. Private health sector

The private health sector includes hospitals equivalent to provincial and district hospitals and outpatient clinics. Home-based medical care services for older persons have not developed because of an inadequate legal basis. At private health facilities, medical examination and treatment for older persons are performed the same way as for other patients. Some private health facilities register as gatekeeper service providers in order to be paid by health insurance. Private health facilities are often for-profit and collect money from service users. The state is encouraging health facilities to provide free-of-charge services for older persons, but there is no information available to assess this practice.

Private clinics and family doctor clinics: in terms of the organization, a family doctor clinic in Vietnam can be a CHS operating on the principle of family medicine, or a private family doctor clinic (including clinics operating after working hours which want to operate as a family doctor clinic), or a family doctor clinic belonging to a (public) district general hospital. Duties of a family doctor clinic are consistent with regulations on PHC at the residence specified in the Law on the Elderly. Their activities include prevention of disease, PHC, first aid, medical examination and treatment of common diseases; healthcare, screening/early detection of disabilities and diseases, medical examination and treatment at the clinic and in the patient’s home; establishment of health records for continuous and comprehensive monitoring of the health of individuals and families in accordance with MOH regulations, and health care for older persons; referral of patients on the principle of family medicine. Family medicine clinics are the first facilities in the medical referral system responsible for referring patients to other health facilities when technically needed or receiving patients from other health facilities for further care and treatment. 30,31 As reported, by June 2016 there were 336 private family doctor clinics in 6 provinces [3].

30 MOH Decision No. 935/2013/QD-BYT approving the Project on Building and Developing the Model of Family Doctor Clinics for the period 2013 - 2020.
2.2.6. Other health services related to diseases of older persons

In addition to the above-mentioned preventive and curative facilities, several units have been established specifically to meet the needs for NCD prevention and control. DOHs in all provinces have an NCD Prevention and Control Steering Committee. The number of NCD prevention and control projects implemented varies among provinces, some provinces have four to five projects, others have two to three projects.

The Project on active prevention, early detection, diagnosis, treatment and management of NCDs (Decision No. 4299/QD-BYT in 2016) aims at enhancing and improving the capacity of the health system for NCD prevention, surveillance, detection, treatment and management, with focus placed on the grassroots health level. The Project has set the following targets for the network:

- 70% of health workers in charge of NCD prevention and control at provincial, district and commune levels are trained in prevention, surveillance, early detection, diagnosis, treatment and management according to regulations.
- 80% of provincial preventive medicine centers and 80% of DHCs perform NCD prevention, early detection and management according to regulations.
- 95% of NCD service providers at all levels ensure the provision of NCD diagnosis, management and treatment services according to regulations.
- 70% of CHSs perform NCD prevention, early detection of NCD risks; 40% of CHSs participate in the treatment and management of hypertension, diabetes and other NCDs.

2.3. Service utilization patterns by health facility level for older persons in Vietnam

Health care for older persons is an important task of all kinds of health facilities. This is reflected in the proportion of older persons in the total number of contacts with health services. In all types of health facilities, older persons account for about 25% of the total number of outpatients, inpatients and health checkup service users (Figure 53). However, when we look at the proportion of elderly patients by type of health facility, it varies. For example, at CHSs, over 30% of medical examination is provided for older persons. At district hospitals, about 35% of outpatients, 33% of health checkup service users and 30% of inpatients are older persons. At upper-level hospitals, older persons account for about 25% of total patients. In private health facilities, the proportion of outpatients and health checkup service users being older persons is not high, but approximately 33% of inpatients are older persons. These statistics are similar to those collected by the National Geriatric Hospital: in many provincial general hospitals, elderly patients accounts for 20 - 30% of the total number of patients annually [71]. This indicates that older persons are important clients for most types of health facilities and health services.
According to the orientation of our state’s policies, health care for older persons should be delivered near the residence of older persons and be continuous. Specifically, this means health checkup, health management and rehabilitation should be provided in communes, and if necessary elderly patient can be referred to upper-level hospitals for specialized healthcare. At the same time, the state promotes the development of private sector to provide free-of-charge services for older persons. However, it is important to understand the current situation as a basis on which to build strategies and plans to adjust toward the desired orientation. This section analyzes the structure of types of health facility visited by older persons for health checkup, outpatient and inpatient services. This analysis is based on data from a household survey, which may show the difference in the pattern of service use by different socio-economic groups, but not enough to confirm whether the current model is relevant to the pattern of disease of such groups or not.

**General model**

In 2012, according to data from the Household Survey 2012, approximately 9 million older people nationwide [20] made 29 million contacts with health services (Figure 54), including outpatients, inpatients and health checkup service users. Of these, the majority used outpatient services (77%), followed by health checkup (14%) and inpatient services (9%). District hospitals were the type of health facility most used (accounting for 33% of total contacts with health services among older persons), followed by CHSs (22%) and upper-level hospitals (20%). Older persons visited public health facilities (including CHSs) mainly for health checkup, public hospitals mainly for inpatient services, and private/other health facilities mainly for outpatient services. According to an MOH report (based on statistics of service providers), the total number of health checkup services provided for older persons at district level was 11.6 million, the total number of inpatient services provided for elderly patients was 1.3 million [62]. Although the two data sources do not totally match each other, they show big needs for health care among older persons being met by the public health system. The difference in data may be partially because interviewees may underreport use of services in the survey, and the survey sample did not include older persons living in social protection centers.
Chapter V. Health care to meet the needs of older persons in Vietnam

Figure 54. Structure of type of services used by facility type among older persons, 2012

Source: GSO-Vietnam Household Living Standards Survey 2012, JAHR team calculations

Financial resources, human resources and technology were used very differently by level of health facility and type of service used. Figure 55 shows the out-of-pocket expenses for health care for older persons by type of service and level of health facility. Inpatient services at provincial and central levels were the most expensive, accounting for 40% of household out-of-pocket spending on health care for older persons, followed by outpatient services at higher levels, accounting for 16% (Figure 55). The high out-of-pocket expenses at higher levels are partly due to use of specialized and high-tech services. Expenses of health checkup are low because it involved only clinical examination and basic services, and at CHSs health checkups for older persons are subsidized by the state budget. Another possible reason is that the co-payment rate for insured services at upper-levels is higher in case older persons bypass to higher levels. The structure of social resources (including health insurance, state budget, and out-of-pocket payments) may show a different pattern compared to this figure but currently there is insufficient information to illustrate it.

Figure 55. Structure of out-of-pocket expenditures for health services among older persons by service type and facility type, 2012

Source: GSO-Vietnam Household Living Standards Survey 2012. JAHR team calculations

123
Healthcare access pattern of older persons by age group

The structure of types of health service used by older persons varied by age group. The 60 - 69 and 70 - 79 age groups had similar patterns of health service use, while the group aged 80 and older was more dependent on grassroots health facilities (Figure 56). Regarding health checkups, nearly 60% of health checkups for people aged 80 years and older were provided by CHSs, compared to only 35% in the two younger age groups. In those two groups, the proportion of health checkups provided by upper-level hospitals was significantly higher. There was no significant difference in the use of outpatient services among age groups. As for inpatient services, 60% of inpatient services used by people aged 80 years and older were provided by the grassroots level, while the figure was only 50% in the two younger age groups. Private health facilities provided mainly outpatient services only and there was not much difference among age groups. The higher use of near-home services by the older age groups suggests that this age group may encounter geographic barriers to use due to lower mobility.

Figure 56. Structure of facility type for use of different types of health services by age of older persons, 2012

Healthcare access pattern of older persons by personal characteristics

Regarding health checkup, there was no significant difference in the groups of men, women, Kinh people and the non-poor (Figure 57). However, in the groups of ethnic minorities and the poor, older persons mainly got health checkups from CHSs. In urban areas, there was a very high percentage of older persons receiving health checkups at upper-level hospitals, while in rural areas they mainly received health checkups at CHSs and district hospitals.
State-owned hospitals played an important role in providing outpatient services for older persons (Figure 58). However, in the two more disadvantaged groups (ethnic minorities and the poor), CHSs still played an important role in delivering outpatient services. In urban areas, older persons almost did not use outpatient services at CHSs at all. Private and other service providers (traditional healers, individual health service providers) provided about 30 - 40% of outpatient services for older persons.
Inpatient services were mainly provided by state-owned hospitals (Figure 59). However, for the poor and ethnic minorities, CHSs were also important providers of inpatient services. The number of contacts with inpatient services by older persons was equal between district hospitals and upper-level hospitals, except in urban areas where older persons were more dependent on provincial and central hospitals.

**Figure 59. Structure of inpatient admissions among older persons by demographic characteristics, 2012**

![Inpatient care chart](chart)


The above patterns show that older persons were still heavily dependent on government health facilities for health checkup (53%) and outpatient services (46%). Regarding inpatient services for older persons, public hospitals provided 86% of the services, of which half at district level and half at higher levels. Private and other health facilities played a significant role in the provision of outpatient services for older persons (33%). CHSs provided only 38% of health checkups and 21% of outpatient services for older persons.

To implement the policy on provision of health care for older persons in a convenient manner and close to where they reside, with continuity in health management and at reasonable costs, it is necessary to improve the quality of health checkup, medical examination and treatment at the commune level for both healthy older persons and older persons with chronic diseases under treatment. Thus, early detection and effective management of diseases are needed to avoid complications, which will require intensive inpatient services and services at provincial/central levels. Regarding older persons with financial means, especially those in urban areas, instead of strengthening CHSs for management of their health, another option is to encourage private service providers to sign contracts with health insurance and provide a health management service package for older persons to increase the continuity of health care for older persons following the family doctor model. It is difficult for hospitals to manage the health of older persons in a comprehensive manner, as they only focus on treatment of acute diseases or management of certain NCDs, but cannot address all healthcare needs of older persons.
3. Human and financial resources for health care of older persons

3.1. Human resources in health care for older persons

According to the Law on the Elderly, MOH is responsible for training and retraining of physicians, geriatric professionals and rehabilitation practitioners, at the same time improving the capacity of social workers engaged in counselling and care activities.

The development of the health workforce must address the special needs of older persons with respect to their pattern of disease, disability and other characteristics mentioned in Section 2.1 above, as well as other needs arisen due to the population aging. Family medicine practitioners, like geriatric specialists, are an ideal workforce because they have responsibility to resolve common health problems in many different specialties. However, there is a need for multi-specialty teams to effectively manage chronic conditions and associated diseases [72]. Integration among curative care, rehabilitation, clinical pharmacy, preventive counseling, health promotion, social work and personal care services. Older persons need care models for the prevention of illnesses, medical examination and treatment and long-term care [73].

3.1.1. Human resources to provide health care for older persons

Health human resources at all levels deliver health care for older persons, but the knowledge on family medicine, geriatrics and special needs of older persons is not evenly distributed among provinces and levels.

Central level

The National Geriatric Hospital is the leading hospital in health care for older persons, with a contingent of geriatric specialists who play an important role in service delivery, research and training. The hospital has 329 civil servants and public employees, including 90 doctors (24%), 131 nurses (40%), 18 technicians, 13 pharmacists and 87 other employees (26%). Most of the hospital’s doctors have received postgraduate training: 40 resident doctors, 24 level-I specialist doctors and masters, 12 level-II specialist doctors and doctorates. In addition to provision of services to older persons, the hospital is also capable of conducting scientific research, directing/training lower levels and advising MOH on geriatric medicine policies. Other central hospitals with a geriatric department also have geriatric professionals actively engaged in medical examination and treatment at the hospital.

Provincial level

The health care for older persons network at the provincial level has developed quite well, as many hospitals have established the geriatric department or geriatrics integrated department (see Section 2.2 above). However, the work force has not been trained adequately in geriatrics and in the skills required for optimal health care for older persons. The geriatric departments or geriatrics integrated departments mentioned above still lack doctors and most of their doctors have not been trained in geriatrics.

Grassroots level

Grassroots health facilities are those most used by older persons, primarily for management of chronic diseases, common illnesses and routine health checkups. The capability of delivering health care for older persons at the grassroots level is weak as most health workers are not trained in geriatrics or family medicine. At the commune level, although 78% of CHSSs have doctors [65], the number of health workers trained on chronic conditions and diseases that

32 Data provided by the National Geriatric Hospital in June 2016.
are prevalent in elderly such as hypertension and diabetes mellitus is small, and very few are trained in prevention and control of cancer and COPD [74].

According to MOH regulations in Circular No. 07/2013/TT-BYT, village health workers (VHWs) have the function of engaging in PHC in villages, including PHC for older persons. Some studies showed that VHWs play an important role in communication, management and mobilization of families to use services at CHSs [75]. However, the training program for VHWs has not focused much on the special needs of older persons.

**Preventive medicine system**

The proportion of health workers receiving post-graduate education is very low (accounting for 6.1%), of whom the majority are level-I specialist doctors (accounting for 5%). Three out of four general doctors in preventive medicine centers have not been trained in preventive medicine [76]. The establishment of the preventive medicine system and the training of preventive medicine personnel aim at prevention and control of infectious diseases. Currently, as the pattern of disease is shifting towards NCDs and the number of older persons is increasing, the preventive medicine personnel have not yet been retrained to meet these new needs.

**3.1.2. Pre-practice training**

**Higher education and vocational training**

Geriatric medicine is not fully integrated into the curricula of health science training programs. In such curricula, there is content related to health care for older persons, but they mainly focus on general medical examination, treatment and care for older persons while knowledge and skills related to communication and psychology receive little attention. The medical training program (i.e. training of general doctors) has no credit hours of training in geriatrics. The traditional medicine training program (i.e. training of traditional medicine physicians) has three credit hours on traditional medicine geriatrics. Family medicine specialty also includes training in many skills of great relevance to geriatric medicine. The undergraduate training program for nurses has two credit-hours on health care for older persons. The junior college training program for nurses has two credit hours on health care for older persons. The secondary medical training program for assistant doctors and nurses has no credit hours on health care for older persons. Currently, there are no consistent geriatrics framework curricula for doctors and nurses. However, the National Geriatric Hospital has developed geriatrics lectures for physicians, nurses and caregivers, which will be printed soon.

Regarding careers related to health care for older persons, there are undergraduate, junior college and secondary training programs for rehabilitation technicians (physiotherapists). The undergraduate occupational therapy training program, with the support from Handicap International and Medisch Comité Nederland-Vietnam (MCNV), is being developed at Hai

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33 Contents of these courses focus on the physiological and pathological characteristics of older persons in traditional medicine theory, description of symptoms, treatment methods, practice applying traditional medicine and non-drug treatment methods in the treatment of common diseases prevalent in older patients.
34 MOET Circular No. 01/2012/TT-BGDĐT dated 13 January 2012 issuing the framework curriculum for undergraduate training in health sciences for bachelor’s degree, which provides basic knowledge on psychophysiological changes and health problems of older patients; care needs of older patients and roles of nurses, nursing techniques and care procedures for elderly patients.
35 MOET Circular No. 11/2010/TT-BGDĐT dated 23 March 2010 issuing the framework curriculum for undergraduate training in health sciences for junior college level, which provides basic knowledge on characteristics of the body and diseases of older patients, structural and functional changes of body organs, development of care plans for some common diseases in older patients.
36 MOET Circular No. 19/2010/TT-BGDĐT dated 29 June 2010 issuing the framework curriculum in health sciences at the secondary technical level.
Duong Medical Technical University. There are currently no separate or integrated training programs in speech therapy.

**Postgraduate training**

At present, there are geriatrics postgraduate training programs for level-I specialist doctors, level-II specialist doctors, masters and doctorates. However, to date there is no level-IV code for geriatrics in the list of master and PhD training programs (Document No. 16/VBHN-BGDDT in 2014). The number of training institutions providing these training programs is limited. The Geriatrics Faculty of Hanoi Medical University was established in November 2015 and has begun to train general doctors in geriatrics since September 2016 and post-graduate geriatricians. The Geriatrics Faculty of the University of Medicine and Pharmacy at HCMC established in 1986 (formerly known as the Gerontology Faculty) is currently delivering training for medical students, postgraduate training and continuous training mainly in HCMC, but has no training for nurses and care workers. In addition, Hue Medical University also has a Geriatric Division under the Internal Medicine Faculty. The Geriatrics Faculty of the National Geriatric Hospital and the Geriatric Unit of the University of Medicine and Pharmacy at HCMC also deliver postgraduate training in geriatrics.

Family medicine is a specialty suitable for health care for older persons as it creates a continuous relationship between health workers and patients, balances preventive medicine, improves health, manages chronic diseases and treat acute conditions. Family medicine training has been provided to physicians and specialists (level-I and level-II specialists). There is also a short-term training program for nurses, technicians, assistant doctors and general doctors.

### 3.1.3. Continuing medical education (CME) for health workers

CME is important to ensure that health workers practice in accordance with the most up-to-date global medical evidence. At the same time, continuous training supplements the basic knowledge that has been learned before starting a practice. This is especially important to geriatrics, as to date, most health workers have not been trained in geriatrics while the proportion of elderly patients is increasing. Health workers who have been granted with a practice license and are practicing medical examination and treatment are obliged to participate in continuous training for at least 48 periods in 2 consecutive years as stipulated in Circular No. 22/2013/TT-BYT to keep their practice license valid.

In implementation of Circular No. 22, to develop a continuous training network, MOH has considered and granted codes to training institution providing continuous training for health workers. By 31 May 2016, 58 out of 63 DOHs, 69 MOH subordinate units and professional associations, and 102 professional education institutions have been granted with a code and been recognized as eligible for continuous training. It is planned that by the end of 2016, all DOHs in the country will be granted with a code for continuous training delivery. Units granted with this code are responsible for organizing certified continuous training courses in accordance with Circular No. 22/2013/TT-BYT and the list of health areas subject to continuous training (Decision No. 492/BYT-K2DT). MOH has also issued regulations on required quality of continuous training institutions (Decision No. 493/QD-BYT 2012), the process of granting codes for continuous training and the process of evaluating continuous training programs and materials.

The National Geriatric Hospital plays an especially important role in organizing continuous training in geriatrics. After being separated from Bach Mai Hospital in June 2006

37 Post-graduate enrollment announcements in 2016 of Hanoi Medical University, HCMC University of Medicine and Pharmacy and the School of Medicine and Pharmacy within Hue University.
to become the National Geriatric Institute (now known as the National Geriatric Hospital), the hospital has organized 48 continuous training courses for 2441 doctors and assistant doctors from central/provincial/district general hospitals of 42 provinces [77] to provide additional knowledge on the most common chronic NCDs in older persons. In particular, in recent years the hospital has updated learners about common geriatric symptoms. Since 2015, the hospital has organized 3 training courses for nearly 100 nurses, geriatric professionals and three on-the-job training courses to enhance practical skills and techniques commonly used in geriatrics such as electromyogram (EMG) interpretation and electromyography, Doppler echocardiography, mental and psychological tests, etc. Although the National Geriatric Hospital has held many continuous training courses on various topics, the number of the courses is not enough for the entire country. It is necessary to expand the institutions involved in continuous training for health workers on topics related to health care for older persons. Currently, a few other central hospitals have been evaluated and granted with a code for continuous training delivery in the field of geriatrics such as the National Traditional Medicine Hospital, Hue Central General Hospital and Thong Nhat Hospital (HCMC). 14 out of 49 provincial and district hospitals with a geriatric department or geriatrics integrated department have been granted with a code for continuous training delivery, but it is not clear whether their continuous training also covers geriatrics or not.

In 2014 and 2015, the National Geriatric Hospital has participated in the development of a variety of geriatrics training materials. Firstly, are the basic geriatrics training program and the advanced geriatrics training program for doctors. Secondly is the document on health care for older persons (for doctors at provincial, district and commune levels). Thirdly, the hospital collaborates with WHO to develop guidelines on health care for older persons for grassroots health workers and caregivers of older persons in the community.

HCMC Geriatrics Association, established in 2010, plays an important role in disseminating geriatric knowledge to people and health workers through workshops, training courses and its website. Currently, the Association has more than 700 members, mainly from southern provinces. A group of geriatricians is carrying out procedures to establish the Vietnam Geriatrics Society to promote the sharing of geriatric knowledge nationwide. Although HCMC Geriatrics Association has not been certified to organize continuous training, the Association is actively involved in delivering basic and advanced knowledge on geriatrics.

In addition to general geriatrics, several organizations have instituted continuous training programs on common health problems and diseases in older persons. CHSs and emergency medical transport units have plans to train staff about stroke to improve their capacity for receiving, assessing and managing stroke patients and informing facilities with a stroke team, stroke department, stroke center or upper-level health facilities before referral (Circular No. 47/2016/TT-BYT stipulating the organization of medical examination and treatment of stroke in health facilities). The “Capacity Building for Community-Based Rehabilitation” cooperation program between MOH and MCNV has developed many rehabilitation training materials, however, contents do not focus on the specific needs for rehabilitation among older persons. The National Cancer Hospital (i.e. K Hospital) has been conducting training to guide the early detection, diagnosis, treatment of and palliative care for cancer within the scope of the National Cancer Program 2012, which is quite important as older persons account for a high proportion in the total number of cancer cases.

38 Bac Ninh, Binh Dinh, Binh Phuoc, Can Tho, Da Nang, Cao Bang, Dak Lak, Dien Bien, Dong Thap, Ha Giang, Ha Nam, Ha Noi, Ha Tinh, Hai Duong, HCMC, Hoa Binh, Hung Yen, Khanh Hoa, Kien Giang, Kon Tum, Lam Dong, Lang Son, Nam Dinh, Nghe An, Ninh Binh, Phu Tho, Phu Yen, Quang Binh, Quang Nam, Thai Nguyen, Thanh Hoa, Thua Thien Hue.
3.2. Health financial protection for older persons

3.2.1. Equity in accessibility to health services

The structure of customers in different types of health facility should reflect different needs by the severity of disease. While CHSs mainly provide basic services, provincial and central hospitals serve people with complex medical conditions that require intensive care. However, currently the utilization of health services at different levels is dependent on the affordability and accessibility to services instead of the severity of diseases. Figure 60 illustrates this situation. The last column shows the percentage of older persons by household living standards. Regarding CHS services, about 60% of service users were the poor and near-poor (accounting for 40% of the total elderly). Service utilization patterns at district and private health facilities were about the same indicating heavy reliance among middle living standards groups. However, at provincial and central hospitals more than 70% of services were used by the rich and near-rich elderly. This situation can be considered as fair if the poor have less illnesses and the rich have more illnesses. In fact, it is likely that the rich and near-rich elderly are unnecessarily using technical services at higher levels while the poor elderly cannot get access to necessary services. More detailed research is needed to have an accurate assessment.

Figure 60. Structure of living standards of older persons using different types of health facilities, 2012

Affordability is an important factor preventing older persons from using health services. A survey conducted by the National Geriatric Hospital in Hanoi, Thua Thien Hue and Ba Ria-Vung Tau showed that unaffordability is one of the reasons preventing older persons from using health care services (accounting for 45.3%). However, financing is not the only reason, as there are many other reasons such as difficult travelling conditions (17.3%), poor local health capacity (16.5%) and other reasons (20.9%)[51]. Although this survey was conducted in 2006, its findings concern us and should be considered when conducting similar surveys and developing policies for older persons. Although PHC is delivered at the commune level, health insurance card holders have to visit district health facilities for medical treatment, which is very difficult for the poor or people living in disadvantaged areas such as the Northern Midlands, Northern Mountains and Central Highlands where the distance from a commune to the nearest district hospital is up to 13.3 km, 22.5 km and 15.6 km respectively [78].
The following Section analyzes the current situation of health insurance coverage and the effectiveness of financial protection of existing health financing policies. There is insufficient information to further analyze other barriers.

3.2.2. Health insurance coverage for older persons

Health insurance is an important tool in Vietnam for reducing barriers to use of health services, at the same time it contributes to the financial protection of older persons in utilization of health services.

The proportion of older persons covered by health insurance increased annually (Figure 61), towards the target of the Health Care for the Elderly Project, i.e., by 2025 100% of the elderly should have health insurance cards. In 2014, 75% of the elderly had health insurance cards compared to only 43.5% in 2006. Health insurance coverage was highest in the group aged 80 and older, slightly lower in the 70 - 79 year age group and was lowest (72%) in the 60 - 69 year age group [61]. By 2016, more than 7.85 million older people had health insurance cards [64]. In implementation of Decree No. 136/2013/ND-CP, by 2015 the country had provided monthly social assistance payments and free health insurance for 1.5 million older people aged 80 years and older without a pension [79]. According to household survey data in 2012, only 10% of people aged 80 years and older did not have health insurance cards, but by 2014 this figure had increased to 25%.

Figure 61. Proportion of older persons with health insurance coverage by age group, 2006 - 2014

Older persons aged 60 - 79 years whose health insurance premiums are not paid by social insurance agencies or the state budget must participate in health insurance on a voluntary basis. Among health insurance participants aged 60 - 79 years, the proportion of voluntary participants is rather high (accounting for about one third) (Figure 62). The high health insurance coverage of people aged 80 and older can be explained by the state budget’s payment of their health insurance premiums.
Chapter V. Health care to meet the needs of older persons in Vietnam

Figure 62. Structure of health insurance types by age group, 2012

![Insurance type chart]

Source: GSO. Vietnam Household Living Standards Survey 2012. JAHR team calculations

The health insurance coverage of the disadvantaged elderly has increased between 2006 and 2014 (Figure 63). The fastest increase and the highest coverage were with ethnic minorities and the poor. In 2014, the health insurance coverage of the male, non-poor, and urban elderly has fallen slightly compared to 2012.

Figure 63. Proportion of older persons with health insurance by individual characteristics, 2006 - 2014

![Proportion chart]

Types of health insurance differ across age groups (Figure 64). The poor and ethnic minority elderly have the highest share of health insurance coverage subsidized by the state budget, while this share among the urban elderly is low. In contrast, in urban areas, the proportion of older persons with compulsory health insurance is high. The compulsory health insurance share is higher in men than in women, and is very low in the rural and ethnic minority elderly. In all groups, the voluntary health insurance share is higher than the compulsory share.

![Figure 64. Structure of health insurance type by characteristics of older persons, 2012](image)


3.2.3. Impact of health insurance on accessibility and financial protection

Health insurance aims to reduce financial barriers to health services and at the same time reduce health financial burden. The following sections will analyze the situation of accessibility to and use of inpatient and outpatient services and the financial burden older persons face when using health services.

Ideally, the extent to which older persons use health services should depend on their need rather than affordability. However, there are factors that impede access to services among people in need, especially when healthcare costs are high and people cannot afford it. Health insurance aims to reduce financial barriers for health service users. However, there is a tendency for sicker people to buy insurance while the healthy do not. This phenomenon is called adverse selection. Older people aged 80 and older are entitled to health insurance without having to pay premiums. Thus, the health insurance coverage of this group should be 100% and there should be no financial impediments to their access to health services. But in the group below age 80 years, many people must pay for their own health insurance. In that context, it is likely that those without health insurance are generally healthier than those with health insurance. Another possible problem is that health insurance card holders may over-use health services - because insurance lowers healthcare costs they face (only co-payments). This phenomenon is known as moral hazard.

For outpatient services, the cost of each contact with services is often not high so financial barriers are not as great as for inpatient services. Figure 65 shows that on average, older persons use outpatient services 3 times a year. There is no significant difference among
health insurance card holders of different age groups, but for people without health insurance the average number of contacts with outpatient services per year tends to increase with age. This phenomenon in the 60 - 69 age group may be caused by moral hazard (i.e. health insurance card holders over-use health services) and adverse selection (i.e. health insurance card holders have more illnesses than people without health insurance). But for the age groups 70 - 79 years and 80 years and older, it is difficult to explain why people without health insurance tend to use more services.

For inpatient services, higher costs create a major impediment to service utilization. However, when health problems threaten a person’s life, the family often finds a way to access health services, including for older persons. Figure 65 shows that the older health insurance card holders are, the more contacts with health services they have. However, for those without health insurance, service utilization of older persons aged 80 and older is similar to that of the 70 - 79 age group, suggesting that there might be financial barriers preventing them from using these services.

Figure 65. Average annual number of outpatient contacts and inpatient visits per older person by health insurance coverage, 2014

![Figure 65](image-url)

Source: Giang Thanh Long 2016 [61].

The second aim of health insurance is financial protection, meaning that health service users will not have to pay catastrophic out-of-pocket expenditures that may lead them to impoverishment. Figure 66 shows that for outpatient services, older people younger than 80 years with health insurance pay about the same amount as uninsured people in the same age group, but in the group aged 80 and older, out-of-pocket payment of health insurance card holders is about half that of uninsured people. The average out-of-pocket payment per contact with outpatient services is about 1-2 million VND, so the financial burden is not large. The co-payment rate for insured older persons using inpatient services is about 4 million VND per year, but this does not rise with age, even though the average number of inpatient admissions per person per year does increase with age. For uninsured people, the 70 - 79 age group has a very high average out-of-pocket spending, more than double that of health insurance card holders. But in the group aged 80 years and older, out-of-pocket spending of uninsured people is lower because they use fewer services.
Survey responses of older persons on household financial issues shows significant impact of health risks on personal financial behaviors. Approximately 10% of older persons report having savings, of whom 68% consider these as precautionary savings, for example to pay for medical expenses. There are many reason older persons fall into debt. Health-related reasons account for 13.8% [28].

4. Provision of health care for older persons

4.1. Preventive medicine and health promotion for older persons

Regarding preventive medicine, policies on health care for older persons includes both primary and secondary prevention services. Primary prevention services for older persons includes equipping them and their caregivers with disease prevention, treatment and self-care skills. In 2016, MOH approves the Project on Communication and Social Mobilization to Prevent Cancer, Cardiovascular Diseases, Diabetes, COPD, Asthma and other NCDs for the period 2016 - 2020 (Decision No. 4298/QD-BYT in 2016). Secondary prevention services include early detection and management of chronic diseases. The Law on the Elderly assigns MOH responsibility to develop and organize the implementation of a program on prevention of cardiovascular diseases, diabetes, Alzheimer’s disease and other chronic diseases of older persons. Secondary NCD prevention will be discussed in Section 4.2.

4.1.1. Health communication and promotion for older persons

*Achievements*

The Law on the Elderly and Circular No. 35/2011/TT-BYT guide localities to implement their responsibilities for promoting the health of older persons through health IEC. Specifically, localities are responsible for “communicating and disseminating knowledge on physical exercise, health promotion and disease prevention, especially for common diseases in older persons so older persons can take their own preventive measures; applying appropriate IEC methods depending on the conditions of each locality; and equipping older persons with disease prevention, treatment and self-care skills”.

Several provinces have paid special attention to older persons in carrying out health IEC activities. Health IEC has been delivered in many forms. Some provinces allocate time in
their IEC programs specifically for older persons or have contents for older persons integrated in to general health IEC programs. For example, in Kien Giang province, the provincial radio and television has two radio programs for older persons every Monday and Wednesday morning [80]. Health IEC for older persons through activities of clubs for older persons (e.g. ISHCs and older persons help older persons clubs) is also a good channel to provide knowledge for older persons on prevention of diseases and health promotion. In addition, there are also health IEC activities of the private sector, for example websites of companies or organizations interested in health care for older persons.

**Difficulties and shortcomings**

Currently, there are no strategies or plans to support localities in conducting health promotion IEC, especially for older persons. Very few provinces have IEC programs for older persons or time in their IEC programs dedicated to older persons. Only some provinces have contents for older persons integrated into general health IEC programs. Usually, communication sessions are organized for older persons only on special occasions such as the International Day of Older Persons (1 October) or the Vietnamese Older Persons Day (6 June). Contents relating to NCD prevention and control have not been integrated into such communication sessions. Health workers at the grassroots level (including VHWs) have not been trained in or provided with knowledge on prevention of disease and care for older persons to enable them to better inform and educate local people and older persons. Health workers in hospitals have not integrated the counseling and education for older persons on prevention of diseases and health promotion in to the treatment and rehabilitation process.

Health IEC contents for older persons are insufficient in terms of quantity and quality. The implementation of IEC activities and development of IEC contents are mainly done by NCD prevention programs/projects [80]. However, many important aspects of health care for older persons have not been adequately addressed such as the impairment of organ function, cognitive impairment, balance disorders and falling, frailty syndrome, urinary incontinence and malnutrition. Mental health IEC focuses primarily on schizophrenia, epilepsy and depression but neglects other problems encountered by older persons such as dementia, Alzheimer’s disease, geriatric depression, anxiety, psychosis and sleep disorders. In addition, older persons face many difficulties not only related to health but IEC fails to cover issues such as the need to improve the lighting system, roads, and floors, availability of assistive devices (walking sticks, glasses, hearing aids, etc.), establishment of health clubs or mobilization of older persons to participate in them.

**4.1.2. Prevention of chronic NCDs**

**Achievements**

Vietnam has begun to develop and implement NCD prevention and control programs, contributing to the goal of healthy aging. The NCD Prevention and Control Program for 2012 - 2015 has focused on common NCDs and implemented many activities including the development of national guidelines, IEC materials for people, training of health workers, and provision of IEC on NCD prevention and control. In the next stage, the sector will implement the National Strategy for NCD prevention and control in the period 2015 - 2025 to decentralize NCD prevention and control activities.

Recently, Vietnam has developed policies to control risk factors for NCDs as recommended by WHO. According to the National Strategy for NCD Prevention and Control, the control of risk factors, such as smoking, drinking, poor nutrition, unsafe food and physical inactivity, is one of the determinants of effective NCD prevention and control. The Law on Tobacco Control, the National Policy on Alcohol Control to 2020 (Decision No. 244/QD-TTg
in 2014), the Food Safety Law and the National Nutrition Strategy for 2011 - 2020 with a vision to 2030 (Decision No. 226/QD-TTg 2012) are the legal basis for the implementation of related activities in Vietnam.

Many NCD control policies and activities are being implemented for the entire society, with the potential to prevent diseases in older persons in the future. The prevention of risk factors also includes IEC activities and other supportive policies such as imposition of the special consumption tax to raise prices of and to reduce the consumption of tobacco and alcohol; non-smoking areas; and food safety regulations. Several risk factor control activities are dedicated exclusively to older persons.

- Decision No. 189/QD-BYT dated 17 January 2013 on “Ten Proper Nutrition Tips to 2020” is issued as the basis for nutrition IEC to improve people’s knowledge and practice regarding proper nutrition. Contents of these tips focus on encouraging people to eat a wide variety of foods, consume both animal protein and vegetable protein, vegetable oil and animal fat, limit salt intake, eat more fruits and vegetable, ensure food safety, drink enough clean water, increase physical activity, limit consumption of sweets, soft drinks, alcohol and cigarettes.

- According to the targets set by the National Nutrition Strategy, hospitals should deliver nutrition counseling and provide suitable nutritional diets to groups with specific dietary requirements, such as older persons. By 2020, 100% of central hospitals, 95% of provincial hospitals and 50% of district hospitals should be implementing these two activities.

- The Law on Tobacco Control recommends “No smoking at home if there are children, pregnant women, patients or older persons.”

- Alcohol and tobacco detoxification is beneficial to elderly addicts and this service is being developed by some psychiatric hospitals at the central level and in HCMC, in combination with online IEC on detoxification.

- The VAE, the sports sector, communities and clubs for older persons are developing a sport movement to help improve health and spiritual comfort of older persons.

Raising people’s awareness of NCD prevention and control is a key activity in national health target programs and in the National NCD Prevention and Control Strategy. The Project on Communication and Social Mobilization to Prevent NCDs aims to improve people’s knowledge and change people’s behaviors in NCD prevention and control. The target group of the project consists of people at risk of NCDs and people living with NCDs; older persons are included in this target group. The project is funded largely by the state budget, including funding from the MOH Health and Population Target Program for 2016 - 2020, together with other domestic and foreign sources of funding. Project activities focus on the development of IEC messages and contents, IEC delivery through mass media and CHSs, and capacity building for IEC staff in localities. Below are the project targets:

- 70% of adults will have knowledge on the causes, harm, preventive measures for cancer, cardiovascular diseases, diabetes, COPD and asthma;

- Over 80% of upper secondary school students will have knowledge on the harm of alcohol, improper nutrition and physical inactivity;

- At least 50% of adults at risk of cardiovascular diseases and diabetes will visit health facilities for medical examination and diagnosis of disease.

- The average salt consumption of adults will be reduced by 15% compared to 2015.
Health IEC is carried out through various channels and in a variety of forms. Communication has been delivered through mass media, printed materials, conferences, events (e.g. World Heart Day, World Diabetes Day - 14 November). The private sector is also actively involved in developing materials and websites for awareness raising and advertisement purposes. Clubs of people having NCDs, e.g. hypertension club, are set up in the community and organize monthly events for club members to share/exchange experience and be advised by cardiologists on hypertension prevention and treatment [81]. A study on the reception of IEC information on NCD prevention and control shows that although many people receive information through mass media, they prefer direct communication such as counselling of health workers because the information is more accurate and they can discuss with health workers when there is a question. The reception of information directly from health workers or through friends and family members helps people remember more information more easily.

People’s knowledge on NCD prevention and control has increased recently. Knowledge of cancer prevention and control has been improved significantly. In 2015, over 90% of people knew about cancer compared to only < 50% found in a survey in 2009. People had a positive attitude towards cancer prevention and control, 69% thought cancer is non-communicable, 66% thought cancer is preventable and 85% knew that when one has abnormal symptoms, they should visit health facilities for examination and early treatment [82]. IEC activities of the COPD Prevention and Control Project have created positive impact and changed people’s awareness of COPD. Regarding access to information, a study conducted in three provinces and cities representing the North, Center and South of Vietnam revealed that 59.1% of people had heard about COPD and 72.65% of people had heard about asthma. The proportion of people with knowledge on COPD and asthma was rather high (71.3% and 82.3% respectively) [83]. There was no information available to assess the accessibility and effectiveness of IEC on NCDs specifically aimed at older persons.

Difficulties and shortcomings

NCD prevention is implemented vertically and independently without close collaboration among NCD prevention and control programs/projects. Within the scope of the national health target program, the prevention and control of each NCD is implemented by a separate project assigned to a leading specialized hospital which is responsible for coordination, development of project work plans, implementation of project activities, use of project budget and monitoring and evaluation. Therefore, the prevention of chronic diseases and NCDs involves different IEC contents, IEC methods, target groups and timeline depending on each project. There is no integration among projects while some NCDs share common risk factors, for example cardiovascular diseases, diabetes and cancer all share smoking, improper nutrition, physical inactivity and alcohol abuse as risk factors. Smoking is also a risk factor for COPD. Consequently, there is duplication and wastefulness, leading to sporadic IEC activities. Moreover, it complicates the assessment of effectiveness of preventive measures. There have not been many studies to assess the positive impact of risk factor control on NCD prevention and control.

Resources for communication are limited and used ineffectively. Budget for communication activities of target programs in the period 2011 - 2015 was reduced substantially. The Health and Population Target Program (Resolution No. 73/NQ-TTg in 2016) has only a few IEC activities, and there is insufficient funding for IEC in 2016 - 2020. At present, health insurance does not cover health counseling and preventive activities, while there is a shortage of funding from the state budget to provide counseling for NCD patients and people with risk factors. There is also a lack of collaboration between NCD prevention and control units and Provincial Health IEC Centers (or units in charge of health IEC). The participation of social organizations has not yet been promoted.
Many people do not have basic knowledge about risk factors and how to prevent NCDs. In 2015, 50.27% (n = 1708) of people with hypertension did not know risk factors for hypertension and 47% (n = 432) of people with diabetes did not know risk factors for diabetes [84]. In 2016, the proportion of people who knew about COPD was relatively low. Up to 45.5% of patients knew very little about COPD [83]. People’s knowledge on warning signs of cancer was quite limited. The proportion of people knowing at least four warning signs of cancer accounted for 22.3%. Up to 19.7% were not able to name any warning signs of cancer. Only 43% were satisfied with available information on cancer prevention and control [82].

A number of NCD risk factor prevention projects planned in NCD prevention and control policies have not yet been established. These include the project to manage and monitor the amount of salt, sugar, fat and additives in processed foods and to intervene to reduce salt consumption in the community, the project to ensure proper nutrition and to increase physical activity among children and students, the project to enhance physical activity for NCD prevention and control in the period 2015 - 2020 assigned by the Prime Minister to the Ministry of Industry and Trade, the Ministry of Education and Training (MOET) and the Ministry of Culture, Sports and Tourism within the scope of the National Strategy for NCD Prevention and Control (Decision No. 376/QD-TTg in 2015).

Mental health is an important issue for older persons, especially dementia, Alzheimer’s disease and depression. However, in Vietnam mental disorders are often not considered as NCDs, so the National Strategy for NCD Prevention and Control includes no objectives and solutions relating to mental illnesses. Instead, projects on prevention and control of diseases that are dangerous to the community (within the scope of the National Health Target Program for 2012 - 2015) have delivered communication to people on mental health in general, with specific messages about schizophrenia, epilepsy and depression, to help with active prevention and management of these diseases. However, mental health IEC at the commune level is only carried out in communes where the projects are implemented, so coverage is not nationwide. In the period 2016 - 2020, mental health care was removed from the Health Target Program.

4.2. Situation of early diagnosis, management and treatment of diseases in older persons

Health care for older persons focuses on early detection and timely treatment of disease. Early detection of disease and timely medical care not only facilitate treatment, but also help reduce complications caused by disease. In this task, the main efforts focus on screening, control and management of NCDs in the community to respond to the rapid increase of NCDs, reducing the risk of acute episodes and, preventing and detecting complications of NCDs. In addition, providing health counselling and rehabilitation in the community contributes to reducing the burden of disease and increasing quality of life.

According to the Law on the Elderly and the Vietnam National Action Program for the Elderly, apart from preventive activities, the health sector is also responsible for early detection and treatment of diseases related to older persons. In implementing the National Strategy for NCD Prevention and Control, MOH has formulated and approved a project on active prevention, early detection, diagnosis, treatment and management of cancer, cardiovascular diseases, diabetes, COPD, asthma and other NCDs for the period 2016 - 2020. The goal of the project is to reduce growth in pre-morbidity, morbidity, disability and early mortality due to NCDs in the community. Although project activities focus on primary prevention for students and workers, the project also has important targets for secondary prevention, i.e. early detection and treatment of each of the NCDs mentioned in the Strategy, which is crucial in health care for older persons (Table 16).
Table 16. NCD prevention and care targets for 2020 and 2025

<table>
<thead>
<tr>
<th></th>
<th>2020 Target of the project</th>
<th>2025 Target of the Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of people with hypertension detected</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>% detected hypertension patients managed and treated in accordance with clinical guidelines</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence in people aged 30 - 69 years old is controlled</td>
<td>&lt; 16% (pre-diabetes)</td>
<td>&lt; 8% (diabetes)</td>
</tr>
<tr>
<td>% of people with diabetes detected</td>
<td>50% (diabetes)</td>
<td>55% (pre-diabetes)</td>
</tr>
<tr>
<td>% detected diabetes patients managed and treated in accordance with clinical guidelines</td>
<td>50% (diabetes)</td>
<td>50% (diabetes)</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of people with cancer detected at an early stage</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>% of people with oral cavity, breast, cervical, ovarian and colorectal cancer detected</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of people with COPD detected at an early stage (before the appearance of complications)</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>% detected COPD patients treated in accordance with clinical guidelines</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>% of people with asthma detected at an early stage (before the appearance of complications)</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>% of treated asthma patients achieving asthma control</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>% of treated asthma patients who achieve asthma control attaining a complete control</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Decision No. 4299/QD-BYT in 2016 (Project for the period 2016 - 2020); Decision No. 376/QD-TTg in 2015 (Strategy for the period 2015 - 2025)

The grassroots healthcare network is responsible for early detection and management of chronic NCDs in older persons. However, the ability to provide screening and NCD management services to older persons is uneven among localities. Regarding older persons who suffer from sequelae and multiple diseases, the grassroots level is responsible for referring them to specialized health facilities to meet their needs. However, after the patients are treated and stabilized on a specific disease management plan, referral back to the grassroots level is preferable for patient convenience and lower costs as it is closer to their house and less costly.

**Achievements**

There have been some recent achievements in health care for older persons at the grassroots level. Some localities have organized routine health checkups for older persons at CHSs, usually on the Vietnamese National Older Persons Day. In 2016, 792 430 older persons...
received routine health checkups at CHSs, accounting for about 7.7% of older persons [64]. The number of elderly without family support receiving home-based medical care is increasing: in 2015, approximately 29,600 older persons without family support with serious illnesses and unable to visit health facilities received home-based medical care by health workers [62]; in the first 6 months of 2016 the figure was 50,266 [85]. Several CHSs manage a list of older persons in their local area. In communes where projects are implemented, CHSs keep a logbook for monitoring the health of older persons in the commune; for example, each of the 20 communes where there are projects in Hoa Binh province (accounting for 9.5% of all communes) has a chronic disease monitoring logbook. CHSs in some other provinces only manage the list of older persons in the commune [71].

The health sector has implemented selected screening and NCD management activities at grassroots or provincial levels depending on the disease. Although these activities serve people of all ages, due to the high prevalence of NCDs in older persons, this has contributed significantly to health care for older persons.

- **Prevention and control of hypertension**: a hypertension management model at the grassroots level has been developed, involving hypertension prevention and control units (belonging to DHCs) and hypertension treatment units (belonging to district general hospitals). Approximately 12% of the communes have also participated in the management of hypertension through counseling and coordination of drug delivery at CHSs [62, 86]. By 2015, the project has contributed to the detection, treatment and management of more than 800,000 hypertensive patients [87].

- **Diabetes**: CHSs are able to detect people with risk factors for diabetes; screen to detect people with pre-diabetes as well as people prone to diabetes for referral to higher levels for diagnosis and timely treatment; and manage and monitor patients who have been stabilized on treatment at higher levels [88]. The Diabetes Prevention and Control Project has gradually contributed to the detection, treatment and management of 250,000 people with pre-diabetes and diabetes [89].

- **COPD and asthma**: The management of COPD patients has been piloted in some districts (of Bac Ninh, Bac Giang, Hai Duong, Tien Giang, Dong Thap provinces), while the prevention and control of COPD and asthma are mainly implemented at the provincial level [90]. In 2015, 32,101 people were screened, 2,506 detected to have asthma and 900 detected to have COPD. A total of 11,235 COPD patients are under management [91]. By 2016, the prevention and control of COPD and asthma covered 63 provinces with 115 COPD management units based in provincial general hospitals, provincial TB and lung diseases hospitals, and provincial centers for social diseases prevention. Outpatient clinics were equipped with pulmonary function testing equipment meeting ERS/ATS standards, computer, stethoscope and blood pressure monitor, etc.

- **Mental health care**: by 2015 mental health care for the community and children has been delivered in 9,594 communes (i.e. coverage of 63.6%) and the intervention model for protection of mental health among older persons has been implemented in two communes [92]. This model has gradually been replicated in 2016 and will continue to expand in the coming years. There are no data available on the implementation results of this model.

- **Cancer**: The Cancer Prevention and Control Project is focusing on capacity building, with the objectives for 2016 - 2020 as follows: to strengthen the capacity of health workers, to have 80% of health workers involved in the project trained on prevention and early detection of common types of cancer, and >70% of provinces should have cancer prevention/oncology units (e.g. Oncology department/center/hospital) [82].
Apart from chronic NCDs, there are other common health problems in older persons which can be detected and treated in a timely manner to reduce disabilities (e.g. stroke, blindness).

- **Stroke**: the delivery of medical examination and treatment of stroke in health facilities is receiving attention in accordance with Circular No. 47/2016/TT-BYT. Stroke is a common disease in older persons and has a tremendous impact on mortality and impairment, however it can be less harmful if detected and treated within a 3-hour window. The Circular allows 4 forms of stroke examination and treatment with different levels of comprehensiveness, from a stroke team, which is responsible for administration of first aid and transportation of the patient, to a stroke center, which provides essential and intensive health care services including vascular interventions, neurosurgery and physiotherapy/rehabilitation. There are no specific objectives related to timely detection and treatment of stroke.

- Older persons also receive community-based eye examination through the “Bright Eyes for the Elderly” Program launched by the V AE. After 4 years of implementation, the Program has provided eye examination and counselling for 3.6 million older people, treatment of eye diseases and cataract surgeries for 542 thousand older people, and improvement of eyesight with prescription glasses for 258 thousand older people. Health facilities have delivered eye examinations, to 598 135 older people and free-of-charge treatment to 104 840 older people[64].

**Difficulties and shortcomings**

The organization of routine health checkups for older persons in communes is still perfunctory and like a spontaneous movement, without specific guidance on contents of the medical examination or monitoring of implementation. In many places, health checkups are only delivered when there are charity activities going on (e.g. free-of-charge eye examination or surgeries supported by VAE, etc.) The budget for health checkups for older persons is limited, some provinces allocate only 15 000 VND per older person per routine checkup, so the checkups cannot be comprehensive. Currently, routine health checkups for older persons are mainly delivered in cities and towns. This activity has neither been implemented widely nor has it prioritized disadvantaged groups, i.e. older persons living in mountainous, island and remote areas. Regarding easy-to-detect diseases, a high proportion of people suffering from these diseases still do not know they have them. For example, according to the latest survey of the National Hypertension Prevention and Control Program, the proportion of adults with hypertension was 47.3%, but 39.1% of these cases had not yet been detected.

The health sector has not developed a routine health checkup package and guidelines suitable for older persons based on evidence on cost effectiveness of the most appropriate screening methods. MOH has issued Official Documents No. 1727/BYT-KCB and No. 1728/BYT-KCB (dated 30 March 2016) on the organization of PHC and routine health checkups for older persons in accordance with the health checkup procedures set out in Circular No. 14/2013/TT-BYT. However, the contents of this health checkup package is mainly aimed at health certification and is not designed to meet the need for early detection of disease among older persons. Furthermore, the budget for routine health checkups for older persons is limited. In 2017, MOH issues a template for individual health management profile for PHC through Decision No. 831/QD-BYT. However, this Decision does not focus on essential health indicators of older persons that should be considered, and does not introduce procedures for screening risks of cardiovascular diseases, diabetes or mental illnesses. At the same time, it does not mention what should be done after the health checkup (counselling, referral, follow-up of treatment, rehabilitation). There are no clear criteria for selecting appropriate contents of the routine health checkup package for the health of older persons as recommended by WHO (Box 2) [93].
Box 2. WHO recommended principles of screening for disease

1. The condition sought should be an important health problem.
2. There should be an accepted treatment for patients with recognized disease.
3. Facilities for diagnosis and treatment should be available.
4. There should be a recognizable latent or early symptomatic stage.
5. There should be a suitable test or examination.
6. The test should be acceptable to the population.
7. The natural history of the condition, including development from latent to declared disease, should be adequately understood.
8. There should be an agreed policy on whom to treat as patients.
9. The cost of case-finding should be economically balanced in relation to possible expenditure on overall medical care.
10. Case-finding should be a continuing process and not a “once and for all” project.


International experience shows that the content of health checkups for older persons does not need to be comprehensive, but must meet the need for early detection and effective management of diseases to reduce the burden of disease in older persons [94]. In the United Kingdom, for example [95], the service package is compact but very effective in detecting risk factors for some of the most common diseases in older persons in latent stages (i.e. without symptoms) (Box 3).

Box 3. United Kingdom model for routine health checkup

NHS (National Health Service) Health Check aims at detecting risks for heart disease, diabetes, kidney disease and stroke as well as advising on signs and symptoms of dementia. The Check itself is usually carried out by a nurse in about 20 - 30 minutes. Through an interview, information about the service user will be collected such as age, gender, ethnicity, family history of the 5 diseases mentioned above, smoking habit, drinking habit, diets, volume of physical activity. The service user’s weight and height will be measured to calculate BMI, and waist circumference may also be measured. Blood pressure will be taken, and a small prick of blood will be taken from a finger to check cholesterol and possibly also blood sugar level. Service users over 65 will be told the signs and symptoms of dementia to look out for.

Normally, results of the health Check will be available in writing right after the health Check is completed. Results are presented in the form of a risk score for each of the 4 diseases mentioned above. The higher the risk score, the more likely the service user is to develop one of these illnesses. After announcing the risk scores, the health workers will advise the individual on next steps, such as changing lifestyle, taking medications to lower cholesterol in case of a very high risk score, or referring the patient to specialized services for confirmatory testing and determination of a proper treatment protocol.

Source: NHS Choices [95]

Vietnam has not developed standard guidelines on screening for early detection of diseases at the grassroots level. Many standard guidelines have been developed by MOH for specialists working in hospitals. The Clinical Guideline for CHSs (Decision No. 2919/QD-BYT in 2014) mention hypertension and diabetes but do not focus on appropriate contents relating to a health checkup for older persons. For example, there is no guidance on screening for dementia and depression at the grassroots level. The ability to provide NCD screening, early detection and management services at the grassroots level is limited in terms of coverage and service quality.
Health care for older persons at the grassroots level does not include all activities stipulated in the Law on the Elderly and Circular No. 35/2011/TT-BYT.

**Health records for older persons are not used widely and the contents are not comprehensive.** In most provinces, there are no logbooks for monitoring the health of older persons in the community. CHSs only manage the list of older persons in the commune. Some provinces like Ha Nam, Nghe An, Kien Giang, Binh Phuoc and Hoa Binh have generated health monitoring logbooks for older persons, but Ha Nam is the only province having this logbook in 100% of CHSs, the remaining provinces only have it in CHSs which have met the national benchmarks for commune health or in communes where there are projects financially supported by non-governmental organizations. However, these logbooks could be made more comprehensive to include more health indicators requiring management and monitoring among elderly patients. MOH has not yet issued a standard template for health management logbooks for older persons, nor specific guidance on creating health management profiles for older persons in the community.

**There is a lack of NCD management at the PHC level:** NCDs are chronic, once they are acquired, they must be managed on a continuous and long-term basis. The provision of NCD prevention and control services is still limited. In particular, at CHSs, long-term care and management services (i.e. management, follow-up, care and rehabilitation in the community), which are especially important for NCDs, are not delivered in a consistent manner [86]. Hypertension and diabetes management services are not available in most communes [86]. COPD prevention and control are implemented mainly at the provincial level, not at district and commune levels [83]. Community mental health care protection only focus on schizophrenia, epilepsy and depression but not on mental disorders in older persons such as dementia and Alzheimer’s or on activities to protect mental health among older persons at the commune level [92].

**Prescription and adherence to NCD treatment** are important to older persons with multiple diseases, risk of drug interactions, or dementia that makes them forget to take medicines. For older patients with stabilized management of NCDs, there is no mechanism to facilitate access to medications without requiring repeated monthly specialist examinations to comply with prescription regulations. Many NCD patients mistakenly think that medication provided by higher levels is more effective than that provided by lower levels, thus they tend to bypass to higher levels, which is more expensive, inconvenient and causes overcrowding at higher levels. Adherence to treatment is weak, which reduces the effectiveness of NCD management: among 60.9% of people who are found to have high blood pressure, 92.8% are treated but 69% of the treated have not yet controlled their blood pressure. It is partially because of weak management of patients until the appropriate dosage of medicine is determined, but it is also due to the patient’s limited knowledge about the importance of adherence to treatment. The management of a number of diseases with early symptoms, e.g. diabetes with signs of pre-diabetes, is not covered by health insurance [96]. Therefore, patients are not encouraged to manage risk factors for prevention of diabetes. In addition to NCDs, older persons due to the impairment of various functions of the body, especially the immune system-are also susceptible to other infections such as influenza, bronchitis, community-acquired pneumonia and urinary tract infections. However, in many cases health workers at the grassroots level lack knowledge to prescribe appropriate medications to avoid side effects on the liver or kidney, or to avoid drug interactions. Currently, the list of drugs covered by health insurance has not been evaluated for relevance for the physical health status and patterns of disease among older persons.

**Home-based medical care for older persons is seldom delivered.** Subjects entitled to home-based medical care by CHS staff include the elderly, without family support meanwhile many older people with disabilities or who are bedridden, even if they have a caregiver, also want to receive home-based medical care as they find it difficult to visit the CHS. Currently
there is a lack of mechanisms for managing home-based healthcare services provided by the private sector as these are not stipulated by the Law on Medical Examination and Treatment. Chapter VI will mention home-based long-term care services (e.g. personal hygiene, dressing, cleaning, cooking, etc. for older persons who have difficulty with ADLs) provided by ISHCs or private service providers.

Although the Law on the Elderly (2009) stipulated the development and implementation of a program for prevention, examination and treatment of Alzheimer’s disease for older persons, to date in Vietnam there has been little support for Alzheimer’s patients and their caregivers. Dementia, including Alzheimer’s disease, due to its characteristics also requires long-term care in combination with palliative care from the time the disease is diagnosed, during the evolution of the disease and during end-of-life care. When the disease is newly detected, along with therapies intended to prolong life, interventions are needed to help patients better understand and manage signs of stress. Palliative care aims to help patients enjoy a happy life until the end of their life. Taking good care of dementia patients is the approach of palliative care. Caregivers also need substantial support from family members, the community and society. Currently, Alzheimer’s disease cannot be cured but medications and non-pharmaceutical therapies can help slow down the progression of the disease. Alzheimer’s disease patients with severe mental disorders (e.g. paranoia, aggression, depression, etc.) should be treated by psychiatrists. In addition, people suffering from dementia or Alzheimer’s disease often have associated diseases that should be monitored for treatment and management. There should be programs to manage dementia and Alzheimer’s disease in older persons in hospitals and in the community.

Input resources

The NCD prevention and control capacity of health workers at district and commune levels remains weak. Although there were a few projects to strengthen NCD prevention and control capacity, in general most health workers in district and commune health facilities have not been provided with guidelines or training on professional skills to detect, provide counseling, prevent and manage NCDs. Only a limited number of district health workers have been trained in geriatrics, while most CHS staff have not been trained in health care for older persons. In addition, there is a lack of funding, direction, support and supervision from higher levels. Health care for older persons has not received enough attention because the commune level has too many tasks and projects to implement while the personnel are insufficient.

The lack of essential medicines and equipment leads to poor PHC quality at the grassroots level. Up to 40% (n = 117) of CHSs in uplands and islands, 36.4% (n = 45) of CHSs in towns and 24.7% (n = 111) of CHSs in plains lack medicines included in the MOH list of essential medicines. Among the medicines dispensed to insured patients, 68% were paid by patient out-of-pocket payment. 41.6% of CHSs surveyed did not have an emergency medicine cabinet [97]. Insured patients were not provided with drugs under a mechanism for chronic disease treatment (i.e. prescription of drugs for 30 days instead of shorter periods) at all PHC registration levels. In particular, essential drugs for chronic lung diseases were not available at grassroots health facilities [83], leading to failure to treat these diseases at the grassroots level. CHSs (except those in urban areas) have traditional medicine gardens where common medicinal plants such as wedelia chinensis, holy basil, etc. are planted, but the combination of modern medicine and traditional medicine is not done frequently.

Medical equipment: health care for older persons in the community does not require expensive equipment and facilities. Equipment equipped to CHSs [40] (in accordance with Decision

39 MOH Circular No. 05/2016/TT-BYT regulating pharmaceutical prescription in outpatient services.
40 MOH Decision No. 1020/QD-BYT dated 22 March 2004 amending the list of medical equipment for CHSs having medical doctors is an update of the list of medical equipment for provincial and district general hospitals, regional polyclinics, CHSs, and village medical kits attached to MOH Decision No. 437/QD-BYT dated 20 February 2002.
No. 1020/QĐ-BYT in 2004) meets most healthcare needs of older persons. However, there is a lack of some basic geriatric medical instruments for assessing health of older persons (e.g. hand dynamometer for Grip test, gauge, stopwatch for evaluating Get Up and Go test, 4-meter walking test, etc.), tools for rehabilitation and therapeutic activities, etc. for older persons at CHSs. It is not necessary to provide CHSs with much equipment as they cannot be used at full capacity. However, there is a lack of financial and legal mechanisms for CHSs and private health facilities to send specimens to district level and receive test results for monitoring NCDs in older persons, which will help older persons manage their NCDs without having to travel a long distance.

The financial mechanism of health insurance has many limitations for health care for older persons at the commune level, as it does not encourage the detection, counseling and management of NCDs at the commune level. Health insurance does not cover screening for NCDs for asymptomatic people, although age is a risk factor for many NCDs. There are no guidelines on routine health checkups for older persons to determine what contents will be covered during the checkup and which ones are paid for by health insurance. The health insurance mechanism does not yet support continuous and long-term management of diseases. Although the circular on referral stipulates “Health facilities at higher levels can refer patients back to appropriate lower levels after patients have been diagnosed, treated and have overcome the emergency stage, and the severity of disease is reduced making it possible to be treated at lower levels”. The clinical guideline for CHSs (Decision No. 2919/QĐ-BYT in 2014) defines the role of CHSs as “managing and monitoring patients whose status has become stable after being treated at higher levels” in relation to some NCDs, however some relevant drugs at commune level are not covered by health insurance (Circular No. 40/2014/TT- BYT). Inpatients upon discharge are only prescribed drugs for 2 - 7 days. If they want to be prescribed drugs for more days, an outpatient medical record must be opened at the same hospital, as hospitals do not prepare care plans for CHSs to continue the management of patients. At present, health insurance only covers medicines provided by the CHS for a certain number of days, so it is inconvenient for older persons to return to CHSs every several days to get medicines while treatment of their chronic diseases will continue over many years.

Funding from the state budget allocated to NCD prevention and control is not secured: The National Strategy for NCD Prevention and Control in the period 2015 - 2025 includes an NCD early detection project using state funding from the Health and Population Target Program. The state funding focuses on control of risk factors, prevention, surveillance and early detection of NCDs, however it is insufficient to carry out necessary screening. Many provinces have not allocated funding to CHSs in accordance with the Ministry of Finance Circular No. 21/2011/TT-BTC dated 18 February 2011 on management and use of PHC budget for older persons at their residence [64].

Governance

The collaboration between DHCs and district hospitals in delivering continuous care for elderly patients (i.e. treatment, rehabilitation, chronic disease management, disease prevention) in many localities is limited. This reduces the effectiveness of prevention and treatment, particularly for older persons. Many provinces have not guided and provided PHC for older persons as stipulated in MOH Circular No. 35/2011/TT-BYT dated 15 October 2011 [64].

The engagement of family doctor clinics in health care for older persons in the community can help increase service delivery and better meet older persons need for medical examination, treatment and care. However, collaboration mechanisms as well as circulars, regulations and guidelines on the operation of health services provided by family doctors, health insurance payment of health services provided by family doctors, referral to/by family doctors, list of technical services/equipment/drugs of family doctor clinic, template for health
management profile at family doctor clinics, etc. have not been promulgated sufficiently. As a result, the operation of family doctor clinics has not reached its full potential in meeting the healthcare needs of people, especially of older persons.

A system of statistical reporting on health care for older persons has not been established to monitor and evaluate the implementation of policies on health care for older persons. MOH has not issued registers, statistical forms and reporting forms on health care for older persons to be used consistently. Information on medical examination and treatment for older persons at CHSSs is recorded in the general logbook, making it difficult to obtain data on health care for older persons. Information on referral, feedback on the reception of older, counseling and follow-up treatment for older persons after the acute phase is poor (there is often no linkage between healthcare levels to ensure older persons are treated and monitored continuously).

4.3. Rehabilitation to reverse or slow down the process of impairment

Rehabilitation is a process that assists patients and people with disabilities to minimize the impact of disabilities, enabling them to have equal opportunities to participate in social activities and integrate into the community through medical methods, rehabilitation techniques, educational and social measures. Community-based rehabilitation is a rehabilitation process carried out in the community with the participation and collaboration of people with disabilities, families, authorities, grassroots health care providers and relevant stakeholders. MOH has issued the National Rehabilitation Development Plan for the period 2014 - 2020, focusing on increasing the capacity to provide rehabilitation services for people with disabilities, including post-treatment rehabilitation and community-based rehabilitation, however it does not emphasize older persons so this group may be ignored during the implementation.

Rehabilitation needs are high for older persons because of their high impairment rate (see Chapter IV) and because their ability to recover from illnesses or to undergo medical interventions is poorer than that of younger people. Older persons need rehabilitation not only due to their weakness caused by illnesses but also because of age-related impairment or the need for disease prevention. Therefore, special attention should be paid to the delivery of rehabilitation services to older persons. Vietnam’s strategy includes the provision of community-based and health facility-based specialized rehabilitation services. However, there have been no policies or direction on development of rehabilitation for older persons in the community.

Financial resources to pay for rehabilitation services include health insurance, state budget and out-of-pocket payment. Technical services and supplies for rehabilitation provided by health facilities which are covered by health insurance also include day services (Circular No. 18/2016/TT-BYT) and supplies for rehabilitation (Circular No. 27/2013/TT-BYT). This policy does not require patients to be hospitalized; instead, they can receive day care services. Community-based rehabilitation services are funded by the Health and Population Target Program for 2016 - 2020 and the state budget allocated to CHSSs and regional polyclinics. Cost norms of activities of the Population and Health Target Program have not been issued. In the MOH list of technical activities allowed to be delivered at each level (Decision No. 43/2013/TT-BYT), there are many techniques that can be used to rehabilitate older persons at the commune level41 such as pulmonary therapy, occupational therapy, moxibustion, acupressure massage, Tai chi, rehabilitation for persons with paralysis, neurological injury, trauma, surgery, etc. However, for rehabilitation services at CHSSs to be paid by health insurance, the service delivery capacity of CHSSs must be approved. To date there are no data available on the number of CHSSs approved to provide insured rehabilitation services.

41 MOH Circular No. 43/2013/TT-BYT dated 11 December 2013 detailing levels of technical service delivery applicable to health facilities.
Rehabilitation professionals include rehabilitation specialists and technicians. Specialist physicians are responsible for examination, diagnosis, prescription of treatment and rehabilitation, while technicians perform the physician’s prescriptions. Technicians who assist rehabilitation including physical therapists, occupational therapists and speech therapists. They may have a bachelor’s degree, junior college degree or secondary medical certificate. For older persons, occupational therapists are very important as they train older persons to perform ADLs so that they can take care of themselves. Currently, there is a lack of training institutions for occupational therapists and speech therapists in Vietnam.

MOH has developed various technical guidelines on rehabilitation with the support of MCNV, with some content suitable for rehabilitation needs of older persons in documents such as the Guideline on Community-based Rehabilitation Practice, the Technical Document on Rehabilitation after stroke and for People with Rheumatoid Arthritis, Visual Impairment and chronic lung disease [98]. Guidelines on occupational therapy were developed with the support of MCNV and USAID in 2016 [99]. In addition, MOH has issued the Guideline on Technical Procedures in the Rehabilitation Field (MOH Decision No. 54/QD-BYT in 2014) and the Guideline on Diagnosis and Treatment in the Rehabilitation Field (MOH Decision No. 3109/QD-BYT in 2014), including rehabilitation for many diseases of older persons such as Alzheimer’s disease, Parkinson’s disease, gout, osteoporosis, heart failure, myocardial infarction, stroke, musculoskeletal diseases and post-surgery recovery, especially after hip replacement.

Despite its high potential, community-based rehabilitation for older persons is still not widely implemented. In 2015, the delivery of community-based rehabilitation for older persons was very limited, to an estimate of only 46,000 people. In the first 6 months of 2016, the number of older persons with disability, post-trauma sequela, accidents, stroke, chronic diseases, occupational diseases, etc. receiving community-based rehabilitation was 114,918 [85]. This is an activity that should be prioritized because community-based health care for older persons is quite effective and will increase accessibility to health services for older persons, especially in NCD management. Rehabilitation helps increase the independence of older persons in performing ADLs while reducing burdens on families, overcrowding of hospitals, and costs to society, while ensuring comprehensive and continuous health care for older persons.

4.4. Palliative care and end-of-life care for older persons

At the end of life, older persons and their families are often faced with the very difficult decision to continue treatment or switch to palliative care. In Vietnam, the thinking “While there’s life, there’s hope” is quite common as people want to show their love and/or filial piety to other family members, or they are afraid of being judged by neighbors if they fail to provide family members with treatment until it becomes hopeless. However, in many cases, treatment reduces quality of life of older persons as their body is weakened and cannot withstand surgeries or special medicines, especially treatment of cancer. Also, physicians often have the mindset of providing treatment to patients until it becomes impossible, otherwise they are afraid that patients’ families will sue them, or they may do so deliberately to increase the hospital’s revenue.

Among the basic competencies of health workers working with elderly patients, the ability to counsel on the most appropriate end-of-life options should be included. Older persons and their families will have to choose between continued intensive treatment and prolonged artificial life or active care to relieve symptoms and pain, i.e. not focusing on treatment of diseases. Normally physicians have more knowledge and experience than families, so they can play a very important role. However, in Vietnam, physicians, nurses and other health workers are rarely trained in this skill, and often do not spend enough time on counselling. Patient families are usually not given an explanation to understand about the end-of-life care, palliative care, and they lack understanding of the benefits of continued treatment or palliative care.
The needs for end-of-life palliative care have been emphasized in Vietnam for cancer, especially because patients suffer a lot of pain. However, currently the country has only 4 palliative care departments at K Hospital, Hanoi Oncology Hospital, Danang Oncology Hospital and HCMC Oncology Hospital. In 2006, MOH issued the guideline on palliative care for cancer and AIDS patients. To date, 15 training courses on symptomatic and palliative care have been organized. The National Geriatric Hospital has also collaborated with Dr. Eric L. Krakauer (Harvard Medical School) to hold two training courses in palliative care for geriatric professionals. The Cancer Prevention and Control Project has developed a model for caring for cancer patients in the final stage in the community [82].

In addition to older persons with cancer, many other older people also have needs for end-of-life care as they have NCDs or disabilities which cause them much pain and discomfort. Apart from pain management, palliative care services also support other needs of patients and their families. For example, older persons at the end of their life may wish to have a will, or have other family members nearby 24/24 hours, or need advice related to funeral, burial, or worship. Families may need psychological support to be ready for the death of older persons, they also need advice on the progression of the disease and options such as continuation of treatment or discontinuation of treatment to improve quality of life of older persons during the last weeks and days. Home-based palliative care services are underdeveloped and hospice care providers are not yet allowed to operate in Vietnam. Families can choose nursing home/centers for older persons but these establishments are neither supported by policies nor trained in end-of-life care for older persons.

Palliative care may require the use of strong and addictive painkillers. Vietnam has developed regulations on management of these drugs to make sure that people in need of these drugs in palliative care can access them, while preventing these drugs from being diverted to the market of drug users (Circular No.19/2014/TT-BYT).

In conclusion, the need for health care services among older persons at present is quite substantial, primarily at the grassroots level, with a focus on preventive care and health promotion, screening for early detection and management of disease, rehabilitation for NCDs and impaired functional capacities. However, currently the scale of organization of the geriatrics care network is extremely modest, and trained human resources are very limited. At the same time, the organization and operational mechanism of the health system lacks interlinkages, which adversely affects the ability to provide comprehensive and continuous care for older persons. The grassroots level and preventive medicine system have not yet been adequately standardized to meet the growing health care needs of older persons; many health workers have not yet received training to boost their knowledge and skills in providing health care for older persons; capacity to provide preventive medicine services, periodic health checkups, screening for early detection and management of disease to control NCDs is quite limited. Some health services specific to older persons like rehabilitation in the community, palliative care and end-of-life care, and home health services have not yet received adequate attention. Even though there are many policies to support health care for older persons, the financial burden for families of older persons remains high. Therefore, in addition to organizing provision of health care services for older persons, health financial protection measures aimed at increasing ability to access and use health care services to reduce the risk of catastrophic spending and impoverishment due to health spending among Vietnamese households requires more attention.
Chapter VI. Long term care of older persons in Vietnam

Long-term care (LTC) is widely recognized as essential to many older people, however at international and Vietnamese fora, consensus has not been obtained regarding the definition of long-term care. One of the reasons for this situation is the lack of agreement on the concepts of “care” (support to ADLs, medical care and other aspects, etc.) and “long-term”.

Therefore, in this Chapter, we use the long-term care definition of the World Health Organization in the World Report on Aging and Health 2015. “According to the World Health Organization: Long-term care refers to the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.”

In other words, long-term care is simply a means to ensure that older people with a significant loss of capacity can still experience healthy aging. As with all stages in the life course, this can be achieved through two mechanisms:

- optimizing the recipient’s trajectory of intrinsic capacity;
- compensating for a loss of capacity by providing the environmental support and care necessary to maintain functional ability at a level that ensures well-being [100].

Figure 67 below illustrates the relationship between the types of care services along a continuum of care and the level of difficulty in performing ADLs and IADLs among older persons. Note that healthy older people, who have not yet faced declines in functional capacity are not shown in this figure. At the base of the pyramid are older people who have begun to face declines in functional capacity, but can still care for themselves. As disease and disability increase, the ability to care for oneself declines, and the need arises for a combination of self-care and professional care. At the peak of the pyramid are the minority of older people with particularly severe disease or disability, who mainly need professional care. Some older people remain healthy their whole lives, and never need professional care. Some people, such as those suffering from stroke, rapidly shift from the green base to the peak. And some older people, through rehabilitation services, physical therapy or occupational therapy, can recover some of their functional capacities to return to a situation in which they can care for themselves again.

Figure 67. Kaiser pyramid of care for older persons

Source: Adjusted from Kaiser Triangle figure in HelpAge International “What is care: concepts and approaches?” presented 12 - 13 January 2017 in Bangkok Thailand.
Older persons with severe impairment of functional capacity due to complicated illness (such as Alzheimer’s disease or paralysis after stroke), cannot care for themselves and need high levels of professional care [dark grey at top of pyramid]. Older persons in this situation, but who have adequate financial resources, may be moved to an elder care home, or the family may hire professional caregivers to provide care at home, rely on day care or short-term care. However, among older persons requiring high levels of professional care, not all will have the economic means to pay the high prices for those services in a facility or at home. Even though the actual need requires professional and comprehensive care, economic circumstances are the deciding factor in accessing necessary professional services. Families without economic means must provide care to their older persons, even in the case that the care needed exceeds their competencies.

1. Long-term care policies for older persons

1.1. International approach on development of long-term care policies for older persons

The Global Strategy and Action Plan on Aging and Health (2016 - 2020) of WHO has introduced criteria as a basis for the development of long-term care policies for older persons, including:

- Developing age-friendly environments
- Aligning health systems to the needs of older populations
- Developing sustainable and equitable systems for providing long-term care (home, communities, institutions)
- Improving measurement, monitoring and research on Healthy Aging
- Enhancing the role of long-term care in the community [101].

The international approach requires a diversified and comprehensive response. In this report, although health care for older persons, long-term care for older persons and environmental-socio-economic support are presented in three different chapters, readers should understand that all these three types of services are necessary. This chapter focuses on items 3 and 5 mentioned above. Item 1 is covered by Chapter VII, Item 2 is covered by Chapter V and Item 4 is dealt with by all three chapters.

1.2. Some key long-term care policies for older persons in Vietnam

This section mentions the major orientation regarding the services needed for those with declines in functional capacities, who are dependent on assistance with ADLs for a long period of time. Policies related to health services are already addressed in Chapter V so they will not be repeated here.

1.2.1. Long-term care entitlements

Older persons are entitled to family care and families are responsible for taking care of older parents and grandparents. The Law on the Elderly (2009) stipulates the rights and duties of older persons, responsibility of families, the State and the society for taking care of, looking after and promoting the role of older persons, guaranteeing legitimate rights and interests of older persons, and respecting opinions of older persons in the care process. The Law stipulates that the children and grandchildren of older persons take primary responsibility for
taking care of older persons, which means caring for their spiritual and material life. Persons having the obligations and rights to take care of older persons shall, depending on their specific circumstances, arrange lodgings suitable for their health and psychological conditions; provide financial assistance; pay hospitalization and healthcare costs and provide moral support for older persons when they fall sick. In situations where the family can not directly take care of older persons, the Law also provides for the authorization of care for older persons, enabling individuals and organizations to sign contracts for providing home-based or facility-based care for older persons.

Some groups of disadvantaged elderly are entitled to long-term care or long-term care support from the state. According to the Law on the Elderly, older persons living in poor households without any persons having the care-taking obligations and rights, and unable to live in the community (due to disabilities or inability to live on their own) shall be admitted to social protection establishments at their request, or are entitled to a monthly social assistance payment to cover an equal level of care as in social protection establishments if someone voluntarily takes on the primary caregiver role for them in the community. The Vietnam National Action Program for the Elderly 2012 - 2020 (Decision No.1781/QD-TTg, 2012) extends beneficiaries of this policy to include also older ethnic minority people. The Healthcare for the Elderly Project 2017 - 2025 (MOH Decision No. 7618/QD-BYT in 2016) sets the target that by 2025, 100% of older persons unable to take care of themselves shall be provided with healthcare by the family and the community. In addition, it sets the target of “increasing, at least by two times from 2016 levels, the number living in residential long-term health care facilities among the population of older persons without family members to support them, who are not able to care for themselves, and have nobody at home to help them, and who have the ability to pay. However, currently, the concept of “residential long-term health care facilities” for older persons is unclear, since social protection establishments currently do not have the function of providing medical services, and hospitals do not have a long-term care function.

1.2.2. Regulations on the State management responsibility for older persons

MOLISA is responsible for state management of issues related to older persons, specifically of long-term care policies (according to the Law on the Elderly). This ministry is responsible for developing and implementing policies on older persons, prescribing professional standards for and training of caregivers of older persons, and planning care settings for older persons nationwide. According to Decree 136/2013/ND-CP stipulating social assistance policies for social protection beneficiaries, MOLISA is responsible for implementing and supervising social protection regulations, including support to the care for and nurturing of older persons in the community, social protection establishments and social shelters. In addition to developing competency requirements for staff of social protection establishments, MOLISA is also in charge of supporting activities of the Association of Social Protection Establishment Directors, examining, inspecting and resolving complaints related to the operation of social protection establishments and submitting reports to the Government. Under the Project on strengthening and developing the network of social assistance facilities for the period 2016 - 2025 (Decision No. 524/QD-TTg in 2015), MOLISA is assigned to finalize regulations and standards for social assistance facilities to facilitate the convenient use of beneficiaries.

42 Depending on legal documents, sometimes this group is also called the lonely elderly, the helpless elderly, or the elderly in especially difficult circumstances.

43 Social protection establishment (center) is the general term used in Vietnamese legislation to refer to residential long-term care facilities for older people, disabled people, orphans and other groups. We will use this term as the general term throughout the report to refer to residential long-term care facilities in the public sector, private charity and private business sectors, even though in some documents the term nursing home or older person’s home is used. In some policy documents the term social assistance facilities is used. We understand this to include social protection establishments (residential) as well as social work centers (non-residential).

44 By 2017, the Association of Directors of Social Protection Establishments has still not come into existence.
Provincial Departments of Labor, Invalids and Social Affairs (DOLISA) have responsibilities related to long-term care for the local elderly including guiding and implementing the Vietnam National Action Program for the Elderly and other relevant social protection projects/programs, aggregating data and quantifying the number of older persons to be provided with social assistance, and organizing the development of the network of social protection establishments for older persons (Joint Circular No. 37/2015/TTLT-BLDTHXH-BNV). The evaluation of applications for establishment of social protection establishments and granting of licenses to non-public care settings for care for older persons are the responsibility of DOLISAs or District Labor, Invalids and Social Affairs Divisions, depending on the type of establishment to be established (Decree No. 06/2011/ND-CP). At district level, District Labor, Invalids and Social Affairs Divisions have the functions of guiding and examining the implementation of social protection related regulations.

Chairpersons of local People’s Committees (provincial and district levels) are responsible for making decisions about the establishment of non-public social protection establishments operating within the province and public district-level social protection establishments (Decrees No. 68/2008/ND-CP and No. 81/2012/ND-CP).

The Business Registration Division under the Provincial Department of Planning and Investment is authorized to grant business licenses to enterprises engaged in the care of older persons (e.g. nursing homes or enterprises providing home-based caregivers for older persons) (Enterprise Law and Decree No. 78/2015/ND-CP). However, before being allowed to operate, the establishment must have additional licenses depending on the field of business registration.

- Enterprises operating in the field of care for older persons must meet the same conditions as social protection establishments (Decree No. 06/2011/ND-CP).
- Labor outsourcing businesses (e.g. enterprises providing home-based caregivers) must pay a deposit to address risks and any compensation that may be required during service provision by the enterprise (Decree No. 52/2014/ND-CP).
- An enterprise providing home-based medical services to older persons must have a license granted by the health sector to operate as a family doctor clinic and the head of the clinic must have a family doctor degree.
- An enterprise providing residential (inpatient) services for older persons, including medical examination and treatment, in principle must have a license granted by the health sector to operate as a health facility. However, according to the Law on Medical Examination and Treatment, inpatient services can only be provided by hospitals. The granting of a license to a non-hospital facility for provision of residential services to older persons is not possible.

In the field of long-term care, in addition to granting operating licenses, MOH is assigned to guide the prevention of disease, provision of health care, medical examination and treatment, and rehabilitation for people living in social protection establishments (Decision No. 524/QD-TTg in 2015). MOH is also responsible for providing guidance on medical care, physical therapy and rehabilitation for people with disabilities and mental health problems in social protection establishments (Decree No. 68/2008/ND-CP). The health sector is responsible for granting practice certificates to health workers in establishments which provide medical care for older persons.

Some social organizations are involved in developing and implementing long-term care models for older persons. The Red Cross Society has been active in developing
Chapter VI. Long term care of older persons in Vietnam

care models for older persons, including the paid home-based care model. Care and support centers for older persons have been established by associations including the Red Cross Society and VAE. ISHCs were established in villages under the management of Commune People’s Committees, often headed by the VAE or the Women’s Union. However, there are currently no legal documents regulating provision of home-based social assistance or health services. Religious associations also engage in organizing charity activities and establishing social protection establishments to take care of older persons.

1.2.3. Diversified orientation for organizing long-term care for older persons in Vietnam

Currently, the State encourages innovation and social mobilization to create different models of long-term care for older persons, including the centralized care model and the model to support families to care for older persons in the community (Figure 68). Centralized long-term care is a kind of inpatient service, which is provided by businesses, charities or public social protection establishments. The services provided by businesses are for profit and serve older persons with good economic conditions. The services provided by social protection establishments and charities mainly serve older persons who have no caregivers and can no longer live in the community on their own. Currently, the centralized care model is not very developed and serves a very small proportion of older persons in Vietnam due to its high costs. The model to support families to care for older persons in the community is based on relatives or caregivers who care for older persons in the community. As the care needs of older persons increase, families may request additional support services to help carry out the care for older persons, including medical care, support to ADLs, entertainment, etc. However, at a certain point in time, older persons may wish to receive centralized care, then the model of care can be changed from community-based care to centralized care.

Figure 68. Comparison of institutional and community-based long-term care models

The Law on the Elderly and the Vietnam National Action Program for the Elderly promote long-term care models in the community and in the family. By law, families have primary responsibility for taking care of older persons. Taking care of older persons means caring for their spiritual and material lives, aiming to satisfy their basic needs for food, clothing, lodging, travel and healthcare as well as entertainment, recreation, information, communication

45 Various terms are used including elder care home/center/institute, center for care of older persons, nursing home, retirement home, etc.
and learning needs. For older persons without family caregivers, the law encourages people in the community to voluntarily take on primary caregiving responsibility for older persons by providing older persons with a monthly social assistance payment equivalent to the payment made to social protection establishments for social policy beneficiaries accepted for care at those facilities. The Vietnam National Action Program for the Elderly sets targets as follows: by 2020, 80% of older persons without any persons having the care-taking obligations should be looked after in the community or in care settings for older persons, of whom at least 20% should be cared for in community-based care models; at least 50% of communes/wards/townships should have ISHCs or other models to care for and promote the role of older persons, with over 70% of the local elderly participating and benefiting from these models. Decision No. 1533/QD-TTg in 2016 approves the Project on scaling up ISHCs in the period 2016 - 2020.

The residential long-term care model for older persons is also promoted, but in the direction of mobilizing social investment capital. The Law on the Elderly encourages organizations and individuals to invest in building care settings for older persons with preferential policies in accordance with legal regulations on encouragement of social mobilization of activities in the fields of education, vocational training, health, culture, sports and environment. According to the Project on strengthening and developing the network of social assistance facilities for the period 2016 - 2025 (Decision No. 524/QD-TTg in 2015), and the Planning of the network of social assistance facilities for the period 2016 - 2025 (Decision No. 1520/QD-LDBXH in 2015), by 2025 there will be 64 social protection establishments to take care of older persons nationwide. 5 public establishments and 26 non-public establishments already in existence in 2015 will be upgraded and expanded. According to the plan, 33 new non-public establishments will be constructed by 2025. The Vietnam National Action Program for the Elderly 2012 - 2020 proposes the planning of residential care facilities for older persons, according to which, by 2020, each province will have at least two residential care facilities for older persons. According to information collected on websites on non-public social protection establishments and care providers for older persons, by early 2017 there were at least 66 establishments,46 most of which care for older persons without family support who cannot take care of themselves.

2. Long-term care needs of older persons

Before describing long-term care patterns for older persons, we need to understand the need for long-term care, i.e. the need for medical and non-medical care of people with chronic diseases or disabilities which make them unable to care for themselves for a long period of time. Of 10.35 million older people, many are healthy and able to participate in economic activities, care for grandchildren or work as volunteers to care for other older persons. There are also those who are temporarily experiencing difficulties in ADLs as they are recovering from an illness, surgery or accident, but if they receive rehabilitation they will be able to return to the healthy group. This chapter addresses the needs of another group, older persons facing poor health, who have little chance of returning to a healthy state through rehabilitation. The long-term care needs of older persons include assistance with simple activities, talking, companionship, or more comprehensive care (e.g. for people with severe disabilities). This section will forecast the need for long-term care among older persons according to their needs assessed using indicators on functional difficulties (hearing, seeing, etc.) or ADLs.

46 Some social protection establishments for older persons are regulated by the planning and investment sector through issuing a business license, while a number of social protection establishments set up by religious organizations are not managed by the labor sector, so there is not yet a complete list of non-public social protection establishments for the elderly.
Chapter VI. Long term care of older persons in Vietnam

2.1. The causes of the increased need for LTC in Vietnam

At present and in the future, the need for long-term care among older persons in Vietnam, especially community-based care (including home care), will increase due to the following reasons:

Firstly, Vietnam is among the developing countries with the most rapid pace of population aging in the world (see Chapter IV), with a rapid increase in the number and proportion of older persons, particularly those in the higher age group, who need more care.

Secondly, the burden of disease due to chronic NCDs and disabilities (vision, hearing, mobility, cognition) in older persons is increasing (see Chapter IV). Many older persons live with disease and disability for prolonged periods, leading to increased physical difficulties in performing ADLs and IADLs. Approximately 54.6% of people with disabilities are ≤60 years old [33], and more than two thirds of older persons experience at least one mobility difficulty (especially with sitting/squatting, stepping up or down the stairs, changing position from sitting to standing up). Nearly 38% of older persons experience at least one difficulty in ADLs, and this figure is up to 50% in the 80+ age group (see Chapter IV).

Thirdly, traditional care of the family for older persons is declining. Smaller family size and adult children working away from home or busy with earning their living have reduced the time available to spend on caring for older persons. In addition, women, who have traditionally played the primary role in providing home-based care for older persons, are increasingly participating in paid employment. On the other hand, the number of older persons living alone, living with their spouse who is also an older person, or living in skip-generation families is also on the rise (in 2014, this group consisted of 304 000 people, accounting for 3.2% of older persons, of whom about 16.4% of persons aged 80 and older lived alone) [102]. It is forecast that the number of older persons living alone will increase in the near future, especially in the 80+ age group, and women will account for a large share. Older persons themselves generally want to live in the community and with their family. The trend of older persons wishing to age in place is on the rise. In addition, home-based and community-based care for older persons is suitable with the existing Vietnamese culture.

Fourthly, income of most older people is low and not enough to cover care services in centralized long-term care facilities (mostly private sector). The majority (66.8%) of older persons are living in rural areas [22]. In 2014, 22.4% of older persons lived in poor households [102]. The number of older persons with retirement pension and social insurance accounted for only 27.9% [103]. Approximately 60% of older persons said their income was not enough for their needs and less than 2% said they were wealthy [28]. Thus, the affordability of expensive care services at private residential care facilities is rather limited. Given that fact, the need for affordable home- and community-based care services will increase.

2.2. Forecast of long-term care need among older persons in the next 10 years in Vietnam

Long-term care needs of older persons are increasing partly due to an increase in the elderly population and increased life expectancy at birth. Social changes also limit home-based long-term care as working age family members must work and cannot stay at home to care for older persons. A situational analysis has been done based on data on disabilities and people with ADL difficulties to forecast the number of older persons with long-term care needs. Figure 69 shows that in 2009 most older persons did not have disabilities (hearing, vision, mobility or cognition). About a third of older persons had difficulties with at least one of the functions mentioned above, but not at a severe level. Only 2% of respondents said they could not perform at least one of the four functions, and 7% said they had difficulties with at least one function.
Figure 69. Structure of the level of disability among older persons, 2015

Level of disability

- No difficulty: 58%
- Some difficulty: 33%
- Much difficulty: 7%
- Incapacity: 2%

10.35 million older people

Note: Based on responses to questions asking about the level of difficulty in the ability to see, hear, move around, concentrate and remember. The responses are coded as the highest level of difficulty if multiple difficulties were reported.

Source: Population and Housing Census 2009, calculated from 15% sample data by JAHR team.

If older persons facing difficulties with or unable to perform at least one of the functions (vision, hearing, mobility, cognition) are presumed to need long-term care, we can quantify the minimum long-term care needs. In combining data on disability prevalence by age group in the 2009 Population and Housing Census and population projection statistics for 2049, we have the results shown in Figure 70. By 2019, approximately 1 million elder people may need long-term care because they will have difficulties with or be unable to perform at least one function. By 2049, if there is no change in the disability prevalence by age group, this figure will increase to 2.5 million. However, the long-term care needs may be even greater if the needs of a third of older persons who have difficulties but are still able to perform these functions are included.

Figure 70. Projection of the number of older persons facing difficulties or incapacity in vision, hearing, mobility, concentration/memory, 2019 - 2049.

Source: Population projections to 2049 and disability rate from Population and Housing Census 2009. JAHR team.
Another possible way to calculate the long-term care needs is based on the proportion of older persons who report difficulties in ADLs, including eating, dressing and undressing, bathing, changing position from lying to sitting and toileting. In combining this proportion from the Vietnam Aging Survey 2011 and data on the number of older persons by age group, we have the results shown in Figure 71. According to this definition of need, by 2019 approximately 4 million older people will need long-term care, and this figure will increase to up to nearly 10 million by 2049.

Figure 71. Projection of the number of older persons facing difficulties with ADLs, 2019 - 2049

In general, older persons prefer aging in place. However, the number of older persons staying in residential care settings tends to increase due to health problems as age increases, such as was found in the China in 2015 [104]. Changes in household arrangements with children working away from home and unable to care for older persons on a daily basis also contribute to this trend. However, social assistance payments and income levels of many households are not enough to cover residential long-term care services.

Some healthy older persons with financial resources may prefer to live in residential care settings for older persons. This demand is receiving attention by providers of services for older persons, therefore more and more projects on construction of private nursing homes are being proposed. However, the number of older persons who can afford these services is very small compared to the huge need for long-term care of older persons who can no longer take care of themselves but lack economic conditions to stay in private nursing homes.

3. Organization of the provision of long-term care services for older persons

Vietnam is developing two long-term care models for older persons (Figure 72). The first is the family-based care model with additional support from the community and from paid services. The second is the institutional long-term care model. The latter model includes different forms, while the former model has many components contributing to long-term care.
for older persons living with the family. At present, the coverage of these models is not high. The main orientation now is to develop ISHCs that are suitable for most older persons living in rural areas and lack economic conditions to use paid services.

Figure 72. Types of services under two long-term care models for older persons

<table>
<thead>
<tr>
<th>Lower cost, subsidized</th>
<th>Long-term care in the community</th>
<th>Institutional LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer caregivers</td>
<td>ISHCs</td>
<td>Public social protection center</td>
</tr>
<tr>
<td>Social work service center, social workers</td>
<td>Advice and support for elder care model</td>
<td>Charity social protection center</td>
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<tr>
<td>Advice and support for elder care model</td>
<td>CHS</td>
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<tr>
<td>CHS</td>
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<td>VHW</td>
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<tr>
<td>Lower cost</td>
<td>Paid caregivers in the home</td>
<td>Private eldercare facility (enterprise)</td>
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<tr>
<td>High cost</td>
<td>Private family doctor, home health care services</td>
<td></td>
</tr>
</tbody>
</table>

3.1. Community based long-term care model

For long-term care models in the community, the family (or voluntary primary caregivers\(^{47}\)) serve as the foundation while related models assist families with long-term care services and support. The purpose of these services is to increase independence, maximize quality of life and meet needs over time. Long-term care is primarily personal care, which is to assist older persons with ADLs such as dressing, eating, toileting, taking medications, etc. For some older persons with severe illnesses such as stroke, additional nursing care such as injection, tube feeding, change of wound dressings, oxygen therapy, sputum suction, rehabilitation care, etc. is to be provided by people trained in nursing services (e.g. relatives or non-relatives). As for the very sick elderly who are dying and do not want to be hospitalized, they need both specialized medical care and palliative care. Among community-based care models in Vietnam, the most comprehensive one is the ISHC, with 8 operational areas. The remaining models applied in Vietnam can usually address parts of the long-term care needs of older persons. Due to the diverse needs of older persons, even partial scope of services contribute to the overall task of supporting Vietnamese families to care for older persons.

The care for older persons by family members has many advantages, but also challenges. Nearly 60% of older persons lived with their spouse and nearly 70% of older persons lived with their children\(^{28}\), which is a good condition for older persons to be taken care at home by family members in accordance with law,\(^{48}\) their economic conditions and the tradition of Vietnamese culture. Family care of older persons predominates. The Vietnam Aging Survey 2011 showed that the main persons providing care to older persons when they needed support in their daily life are family members, especially the spouse (among older persons living with spouse, over 80% of husbands were cared for by their wives and nearly 30% of wives were cared for by their husbands), daughter and daughter-in-law. Very few older persons said they were mainly cared for by volunteers (neighbors) or by paid care service providers\(^{28}\).

47 Note, for this report, the term “voluntary primary caregiver” refers to people who have taken on a role similar to family members taking care of older family members. The term “volunteer caregiver” refers to those in the community who have a more limited role to help part-time with older persons in some aspects of daily life, health care, housework, companionship, etc.

48 According to the Law on the Elderly “Family members have primary responsibility for taking care of older persons.” (Clause 3, Article 5 of the Law on the Elderly).
However, the care of family members is also facing many challenges. The number of caregivers being family members has fallen compared to previously, as families nowadays have fewer members, children of older persons are often busy and must work away from home, or women - the primary caregivers in the family - lack the time to care for older persons as they are employed in the workforce. Caregivers can experience long-term care compassion fatigue, due to the complex care requirements of diseases faced by older persons (chronic, multiple diseases), while alternative care services and assistive devices are almost not available or are very limited. Family members often lack necessary knowledge and skills, which affects the quality of care. In addition, the proportion of older persons living alone, living with their spouse who is also an elder person or in skip-generation families is on the rise [28].

3.1.1. State management of long-term care in the community

Under the Law on the Elderly, family members of older persons have primary responsibility to take care of their older family members. Persons who are obliged to take care of their parents as stipulated in the Marriage and Family Law include children, adopted children and paternal grandchildren. Stepchildren are also obliged to take care of step parents and daughters in-law or sons-in-law are obliged to take care of parents-in-law if living in the same house. Failure to take care of older persons is prohibited by the Law on the Elderly.

For older persons who lack family members to care for them, Decree No. 136/2013/ND-CP provides for voluntary primary caregivers in the community to take on this responsibility as an alternative to admitting them to social protection establishments. Voluntary primary caregivers for older persons must meet the following criteria:

- Have full capacity for civil acts and comply with the policies and guidelines of the Party and law of the State;
- Be healthy and have experience in taking care of older persons;
- Have stable accommodation and shelter for older persons;
- Have adequate economic conditions;
- If living with a spouse, the spouse must meet the same conditions for full capacity for civil acts and health status as the voluntary primary caregiver for older persons.

Decree No. 136 also stipulates cases when the care for and nurturing of older persons must be discontinued as follows: mistreatment towards older persons; taking advantage for profit; lost capacity to ensure care for and nurturing of older persons due to economic conditions or other reasons; serious violation of the rights of older persons receiving care.

If persons with primary caregiver obligations cannot directly take care of older persons, they can authorize the task to service providers providing care for older persons. The authorization can be done through a contract between the family member obligated to care for the older person and the service provider providing care for older persons. Such a contract must comply with the principles of respect for and protection of the legitimate rights and interests of the older persons and the older person must agree to the arrangement if possible. It must contain the following principal contents: (i) health conditions and ailments of older persons; (ii) the care-taking time, location and method; (iii) the service charge and payment mode; (iv) the rights and obligations of the caregivers; (v) the rights and obligations of the individual or organization providing care services; (vi) other contents. (Decree No. 06/2011/ND-CP). However, there are no legal documents prescribing the responsibility for checking the eligibility of individuals providing elderly-care services. The contract is only applied to paid services.
Several models to support families to take care of older persons by themselves are being piloted or applied in Vietnam under the management of different agencies (Figure 73).

**Figure 73. Governance of long-term care models for older people in the community**

The following part will describe each model to clarify types of beneficiaries/caregivers/services provided, and the development and challenges of each model.

### 3.1.2. Intergenerational Self-help Club (ISHC)

ISHCs are a community-based model established at the village level. The clubs were established by Commune People’s Committees and managed/supported by a mass organization, usually the VAE or Women’s Union. Each club has a management board (with 5 board members) to manage and operate its activities. The clubs aim to care for and promote the role of older persons in the community, with 8 operational areas, including home-based care and healthcare, which are the two areas most directly linked to long-term care for older persons (Figure 74). The clubs meet monthly with diversified activities, meeting the needs of members.

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49 Initially (in 2006), these clubs were established under the framework of projects technically supported by HelpAge International and financed by various international organizations (HelpAge, EU, KOICA, UNFPA, Atlantic Philanthropies, Lottery UK, …).
**Figure 74. ISHC activity areas**

**Beneficiaries:** Each club has 50 - 70 members, the majority of whom are older persons and women with material and/or social disadvantages such as people without caregivers, living with the spouse who is also an older person, or having children/grandchildren working away from home. The clubs have activities suitable for the healthy elderly as well as for those with disabilities or severe illnesses.

**Caregivers:** Each club has at least 5 volunteers trained in knowledge and skills to provide basic care for older persons. Each volunteer delivers home-based care/assistance at least twice a week to older persons they support without any payment. To provide some medical care, the use of paid care assistants is being piloted in this model. Paid care assistants are retired health worker or VHWs trained by the HelpAge International Project in skills to provide basic care for older persons.

**Healthcare activities:** at monthly meetings, the clubs regularly invite communication professionals to discuss health-related topics. The clubs also organize physical activities, increase access to health insurance, actively collaborate with health facilities to provide health checkups for members twice a year. Since the needs of many older people with disabilities or chronic illnesses are beyond the capacity of the volunteers, some clubs are piloting the provision of home-based medical care services (e.g. guiding older persons to practice rehabilitation exercises, Tai Chi; monitoring of blood pressure, blood glucose, medication compliance) provided by paid care assistants.50

**Home-based care for older persons:** This activity prioritizes disadvantaged older persons (with disabilities, or illnesses) and people without family caregivers. Depending on the status of the person being cared for, the clubs may send one or more volunteers to help older persons. The jobs of volunteers include companionship, confiding, providing information, doing housework (cleaning up the house, gardening, washing the dishes, doing laundry, cooking), buying things in the market, helping older persons get dressed or taking them out for a walk. Many volunteers also provide additional support to older persons like

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50 Technical assistance project of HelpAge International in South Korea and ASEAN.
money, belongings and food from their own families. Some capable volunteers also help older persons in personal hygiene, simple exercises, monitoring of weight and blood pressure. For needs beyond their abilities, the volunteers will report to the Club Management Board for further assistance.

**Support older persons to receive their entitlements:** in collaboration with the VAE or Women’s Union, the clubs assist older persons to complete procedures or advocate to local governments for older persons to receive their entitlements, or to connect with mass organizations and local authorities to help with issues beyond the clubs’ capabilities.

**Financial solutions:** the funding for sustaining the clubs’ activities is primarily from the interest of the Clubs’ Revolving Fund (which is established with cash or in-kind donation of donors), membership fees, resources mobilized from the community and collective income-generating activities.

**Replication of the model:** the model has contributed to the institutionalization of community-based long-term care for older persons. The Vietnam National Action Program on the Elderly 2012 - 2020 has set a target that by 2020, at least 50% of communes/wards/district towns will have ISHCs or other models to care for and promote the role of older persons (Decision No. 1781/QD-TTg in 2012).\(^5\) In 2016, the Prime Minister approved the project on replication of ISHCs in the period 2016 - 2020 (Decision No. 1533/QD-TTg), with the target to have at least 2000 clubs operating in 45 provinces by 2020 (with at least 100 000 members, of whom 65 000 are older persons). The Steering Committee for the project on replication of ISHCs in the period 2016 - 2020 has been established under Decision No. 78/2017/QD-HNCT. By the end of 2016 there were 1056 clubs of this type operating in 18 provinces with more than 55 000 elderly members (Figure 75) [64].

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\(^5\) The Vietnam National Action Program on the Elderly includes not only ISHCs, but other clubs as well, and has a target to establish 5000 community-based clubs of all types to care for and promote the role of older persons.
Chapter VI. Long term care of older persons in Vietnam

Figure 75. Map of the development of the ISHCs in Vietnam by the end of 2016

Source: Data for monitoring development of ISHCs from VAE.
**Recommendation:** To better care for the sick and disadvantaged elderly in the community, it is necessary to involve the participation of the health sector, firstly through annual professional training for paid care assistants and volunteers of the clubs, periodic health checkup, and health communication for club members to learn how to take care of themselves. There should be closer links between the clubs and local authorities (especially the social protection and health sectors) to provide technical assistance and financial support to paid care assistants in delivering health care to older persons.

### 3.1.3. Home care services for older persons

The scope of home-based care for older persons can be broad or narrow depending on the needs. For example, the home-based care for older persons in a model in a Thai district includes: helping patients to take medications, arranging appropriate placement in bed, recording important symptoms, supporting daily activities such as bathing, dressing, supporting with mental health like reading news to patients, talking, supporting reintegration, doing housework like cleaning the house, advising patients, and coordinating with relevant stakeholders.

According to Vietnamese regulations, if the care involves personal care or housework only, no license is required. However, if the care includes medical services, it must be permitted by the health sector. Regarding home-based healthcare services, according to Circular No. 41/2011/TT-BYT, care can be provided following a doctor’s orders, but IV drips, medical examination and treatment and prescribing drugs are not allowed. If service providers want to deliver a wider range of medical services at older persons’ home, they must register as a family doctor clinic. According to Circular No. 16/2014/TT-BYT, family doctors are allowed to carry out some activities at the patients’ home, including: medical examination, prescription of medicines for common diseases, performance of some procedures: changing wound dressings, removing sutures, taking blood/urine samples for testing, nebulizer, injecting/infusing fluids in case of emergency. To deliver either type of service, the health care practitioner must obtain a practice certificate.

**Volunteer-based care models**

The volunteer-based care model for older persons aims to provide free-of-charge home-based care services for older persons through volunteers. At the grassroots level, there are models organized and managed by the VAE and the Center for Aging Support and Community Development (CASCSD) under the Red Cross. There are also volunteer caregivers in the model of counselling and care in the community of the General Office of Population and Family Planning.

**VAE and CASCSD models**

**Beneficiaries:** this model is intended to help ailing older people who lack family support when they face difficulties in ADLs.

**Caregivers:** home-based caregivers may be members of mass organizations, relatives or neighbors who voluntarily come to the home of an older person to provide help 3-5 times a week. They are unpaid and are committed to activities of an organization for a certain period of time, with clear regulations and work plans. Volunteers are trained by the Project in necessary knowledge and basic care skills.

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52 The volunteer-based home care model for older persons has been deployed since 2003 through a “Cooperation project between South Korea and ASEAN on volunteer-based home care for the disadvantaged elderly”, which is managed by HelpAge Korea, technically supported by HelpAge International and implemented in Vietnam by Research Center for Aging Support (RECAS) under the Vietnam Red Cross Society.
Chapter VI. Long term care of older persons in Vietnam

**Home-based care for older persons**: the work of the volunteers includes talking, confiding, providing information, doing housework (cleaning house, gardening, washing dishes, washing clothes, cooking), buying things in the market, helping to dress older persons, taking older persons around, and connecting older persons to mass organizations and local authorities for additional assistance when needed. Each month, the volunteers meet once to review the situation of the person being cared for, exchange experience as well as come up with solutions and future care plans.

**Replication of the model**: In 2012, after 9 years of piloting and expanding the model, the Project had 1223 volunteers caring for 1094 older persons in 93 communes of 24 districts of 12 provinces [105]. The impact assessment of this model shows that although it is easy to implement, inexpensive, suitable for Vietnamese conditions and older persons’ preference for aging to place, there exist challenges relating to the sustainability. At the end of the project, the VAE and the Red Cross Society at all levels lacked funding to continue training, maintain meetings of volunteers and acknowledge volunteer contributions, leading to a gradually declining number of volunteers and the model could not be sustained in many provinces. This model can be integrated in the model of ISHCs to overcome difficulties relating to organization and financial resources.

**Model of Counselling and care for older persons of the General Office of Population and Family Planning**

The project for health care of older persons for the period 2017 - 2025 (7618/QD-BYT in 2016), run and coordinated by the General Office of Population and Family Planning of the MOH, is responsible for implementing activities to develop health care clubs for older people to provide long-term health care for older persons. Physical health and spiritual health of older persons is supported through activities of the volunteer network in the community

**Beneficiaries**: Older persons living with their family who are still able to take care of their own health but who lack knowledge to do so. Some training activities are for the benefit of family members of older people. Priority is given to older people facing economic difficulties or who have no family to support them.

**Service providers**: healthy older persons who have been provided with training and knowledge of health care for older persons

**Health-related activities**: Advice and care for older people on a periodic basis in their families, social visits for companionship and encouragement of older people; updating of information on care of older persons through visits to the family, recording information to monitor and report on health to the CHS; and regular meetings to discuss care of older persons. This model also collaborates with the Older persons help older persons clubs, which have activities related to IEC and improving knowledge of health care for older persons.

**Development status**: By 2016, almost all communes implementing the model (370 communes in 32 provinces) had established volunteer teams with a total of 4492 volunteers participating [106].

**Paid home-based care for older persons**

Paid home-based care for older persons can be organized as a charitable activity performed by mass organizations/associations or as a for-profit/social enterprise activity.

**Beneficiaries**: are mainly older persons able to pay. Older persons served by this model have diverse health care needs, from those who are bedridden to those who need chronic disease monitoring or rehabilitation, or those who just need social interaction or help with housework.
The model of CASCD (under the Red Cross Society) is operated as a not-for-profit social enterprise, contributing to supporting family members to fulfill their obligation to care for older parents and grandparents while maintaining performance in studies and employment. Home-based care service providers are considered as professionals who are qualified, paid and well-trained in various skills and knowledge. From 1995 to 2009, with financial and technical support from HelpAge International and other resources, the model recruited and trained 1073 workers to care for 6176 older persons.

The model of the Home-Based Care Center for older persons (under Hai Phong Union of Science and Technology Associations) is a charitable, not-for-profit and humanitarian organization operating on the principle of voluntarism. It aims to serve older persons living alone and bedridden older persons. The physicians and staff working in the Center are all retired professionals. The nurses working in the Center must have good health, no chronic diseases, be honest and dedicated to older persons, have identity documents certified by local government. The Center provides 5 services: food processing and catering (even feeding older persons with rice or porridge if necessary); personal hygiene and cleaning (bathing, clothes washing, house cleaning); talking, book reading, confiding; taking older persons out upon request and as ordered by physicians; massage and medication administration as prescribed by physicians. Before initiation of service delivery, physicians will examine older persons, check their health, set up their health book and specify what services are to be delivered to older persons. Every week, the in-charge physician will directly perform a health checkup, and mental examination and monitor performance of the staff assigned to care for older persons. The Center also provides care service for sick older persons in hospital. After 15 years of operation, the center has provided care for 12,870 older persons.

Private businesses operating in the field of home-based health care for older persons are beginning to be developed in large cities, where families can afford this service. For example, in HCMC, there are Vina Healthcare center and Phuoc Thinh Service and Healthcare joint stock company, while in Hanoi there are Vietnam-Australia Family Health Services and Home Care limited company, Medicviet Family Doctor Center, Orihome Elderly Care Center and family doctor services of Medlatec limited company which provide home-based healthcare services for older persons. The service providers include physicians, nurses, rehabilitation technicians and staff trained in care for older persons.

The scope of services provided by home-based healthcare service providers in Vietnam is similar to that in the United States [107]. The main activities include: support to ADL (feeding, personal hygiene, confiding/walking, looking after people with cognitive and mental impairment), and some nursing care such as medication administration, injections, prevention of bed sores, monitoring of vital signs, massage, physical therapy and implementation of physician’s orders. There are companies that provide package services for patients for specific diseases such as post-stroke care, or care for cancer patients, and terminally ill patients.

The scope of healthcare activities allowed by licenses for provision of home-based health services which are granted by the health sector is narrow compared to the healthcare needs of older persons, especially those who are bedridden, have difficulties in mobility, are dying, need medical examination and interventions like pain relief. At present, companies wishing to register for provision of home-based healthcare services can obtain an operating license through two options: the first is an operating license for home-based healthcare service providers, but the scope of services provided is very limited and focuses only on support to ADL such as personal hygiene, and feeding; the second is an operating license for family doctor clinics. One of the difficulties with the second option is that the medical director of the family doctor clinic must be a doctor with a family doctor practice certificate and have practiced medical examination and treatment in this specialty for at least 54 months. Family medicine is a relatively new
Companies that provide domestic workers, who also work as caregivers, for older persons are also developing in big cities. These direct care workers often do not have a medical degree, but are trained in skills to provide basic care for older persons. Some companies operating in this field include Phuong Nam Investment Development limited company and Nhan Ai limited company. Some other companies provide training for caregivers and at the same time provide domestic care workers for older persons like Truong Son Youth Volunteer Vocational Training Center, Tam Duc limited company, and Hong Doan Domestic Workers Center. The service package provided includes support for ADLs and housework.

Retention of staff is a big challenge for home-based care for older persons models in Vietnam. After being trained and gaining skills, many caregivers leave companies or centers to work directly with their clients so that they do not have to pay the management fees. It is particularly difficult for not-for-profit centers which charge a low service fee and pay a low stipend to their staff. Therefore, the sustainability of this model to older persons with low income who cannot afford expensive services is in question. This challenge exists not only in Vietnam but also in many countries, and in the private sector.

3.1.4. Social work service providers

In the network of public and non-public social assistance centers, social work centers provide counseling, urgent care or other necessary support to those who need social assistance. (Decision No. 524/QD-TTg in 2015). District social work centers are a new model of social assistance service (Decision No. 32/2010/QD-TTg). In addition, there are also social workers working in health facilities and in the communes, who play an important role in providing social work services for older persons.

Beneficiaries: currently social work services are only provided to older persons who are social assistance beneficiaries who have need to use social work services. Among these people are some who have no primary family caregiver, and require assistance to benefit from their entitlement for residential care in a social assistance center or care provided by someone in the community who agrees to be the primary caregiver.

Service providers: are social workers who are professionally trained and are working at all levels, including social workers working in communes/wards, districts and health facilities.

Care for older persons: current social work services related to older persons include counseling, therapy for psychological crisis, physical rehabilitation, counseling and assistance to older persons to benefit from social assistance policies (for example, determination of older persons’ eligibility for admission to public social protection centers), collaboration with agencies and social work service providers to protect and assist older persons; search for and arrange for care (e.g. ISHCs). In addition, centers also develop intervention and assistance plans for older persons, monitor and review interventions/assistance, adjust plans, take measures to prevent older persons from falling into disadvantaged circumstances, abuse, violence, maltreatment, and manage users of social work services. Community development activities include contacting people and authorities at all levels to identify problems of the community, developing community support programs/plans, establishing a network of social workers and social volunteers, mobilizing resources to assist older persons and organizing communication activities to raise awareness (Joint Circular No. 09/2013/TTLT-BLDTBXH-BNV). Please note that social work services do not include long-term personal care such as support to personal hygiene, eating/drinking, etc.
Development of the model: by September 2015, 37 provinces and cities have formulated, approved and implemented the Project on Establishment of Social Work Centers. According to the Project, 10 social work service provision models are to be piloted at district level, but no information about these models is available.

Challenges: currently the model of social work centers is not consistent. In several provinces, social work centers are actually a new form of social protection centers, but in some other provinces there are only a social protection centers, or a social protection center and a social work center. At district level, social work centers are developed in the direction of social mobilization, i.e. the state budget only covers parts of the operating expenditures, so it is difficult for them to develop.

3.1.5. Commune health workers and VHWs

In many countries, health care workers with elementary and secondary medical training certificates are deployed to provide long-term care for older persons. For example, in Thailand, the long-term care model in Lam Sonthi district provides both medical and personal care. Due to the complexity and high number of services to be provided, they have organized care groups with members being care assistants, of whom most are former VHWs. District hospitals and community health centers manage the work of care assistants and provide technical assistance to them. Currently, Germany and Japan recruit Vietnamese nurses with medical secondary training certificates to provide care for their older persons.

The roles of commune health workers and VHWs in the care for older persons are evident in the Healthcare for Older Persons Project in 2016 - 2025 (Decision No. 7618/QD-BYT in 2016). The Project has proposed some activities to strengthen the capacity of commune health workers for performing healthcare for older persons, e.g. providing PHC for older persons, building and sustaining the operation of volunteer home-based caregivers of older persons through training and provision of some essential equipment to be used in healthcare and rehabilitation for older persons. To date, there has been no evaluation of the implementation of these activities. The following section is a brief review of the performance of VHWs and CHS staff in supporting home-based long-term healthcare for older persons. Facility-based healthcare has been analyzed in Chapter V.

VHWs

VHWs have great potential in health management and health promotion for older persons living in the community in accordance with the PHC function stipulated in Circular No. 07/2013/TB-BYT.

Beneficiaries: older persons living with the family, having difficulties in mobility, or bedridden and unable to hire home-based healthcare service providers.

Service providers: VHWs who are PHC service providers with elementary or higher medical qualifications or having completed a 3-month or longer training course using the VHW training curriculum of the MOH.

Care for older persons: VHW tasks related to care for older persons include community-based health education and communication, detection, surveillance and reporting of NCDs, participation in the implementation of community health promotion campaigns, care for local patients of some common diseases, and provision of healthcare guidance for older persons and people with disabilities, social diseases or NCDs at their residence (Circular No. 07/2013/TB-BYT).
**CHS staff**

CHS staff also have the potential to make a great contribution to healthcare for older persons in case their needs exceed the capacity of VHWs but do not require inpatient or specialist care. CHS staff can also manage health of older persons including NCDs, following treatment plans of physicians at higher levels, so that older persons can receive health care services near home or even at home.

**Beneficiaries:** older persons living with the family, including those who are able to go to the CHS and those who are unable to go to the CHS and need home-based care.

**Service providers:** general doctors, general assistant doctors, nurses, traditional medicine practitioners with medical qualifications.

**Care for older persons:** CHS tasks related to older persons include monitoring and prevention of NCDs, medical examination and treatment, rehabilitation in accordance with the authorized level of technical service delivery and scope of professional activities, combining traditional medicine and modern medicine in medical examination and treatment, guidance on safe, rational and effective use of drugs and management of the health of older persons and, patients with NCDs and chronic diseases (Circular No. 33/2015/TT-BYT).

**Challenges to CHS staff and VHWs:** CHS staff and VHW support to long-term healthcare for older persons is encountering challenges in terms of capacity, as training programs for them do not cover all aspects relating to care for older persons. The second challenge is financial resources, as stipends for VHWs are low while CHSs do not collect fees from service users or pay performance bonuses to health workers who provide home-based care for older persons.

### 3.2. Residential long-term care for older persons

Although most older persons receive long-term care at home and in the community, a growing proportion of older persons is being cared for at institutional settings. A general characteristic of these settings is that they provide long-term residential care, including personal care and medical care, as well as “hotel services” such as cooking, laundry and cleaning. In Vietnam, there are both public and non-public residential care centers, which are called differently such as social protection centers, charity homes, nursing homes/centers, lodges, or homes for the aged. Several social protection centers take care of both older persons and other groups (e.g. people with disabilities). Regulations on state management of social protection centers are only applied to those which care for at least 10 people (Decree No. 68/2008/ND-CP).

#### 3.2.1. State management of residential long-term care facilities

The labor sector is primarily responsible for state management of social protection centers, including those for older persons. Non-public social protection centers (both charities and businesses) should meet eligibility criteria for establishment, including the standards of care (described below) in order to be granted with an operating license by the labor, invalids and social affairs sector for providing care for older persons (Figure 76). People’s Committees at provincial or district level will make decisions on the establishment of public or non-public charitable social protection centers after their application for establishment is evaluated by the labor, invalids and social affairs sector. Regarding social protection centers for older persons set up as an enterprise, the Business Registration Division under the Provincial Department of Planning and Investment will grant business licenses if they meet requirements for business establishment. However, at present, the list of business fields subject to special conditions...
for business registration as stipulated in the Investment Law does not impose any special conditions for granting operating licenses for nursing homes and healthcare services for older persons and do not require a licence issued by the labor sector.

**Currently residential care establishments for older persons can provide healthcare and nursing services,** such as personal hygiene, feeding and massage, but cannot provide medical services such as medical examination of older persons, blood tests, prescription of medications or rehabilitation. Care settings that wish to provide medical services must sign a contract with a family doctor clinic to outsource the services. The Law on Medical Examination and Treatment allows only hospitals to provide inpatient services. The option of investing in the establishment of hospitals for provision of nursing services including suitable medical services is not feasible because of high costs for facility investment.

**Figure 76. Mechanism for establishment of residential long-term care facilities for older persons**

Source: Decrees No. 06/2011/ND-CP (elder care facilities), 68/2008/ND-CP (social protection centers), 81/2012/ND-CP (revisions to decree on social protection centers), 109/2016/ND-CP (medical facility), 96/2015/ND-CP (social enterprise), 78/2015/ND-CP (enterprise licensing), Law on Investments (67/2014/QH13) and Revisions to Law on Investments (03/2016/QH14) including the list of investment fields with special conditions in the Law on Investments.

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53 The Investment Law was amended and supplemented in 2014, Article 6 and Appendix 4 provide a list of business fields requiring special conditions for registration. According to current business registration regulations, enterprises running social protection centers are not subject to special conditions for their operation, however Decree No. 06/2011/ND-CP guiding implementation of the Law on the Elderly stipulates that organizations providing care to older persons must be licensed by the labor sector.
3.2.2. Beneficiaries

Public and charitable social protection centers prioritize the admission of social protection beneficiaries, i.e. older persons from poor households, without any close family members to care for them, unable to live in the community, or older persons with very severe disabilities. In addition, Decree No. 68/2008/ND-CP allows people who are not social protection beneficiaries, but who are unable to live in the family and wish to live in social protection centers to voluntarily pay or have relatives/sponsors pay for their stay in such centers. This provision is applied to both public and non-public social protection centers. The Minister of Labor, Invalids and Social Affairs stipulates the order, procedures and dossiers for admission of older persons to social protection centers. Most people who are admitted to private social protection centers for older persons, which operate as businesses and are costly, are wealthy. Most older persons living in residential social protection centers for older persons have severe illnesses and disabilities, and have needs for medical care and daily personal care.

3.2.3. Service providers

Staff at social protection centers are mainly providers of personal care (e.g. eating/drinking, dressing, personal hygiene, etc.). In addition, there are also health workers, rehabilitation and nutrition staff to provide service packages depending on the type of care setting.

The State has stipulated staffing norms for social protection centers for older persons (Decree No. 68/2008/ND-CP). Regarding direct caregivers, the ratio is 1 caregiver to 8 - 10 older persons (who can take care of themselves) and 1 caregiver to 3 - 4 older persons (who cannot take care of themselves). As for nutrition staff (both food purchasers and cooks), the ratio is 1 nutrition staff to 20 older persons. In care settings where rehabilitation service is provided, there is a rehabilitation technician for every 5 older persons.

There are regulations on character of caregivers but no regulations on the qualifications required. According to Decree No. 06/2011/ND-CP, individuals who directly care for older persons must meet the following criteria: (i) have full civil capacity; (ii) have good moral qualities, no social vices, are not subject to criminal prosecution or in a situation of having been convicted and not yet had their criminal record erased; and (iii) have adequate health and skills to care for older persons.

3.2.4. Operating conditions for facilities and standards of care

Table 17 presents the regulations on requirements for social protection centers in relation to their environment and facilities to be licensed to care for older persons (Decree No. 68/2008/ND-CP, Decree No. 81/2012/ND-CP and Circular No. 07/2009/TT-BLDTBXH). However, some charity social protection centers are still operating without an operating license due to failure to meet these conditions.

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54 Legal documents do not provide a clear definition of "unable to live in the community" but it can be understood that these people are unable to take care of themselves due to diseases and/or disabilities.

55 For example: Thi Nghe nursing home (HCMC) has some beds for older persons who can pay. http://baodansinh.vn/trung-tam-duong-lao-thi-ngheiroi-tri-an-nguoi-co-cong-voi-nuoc-d36721.html
Table 17. Operating conditions according to regulations on social protection establishments

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Minimum requirements according to Decree 68/2008/ND-CP and Circular 04/2011/TT-BLDTBXH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment and location</td>
<td>Convenient in terms of access to transportation and hospital; Clean atmosphere advantageous to health. Garden, area appropriate for physical exercise, recreation and sports. Electricity, clean water, location to dispose of garbage and sewage on a regular basis and appropriate methods for treatment of solid waste and sewage. System of water drainage. Wall/fence, lighting to ensure security.</td>
</tr>
<tr>
<td>Area</td>
<td>Land area 30m²/resident in rural areas; 10m²/resident in urban areas Average area of room should be 6 m²/for regular resident; 8m²/resident needing 24-hour care.</td>
</tr>
<tr>
<td>Physical facilities</td>
<td>Facility with 10 to 25 residents must ensure basic conditions for living quarters, kitchen and workspace for staff. Facility with 25 or more residents must have living quarters, kitchen area, dining hall, workspace for staff, recreation space, and walking paths. Toilet, bathing room appropriate for the residents, and separate for females and males. Bedrooms of residents must have an appropriate area, not more than 8 people per room. Sleeping and rest arrangements appropriate for age and gender. Infirmary to implement primary health care for residents. Funeral room, room for lighting incense for those who have died. Facilities, equipment must be appropriate for disabled people, older persons to access and use conveniently. Must provide basic items for ADLs (e.g. soap, shampoo).</td>
</tr>
</tbody>
</table>

Care standards at social protection centers are detailed in Circular No. 04/2011/TT/LDTBXH. The standards include procedures for admitting and caring for beneficiaries; standards relating to health, hygiene, clothing and nutrition; standards relating to culture, sport and entertainment; rights of beneficiaries in social protection centers; prohibited acts; and standards relating to administrative management.

Conditions for and operation of healthcare, rehabilitation and nutrition activities. Regarding medical standards, Circular No. 04/2011/TT-BLDTBXH stipulates that social protection centers must have medical personnel, appropriate medical equipment, medicine cabinets in service of PHC and first aid when needed; and rehabilitation personnel and equipment in case the social protection center provides rehabilitation services. There is no specific list for these items. These centers must provide treatment, set up health registers and organize health checkups for every older person 2 times per year. In relation to nutrition, the Circular stipulates that at least three meals (breakfast, lunch and dinner) are to be provided per day, with adequate calories, protein (meat, fish, soybean, carbohydrates, grains, fruits and vegetables) and there must be special diets for older persons and those on a diet due to their illness, religion or belief.
**Other care activities for older persons:** In addition to healthcare and nutrition services, social protection centers for older persons are responsible for receiving, managing, providing care and nurturing older persons, assisting them to take care of themselves, and to participate in cultural activities, sports and other activities suitable for their age and health (Decree No. 68/2008/ND-CP). Upmarket nursing homes (business model) provide more types of service for older persons and family members such as residential care, day care and home-based care. In addition to basic care, these facilities also provide PHC, recreational/entertainment activities, encouragement, other assistance and visits to older persons when necessary. However, they charge a high service fee, equal to ≥ 6 million VND/month and even higher in the case that the older persons cannot take care of themselves.

### 3.2.5. Status of development of social protection establishments

In 2015 - 2016, there were about 153 social protection centers for older persons nationwide. Of the total number of social protection centers, 36% were public, 36% were non-public charities (small-scale social organizations or religious organizations), and 27% were private. By the end of 2015, according to statistics of the Social Protection Department, 82% of existing centers were licensed to provide care for older persons, 18% did not have a license to provide care for older persons but were still operating, most of which were charitable organizations and businesses. The scale of social protection centers for older persons is relatively small, with 18% caring for <10 older persons, 42% caring for 10 - 49 older persons and 9% caring for ≥50 older persons (no information is available on the scale of the remaining 30%) [79].

Currently, there is no complete information covering all social protection centers. In looking at the care needs of older persons encountering ADL difficulties (nearly 4 million people) or of older persons with severe disabilities, in 98% of cases families and communities provide care, while social protection centers only meet a very small proportion of the need in this population (Figure 77). The distribution of social protection centers for older persons is uneven, more than 70% of non-public centers operate in the South. In the Mekong River Delta and the Southeast, most of the care settings for older persons are charities. At present, there is no information to help us know the aspirations and needs of older persons and their families for residential care at social protection centers. That is why the Healthcare for the Elderly Project proposes to conduct a survey on the status quo of healthcare service delivery to older persons and the need for health care among institutionalized older people. Elderly care businesses are usually located in big cities (all non-public care settings in Hanoi and one third of those in HCMC are businesses).

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56 Statistics from the Social Protection Department, 2015, supplemented by internet searches. Around 17 elder care facilities found online by the JAHR team were not in the list compiled by Social Protection Department, of which one was just established in 2016 thus not yet included in the list, the rest operate mainly as businesses rather than charities.

57 Note that the 17 elder care facilities not listed by the Social Protection Department are counted as unlicensed.

58 Statistics from the Social Protection Department in 2015, supplemented by internet searches.
3.2.6. Challenges to the institutional model of social protection centers for older persons

The public social protection center model for older persons has the following shortcomings and problems:

- The number of social protection centers providing residential care for older persons is limited compared to the needs of older persons who require it, i.e. older persons who have severe disabilities or need ADL support.

- Most non-public facilities were not set up or managed strictly according to any master plan. At present, there are no agencies responsible for collecting all information about social protection centers for older persons, especially about non-public ones, so it is difficult to assess their performance and compliance with policy.

- There is a lack of information on need (from surveys of older persons) to adjust plans accordingly. Social protection centers currently only focus on facility-based care (residential care) but not on the linkage to community-based care, or day care, or short-term care.

- The infrastructure of many public centers for older persons and charities is degraded, with a lack of rehabilitation facilities. Many fail to meet the standards for environment and infrastructure stipulated in Decree No. 68/2008/ND-CP, Decree No. 81/2012/ND-CP and Circular No. 04/2011/TT-BLDTBXH.

- In relation to long-term care, the Healthcare for Older Persons Project in 2016 - 2025 (Decision No. 7618/QD-BYT) does not mention the role of the labor, invalids and social affairs sector and social protection centers. Although Circular No. 04/2011/TT-BLDTBXH has assigned these facilities responsibility for medical care, including...
treatment and rehabilitation services, there is currently no mechanism for the health sector to regulate health care activities in social protection centers or services provided by social caregivers in the home.

- The control of quality of social protection centers for older persons is implemented based on annual reports submitted by those centers to the labor, invalids and social affairs sector, but this control mechanism is not strong enough to protect older persons being cared for, especially those without closes, family members to care for them.

4. Human resources for long-term care of older persons

In Vietnam, the understanding of many people about the different roles of social workers and caregivers of older persons is limited. Some people think caregivers of older persons must be health workers, while the main task of these people is to provide support in eating/drinking, dressing, daily personal hygiene, and medication taking, which does not require many medical skills. Others think social workers are daily caregivers of older persons, but social workers have a different role, which includes needs assessments, support to older persons to access needed services and case management, rather than daily personal care.

In Vietnam, long-term care for older persons who are unable to take care of themselves or need support to perform ADLs relies on laypeople, including family members or voluntary primary caregivers for older persons in the community and volunteer caregivers of older persons in the community-based care models. Although they are not professionally trained, many of them perform professional activities daily, such as tube feeding or helping to use oxygen. Among the professionals who take care of older persons, the majority are providers of personal care services to older persons, whose task is to support older persons in eating/drinking, dressing, personal hygiene, comfort, medication taking, etc. For older persons living in the community or in social protection centers who need daily medical care, nurses or VHWs may provide basic healthcare following a doctor’s orders. Some types of staff are not involved in daily care of older persons but play an important role such as physicians and rehabilitation technicians, who examine older persons and make orders to be performed by caregivers of older persons. As for social workers, they assess the needs of older persons, manage cases and assist older persons in accessing needed services. The main types of staff involved in long-term care are shown in Figure 78. This section does not discuss most health workers and rehabilitation experts with specialized expertise, as they were already covered in Chapter V.

59 There are various names for long-term care workers including direct care workers, (personal) care assistant, home care aide, home health aide, domestic care worker or domestic helper for older persons.
4.1. Policies on development of human resources to provide long-term care for older persons

According to the Law on the Elderly 2009, MOLISA is responsible for developing professional standards for and training caregivers for older persons, in collaboration with MOH. In relation to primary caregivers, i.e. relatives, people voluntarily taking on a primary caregiver role for older persons and personal caregivers of older persons (volunteers or professional caregivers), there are currently no plans or strategies on training, development of ethical and professional standards or other relevant state management documents for them. In relation to health workers, MOH has issued regulations on training, practice certificates and professional standards in line with the Law on Medical Examination and Treatment. In relation to social workers, MOLISA is implementing the Social Work Profession Development Project in 2010 - 2020 (Decision No. 32/2010/QD-TTg). With this Project, MOLISA has issued professional Standards for public employees working in the field of social work (Circular No. 30/2015/TTLT-BLDTBXH-BNV), professional standards for commune/ward/township social workers, undergraduate framework curricula on social work (Circular No. 10/2010/TT-BGDDT), ethical and professional standards for social workers (Circular No. 01/2017/TT-BLDTBXH). In addition, MOH has developed a project on development of the social work profession in the health sector in 2011 - 2020 (Decision No. 2514/QD-BYT in 2011). This Project aims to create a professional title for social worker in hospital personnel structure for provision of social work services (e.g., counseling on treatment protocols or preventive measures, reassuring patients) and delivered training in social work to community-based workers (VHWs, staff of mass organizations) who are implementing various health programs such as community-based rehabilitation and management of household health.
4.2. Layperson caregivers of older persons

4.2.1. Family members serving as caregivers for older persons

The most important caregivers of older persons are family members, with obligations and rights to care for older persons. They are unpaid and often not trained or regulated in providing long-term care for older persons. Knowledge of family members taking care of older persons is being improved through health information, education and communication (IEC) programs on television, radio, newspapers and activities of several healthcare clubs for older persons. However, the system of medical examination/treatment and healthcare at the grassroots level is not yet fully operational to ensure the delivery of care as required by older persons, especially by those with chronic diseases or disabilities. There is no study conducted to assess the training needs in this aspect.

4.2.2. People voluntarily taking on primary caregiver role for older persons in the community

According to Joint Circular No. 29/2014/TTLT-BLDTBXH-BTC, people who voluntarily agree to become the primary caregiver for older persons are to be instructed and trained in caring for older persons. District Labor, Invalids and Social Affairs Divisions are responsible for implementing this policy. The training delivered to them will cover the following contents: (i) proper nutrition; (ii) accommodation arrangements, support to ADLs; (iii) psychological/physiological counseling and assessment; (iv) relevant policies and legislation; (V) other related activities. There is currently no information available on the level of implementation of this policy.

4.2.3. Volunteer caregivers of older people

Some of the community-based care models for older persons supported by non-governmental organizations are based on volunteers, e.g. ISHCs, self-help clubs of older persons. A common task of volunteers is to support older persons in their daily life [108]. Some volunteers are retired health workers while some others are trained through club activities. However, the training content has not been standardized and currently there is a lack of funding for more professional training.

4.3. Professional (paid) caregivers of older persons

In public and charitable social protection centers, human resources are limited in both quantity and quality, and the organizational structure and capacity for providing care to older persons do not meet requirements [108]. At present, there are 2789 staff in public social protection centers in general and 443 staff in those caring for older persons. Most staff have not received formal training in related specialties such as medicine, care of older persons, or social work [108].

In non-public social protection centers operating as businesses, the human resources are considered better qualified and better able to mobilize resources [108]. Staff of private care settings for older person are diverse and recruited according to the care needs of older persons, including health care workers (e.g. nurses with secondary training certificates, technicians), personal care workers for older persons and other types of staff; thus, they effectively meet care needs. Physicians in social protection centers usually work on a part-time basis, which is sufficient to meet the needs for medical care at the centers. Full-time staff include nurses, technicians and other social workers. These centers often recruit young staff and provide them with training in skills to care for older persons, including specialized care
skills and especially interpersonal skills. However, there is a lack of uniform standards in these centers and the referral system is weak.

**The provision of care for older persons in social protection centers or home-based care services is not considered a formal occupation.** Legal documents have stipulated requirements for individuals providing care services for older persons (Article 1 of Decree No. 06/2011/ND-CP guiding the Law on the Elderly). Individuals who directly care for older persons must: have full civil act capacity; have good moral qualities, no social evils, are not subject to criminal prosecution or in a situation of having been convicted and not yet got the criminal record erased; have adequate health and skills to care for older persons. In Vietnam, caregivers of older persons usually do not have a degree in medicine or in other specialty. They often come from rural areas, learn care skills from experienced caregivers, friends and relatives. Their work is not considered a profession, instead they are often regarded as domestic workers.

In some countries like South Korea, care models for older persons are mostly community-based and caregivers of older persons receive systematic training and certification by the government. However, in Vietnam, there are no professional standards specifying the level of training or the granting of practice certificates. Despite the lack of professional standards and competency requirements, in 2009 MOLISA issued a framework curriculum for training domestic care workers (Circular No. 23/2009/TT-BLDTBXH), which also covers skills to care for older persons.

The framework curricula on domestic work for secondary and junior college training programs fits relatively well with needs, but at present there is a lack of technical training institutions using these curricula. The curricula cover psychological and physiological knowledge by age, nutrition and general health in service of healthcare for family members, handling of emergency situations, principles for and tasks to be performed in caring for older persons and sick persons in the family. The skills to be taught include developing menus that meet the nutrition needs of each age group, food safety, and caring for older persons and sick persons (including bedridden patients) upon request. For junior college training programs, the skills are extended to tube feeding, support for bathing, dressing, toileting with a bed pan, change of wound dressing, administering oxygen, sputum suction and rehabilitation for patients. The secondary training program lasts 1.5 years and the junior college program lasts 2.5 years, with most training time being spent on practice. In 2017, the list of training codes (Circular No. 04/2017/TT-BLDTBXH) includes codes for domestic care and support at the secondary training level (code No. 5760202), domestic care at secondary training level (code No. 5760203) and domestic care at junior college level (code No. 6760203). However, no institutions of the national education and training system deliver these training programs using the approved framework curricula.

**Many training institutions and employment centers which find jobs for domestic workers** and export workers have developed different training programs on care of older persons (Table 18), some of which aim to provide nurses/technicians for nursing homes/centers in developed countries like Germany and Japan. These courses are designed to meet the needs of the country that will receive workers and most trainees are expected to find work abroad. In addition, there are also short-term training courses for people who wish to take care of people with disabilities and older persons. Participants in these courses are very diverse, including family members, home-based/hospital-based care workers for older persons, and some health workers who have a university, junior college or secondary degree or certificate and want to learn more skills to care for older persons. However, each training program has different duration and contents, and the training standards developed by MOLISA do not seem to be applied.
### Table 18. Some training programs for caregivers of older persons in Vietnam

<table>
<thead>
<tr>
<th>Training facility</th>
<th>Position</th>
<th>Training duration</th>
<th>Contents of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nhan Ai International Stock Company</td>
<td>Nurses and caregivers for older persons</td>
<td>3 months/course</td>
<td>Communication, nutrition, psychophysiology, techniques for caring and nurturing older persons.</td>
</tr>
<tr>
<td>Viet Education and Technology Stock Company</td>
<td>Nurse for sick people</td>
<td>2 months basic and 2 months advanced</td>
<td>Health care for older persons, maintaining hygiene in the home, living environment, ability to recognize some common diseases and provide emergency first aid.</td>
</tr>
<tr>
<td>Hong Doan Center for Helpers</td>
<td>Paid home caregivers for older people</td>
<td>Not clear</td>
<td>Skills to care for older persons and do housework.</td>
</tr>
<tr>
<td>Pham Ngoc Thach Medical University</td>
<td>Paid caregivers for sick people and older people</td>
<td>6 weeks</td>
<td>Knowledge and skills to care for sick people and older people. Primarily practical training.</td>
</tr>
<tr>
<td>Hue Medical and Pharmaceutical University</td>
<td>Nurses to care for older persons (Japanese standards)</td>
<td>1 year (3 terms)</td>
<td>Strengthen skills to care for older persons among people who already have secondary or higher nursing degrees.</td>
</tr>
<tr>
<td>Mekong Secondary Medical and Pharmaceutical School</td>
<td>Profession to care for older persons (elementary level)</td>
<td>3 months</td>
<td>Prevention and treatment of common diseases in the family, skills to care for health of older persons, practice of skills to care for older persons in the home.</td>
</tr>
<tr>
<td>Institute of Formation and Promotion (IFP) HCMC</td>
<td>Paid caregivers for older persons and people with chronic disease</td>
<td>3 months</td>
<td>Communication, ethics, monitoring of vital signs, nutrition, patient hygiene, taking blood sample for rapid tests, preventing bedsores, etc.</td>
</tr>
<tr>
<td>Dong Duong Secondary School</td>
<td>Technicians to care for older persons (German standards)</td>
<td>6 months to one year</td>
<td>Implement technical procedures and plan basic care of older persons. Advise, educate on health of older persons, provide emergency first aid, ensure safety for older persons. Take care of older persons at home and at medical facilities</td>
</tr>
</tbody>
</table>

### 4.4. Health workers (nurses, VHWs)

Health workers also contribute to long-term care for older persons, especially nurses, who provide care services at the client’s residence or at social protection centers, and VHWs. Physicians, physiotherapists, occupational therapists and speech therapists are responsible for developing treatment plans for older persons. In case older persons contract diseases while they are receiving long-term care, they will have to go to a health facility or physicians will come
to their house/nursing home to provide medical care suitable for their condition, or visit them periodically to manage chronic diseases or provide health checkups. It is the responsibility of health workers (e.g. nurses, VHWs), paid care workers and family members to implement the medical care, chronic disease monitoring or rehabilitation plans ordered by physicians or physiotherapists. Social protection centers and private care settings often have many staff with degrees in the health sciences such as physicians, nurses and technicians. At present, the number of nurses, technicians and physicians graduating annually is substantial and can meet the requirements of care settings for older persons and home-based care services. Chapter V mentioned the training of doctors to deliver health care to older persons, so this Chapter refers mainly to the training of nurses and VHWs.

Nurses are responsible for caring for patients and implementing physician orders at health facilities or in the community (Circular No. 26/2015/TTLT-BYT-BNV). Their tasks include making care plans, daily monitoring of patient progress, detecting and reporting unusual symptoms, participating in palliative care for dying patients, providing psychological support for family members of older persons, implementing physician orders relating to nutritional care, dealing with medical records, health counseling and education, and provision of safeguards for older persons. In the community, nurses provide home-based care services including injection, wound care, care of patients with a surgical drain, rehabilitation, bathing and change of wound dressings following a physician’s orders. The care of older persons at social protection centers is not regulated by Circular 26, but patient nursing care is similar in both health facilities and social protection centers.

Depending on the level of training received, nurses have different skills. Long-term care for older persons on a daily basis usually includes feeding, personal hygiene, comfort, medication administration, blood pressure monitoring, which is suitable for nurses with secondary medical training certificates. Nurses with undergraduate or junior college or higher degrees have more specialized skills in medical care, which are needed for older persons with severe illnesses or disabilities who require special medical care at health facilities.

Nurses providing long-term care for older persons are trained in nutrition like other nurses with undergraduate or junior college degrees and secondary medical training certificates. For undergraduate and junior college training programs, their framework curricula have a subject called Healthcare for Older Patients, while that of the secondary level program has a subject called Care for Internal Medicine Patients, which includes a section on healthcare for older persons. In terms of quality, in general training programs for nurses and technicians there are no intensive modules on care for older persons, especially daily care. Therefore, they need more specialized training in healthcare for older persons, including both medical care and daily care before they can work in this field.

VHWs are responsible for providing PHC, and must meet certain criteria. First, they must be local people living and working in the village, acting as VHWs on a voluntary basis. Secondly, they must have a sense of responsibility, enthusiasm for social activities, ability to mobilize the public, and gain trust of the community. Third, they must have good health to perform the assigned tasks. Duties of VHWs has been mentioned above, mainly health IEC, participation in disease surveillance, participation in community health promotion movements and care for some common diseases.

Regarding qualifications of VHWs who act as PHC providers: they must have primary or higher medical qualifications or have completed a training course with duration of 3 months or more. There is currently no framework training curriculum for VHWs promulgated by MOH.
4.5. Social workers

Social workers play an important role in the coordination of care, however they do not provide assistance for daily personal care. As of September 2015, 37 provinces and cities in the country have developed, approved and implemented the Project on Establishment of Social Work Centers with the total number of staff working in public social protection centers being 778 (21 staff/center) of whom 546 are women, accounting for 70.18%. According to a MOLISA report, by the end of 2015, 21 provinces and cities had approved the plan to set up a network of social work collaborators with a total of 8784 collaborators. Some provinces already have a network of social work collaborators and social workers actively supporting social protection beneficiaries [79].

4.5.1. Professional standards and workplace

The professional standards for public employees working in the field of social work are stipulated in the Joint Circular No. 30/2015/TTLT-BLDTBXH-BNV. This policy stipulates the three main titles of personnel working in the field of social work: principal social work expert (code: V.09.04.02), social work expert (code: V.09.04.02), and social work officer (code: V.09.04.03). Social workers in general are professionals who are responsible for screening, classifying and receiving social protection beneficiaries, assessing their psychophysiology and needs for services, and developing and implementing assistance plans. At the same time, they monitor and review interventions, and support beneficiaries to integrate in the community. But they do not provide daily personal care, they only help older persons to access needed services and provide necessary support. The professional standards for social work collaborators working in communes/wards/townships are stipulated in Circular No. 07/2013/TT-BLDTBXH, including reception, collection of information, assessment, development of assistance plans, counseling, advice, therapy, mediation, education, persuasion, prevention, implementation of support policies, monitoring, evaluation, etc.

4.5.2. Training social workers

The Social Work Profession Development Project in 2010 - 2020 set the target for building a contingent of social work officials, public employees, staff and collaborators sufficient in quantity and quality in parallel to the development of the system of social work service providers at all levels, contributing to the development of an advanced social protection system.

Currently in Vietnam there are elementary, secondary, junior college, undergraduate and graduate training programs in social work. The framework curricula on social work for undergraduate and junior college degrees have been updated by Circular 10/2010/TT-BGDDT to replace the ones developed in 2005. Their contents include general knowledge on social work, psychology, human behavior, gender, community development, social work for special groups, including a subject called “social work for older persons”.

Although these programs are relatively new, the number of training institutions and people trained in social work is sufficient to meet the needs of society.

By the end of 2015, there were 55 universities/colleges and 21 secondary training institutions with specialized training in social work, enrolling 3500 students per year, of which three provide master’s level and 2 provide PhD level training in social work (Table 19). In addition, the Social Protection Department (MOLISA) has also collaborated with universities and colleges to organize training courses for senior social work managers, officials and lecturers [79].
Table 19. Summary of human resource training for social work, 2015

| Number of facilities providing professional training in social work | 21 |
| Number of education facilities at university and junior college level | 55 |
| Number of schools training at Master’s level (MSW) | 3 |
| Number of schools training at PhD level (DSW) | 2 |
| Quota for training bachelor’s in social work per year | 3500 |
| Number of MSW trained (nationally) | 205 |
| Quota for training in the in-service program per year in the field of social work | 3000 |
| Number of government staff who have received short-term training in social work | 10 000 |


Since 2017, Hanoi School (now University) of Public Health under MOH started the training for a bachelor’s degree in social work with the aim of training social workers who are capable of studying, detecting and assisting individuals/groups/communities in addressing social problems in the field of health and people’s healthcare at hospital, community and policymaking levels. This is the first school in the system of health-related training institutions providing training in this major, demonstrating health sector attention to social work.

4.6. Human resource challenges in long-term care for older persons

In most parts of Viet Nam where families are unable to hire paid caregivers, the primary caregivers for older persons are mostly family members. In many families, members are overwhelmed, lack knowledge and skills to care for older persons and do not receive the needed assistance and support.60

Long-term caregivers of older persons in the community and mass organizations are not considered as professionals (there is no professional registration for this category of worker) and many have not been trained in basic knowledge and skills to care for older persons. There is no elementary level training curriculum for home-based caregivers of older persons.

Staff working at social protection centers are insufficient in quantity and have not been trained in professional social work [109] and skills for providing care to older persons; thus they lack scientific care skills and methods, and do not meet the required standards.

5. Financing for long-term care for older persons

Currently, funding for long-term care for older persons primarily comes from household budget and savings of older persons. Financial support from the state budget or charities to long-term care for older persons is mainly used for older persons who are poor, unable to take care of themselves, have no close family members to care for them or have very severe disabilities. Home-based care services and business-type care settings which provide residential care for older persons are developing but their services are very expensive compared to capacity to pay of many families, especially families with older persons unable to take care of themselves, including those with and without close family members to care for them. Currently, there is no long-term care insurance in Vietnam. VSS’s sickness benefits are not applicable in case workers take leave to care for older persons.

60 Expert opinions in the roundtable discussion on 12 December 2016 at DPF, MOH.
Chapter VI. Long term care of older persons in Vietnam

5.1. Social assistance and other financial benefits for older persons

When older persons are unable to take care of themselves and need support to perform daily activities for a long period of time, their families encounter great difficulties because they not only lack knowledge and care skills but also have financial burdens. Very few families are wealthy enough to hire home-based caregivers for older persons or send older persons to non-public social protection centers. In many cases, family members must take leave from work to care for older persons, affecting the family’s income. Family members who care for older persons in the community are not entitled to any social assistance payments. However, in certain special circumstances, monthly social assistance payments are paid to older persons or caregivers of older persons. Funding for social assistance payments comes from the social security budget estimates within the decentralized local budget (Circular No. 29/2014/TTLT-BLDTBXH-BTC).

The amount of social assistance payments for older persons without a retirement pension is currently very low and the number of beneficiaries is limited (Table 20). Older persons aged 80 and older who do not come from poor households, have neither close family members to care for them nor retirement pension/other monthly social assistance (e.g. people with disabilities) are provided with a monthly social assistance payment of 270 000 VND (coefficient of 1 x social assistance norm). Older persons who come from poor households and have no family members to care for them are provided with a social assistance payment of 405 000 VND/month (coefficient of 1.5) if they are in the 60 - 79 age group and 540 000 VND/month (coefficient of 2) if they are in the 80 and older age group. Some groups of older persons benefit from higher payments as explained below.

Table 20. Monthly social assistance payments for various categories of older persons, 2017

<table>
<thead>
<tr>
<th>Type of beneficiary</th>
<th>Monthly social assistance (VND)</th>
<th>Support for caregivers/funds for care</th>
<th>Total support from state budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older persons from 80 years and older not receiving pension, social security or other social assistance payments</td>
<td>270 000</td>
<td>270 000</td>
<td>270 000</td>
</tr>
<tr>
<td>Older persons in poor households without family support (60 - 79 years)</td>
<td>405 000</td>
<td>405 000</td>
<td>405 000</td>
</tr>
<tr>
<td>Older persons in poor households without family caregivers (80 years and older)</td>
<td>540 000</td>
<td>540 000</td>
<td>540 000</td>
</tr>
<tr>
<td>Older persons without family support, in a poor household, unable to care for themselves but received by voluntary primary caregiver in the community</td>
<td>810 000</td>
<td>405 000 (for individuals voluntarily accepting role of primary caregiver for OP in the community)</td>
<td>1 215 000</td>
</tr>
<tr>
<td>Older persons with extremely severe disability cared for by family</td>
<td>675 000</td>
<td>270 000 (family caregiver)</td>
<td>945 000</td>
</tr>
</tbody>
</table>

Since social protection centers cannot accommodate all older persons with care needs, the state has an incentive policy for voluntary primary caregivers for older persons in the community. According to this policy, older persons who come from poor households, have no close family members to care of them, are unable to live in the community and are eligible for admission to social protection centers (i.e. unable to take care of themselves), can

185
receive care at the residence of volunteer primary caregivers in the community. Such older persons enjoy a monthly social assistance payment of 810 000 (coefficient of 3). In addition, voluntary primary caregivers for elderly social protection beneficiaries in the community (i.e. these households/individuals do not have legal obligations under the Law on Marriage and Family to care for those older persons) are provided with a monthly payment of 405 000 VND (coefficient of 1.5) for their care.

**Older persons with severe disabilities and very severe disabilities who need support for ADLs receive special assistance entitlements.**61 Older persons with very severe disabilities receive a monthly social assistance payment of 675 000 VND (coefficient of 2.5 x social assistance norm), while older persons with severe disabilities receive a monthly social assistance payment of 540 000 VND (coefficient of 2 x social assistance norm) (Decree No. 28/2012/ND-CP). If an older person is eligible for multiple social assistance benefits, they will receive the highest entitlement level. Family members obligated to care for older persons with very severe disabilities are provided with a monthly support payment of 270 000 VND (coefficient of 1 x social assistance norm) for their care. Voluntary primary caregivers for older persons with very severe disabilities are provided with a monthly support payment of 405 000 VND.

**People who participate in social insurance for a pre-defined period, upon reaching retirement age can receive a pension.** The amount of the pension depends on the salary level and the duration for which social insurance contributions were paid, and is equal to 75% of salary but must be at least equal to the minimum wage (Social Insurance Law). There is also a retirement pension provided for people who have lost the ability to work. Pensioners are not entitled to social assistance payments for older persons, but if they have very severe disabilities, they can receive both retirement pension and social assistance to people with disabilities.

**For older persons with meritorious service to the country, special benefits are paid by the state in addition to the social assistance explained above.** Depending on the type of beneficiary, these older persons and their caregivers will receive monthly benefit payments (Decree No. 20/2015/ND-CP). For example, older persons who are Vietnamese heroic mothers are entitled to 1 318 000 VND/month as survivor benefit and their caregivers are entitled to 1 318 000 VND/month to provide home-based care.

**VSS’s sick leave benefits are intended to guarantee income of workers when they take time off from work due to illnesses or accidents.** People entitled to sick leave payments also include those who take leave to care for their sick children who are under 7 years old. However, this policy is not applicable to workers who take leave to care for sick older persons.

### 5.2. Financing at social protection centers

As stipulated in State regulations, the list of long-term care services provided for older persons who are social protection beneficiaries is covered by the state budget. According to the Prime Minister’s Decision No. 1508/QD-TTg (2016), the state budget will cover social services relating to long-term care for social protection beneficiaries. Thus, regarding older persons who are poor, have no close family members to care for them and are unable to live in the community, the state will pay the costs for screening and admitting them; assessing their needs for mid-term or long-term care; providing health checkup and PHC; developing care plans; organizing the implementation of care plans; providing shelters, food, clothes and other necessities for living; managing beneficiaries; providing rehabilitation; organizing cultural, recreational and entertainment activities; and delivering healthcare.

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61 According to Decree No. 28/2012/ND-CP, people with very severe disabilities are those unable to take care of themselves or whose work ability is diminished by at least 81%; people with severe disabilities are those able to take care of themselves if assisted by other people or devices, or whose work ability diminished by 61% - 80%.
The state budget covers the costs for care and nourishment for older persons admitted to social protection centers. For older persons living in social protection centers or social shelters, the state pays the center/shelter a monthly amount of 1,080,000 VND (coefficient of 4) per beneficiary who is poor, has no close family members to care for him/her and is unable to live in the community, or has very severe disabilities (Table 21).

### Table 21. Monthly payments for care of older persons at social protection establishments

<table>
<thead>
<tr>
<th>Type of beneficiary</th>
<th>Assistance for caregiver/ costs of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older persons without family support, living in poor households, unable to care for themselves, living in social protection center</td>
<td>1,080,000</td>
</tr>
<tr>
<td>Older persons with extremely severe disability living in social protection center.</td>
<td>1,080,000</td>
</tr>
</tbody>
</table>

Source: Decree 136/2013/ND-CP and Decree 28/2012/ND-CP

Apart from the above-mentioned social assistance payments, older persons are also provided with health insurance cards and basic necessities for living such as blankets, mosquito nets, mats, clothes, shoes, toothbrushes, basic medicines and other allowed expenses. Older persons living in social protection centers and enjoying the above-mentioned benefits are not entitled to monthly social assistance payments.

The cost norm for care and nourishment at public social protection centers is too low compared to need. The cost norm for caring for and nurturing an older person is approximately 36,000 VND/day (Decree No. 136/2013/ND-CP). Older persons admitted to public social protection centers are those coming from poor households and having no close family members to care for them. Apart from social assistance, this group often does not have any other financial resources to contribute to care services. Public social protection centers get funding from local budget (social security budget) to cover recurrent expenditures such as wages, electricity and water. Currently, the costs for care and nourishment of older persons in line with Decision No. 1508/QD-TTg (2016) have not been assessed systematically and transparently to determine if they are rational. Only about 5.2% of centers reported no material and financial support from the community. As evaluated by the Social Protection Department, the material and spiritual life of older persons in social protection centers (or of those who are cared for by people in the community) is still encountering difficulties and older persons’ needs have not been met. Resources mobilized from the community and the society are limited.

Non-public social protection centers receive funding from the state budget, charitable contributions or fees paid by older persons’ families under contract. For older persons who are eligible for admission to social protection establishments, if they are cared for in non-public establishments (charity or enterprises), these non-public centers will enjoy the same assistance payments for their care as public ones. Other operational expenditures may be covered by contributions from charities (e.g. from businesses like VinGroup, religious organizations, Red Cross Society or other organizations), or families of older persons (this is the case in most enterprise-type facilities). Charitable social protection centers often face shortfalls in operating budget so they encounter many difficulties in the day-to-day operation and maintenance of their infrastructure, and have insufficient funding to provide necessary rehabilitation services.

**Prices of care services at private social protection centers for older persons are often very high.** Prices of care services for older persons at private nursing homes vary

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62 Source: survey data of the Social Protection Department 2015
depending on how much older persons are conscious and able to take care of themselves, as well as on their room requirements (private or shared room). In general, the prices range from 6 million to 13 million VND/month for basic services (furnished bedroom, shared living room, laundry, diet, daily acupressure massage, personal hygiene, daily health monitoring, physical activity). Additional services such as tube feeding, endotracheal intubation, care of bedsores, bladder catheterization and rehabilitation will incur additional costs of 5 - 8 million VND/month.

5.3. Finance for social work services

Funding for the operation of social work service centers is to be raised through social mobilization. In addition to support from the state budget, they also have other sources of revenue such as contracts to provide services for domestic and international programs/projects, voluntary contributions of older persons, support from local and foreign organizations and individuals. The state budget covers the construction and initial procurement of equipment for these centers during the pilot period of the project (Social Work Profession Development Project in 2010 - 2020).

Social work services provided to older persons who are social protection beneficiaries are covered by the state budget. These services can be divided into three categories. The first is social work services, which include counseling, communication, advice, community-based rehabilitation, prevention of harassment, violence, ill-treatment against older persons or the risks of falling into other difficult circumstances, case management and community development (e.g. club development). The second is services related to voluntary care and nurture of older persons, including care needs assessment, establishment of profiles of older persons seeking voluntary primary caregivers in the community, establishment of profiles for care of older persons, assessment and certification of the eligibility for care by registered families, training and capacity building for eligible families to act as voluntary primary caregiver for older persons, provide psychological support for older persons, bringing older persons to live with voluntary primary caregivers in the community, and monitoring the care they receive. The third is home-based or center-based residential care. At centers, residential care services include assessment of the initial state and needs of older persons, healthcare, physical rehabilitation, training of daily life skills, organization of cultural, recreational and entertainment activities, and rehabilitation. Home-based residential care services include visits, medical examination, need assessments of older persons, rehabilitation, counseling, advice and care.

Regarding older persons who are not social protection beneficiaries, there are no regulations on payment mechanism and service prices for this group. Older persons who are 60 - 79 years old, not poor, have close family members to care for them and do not have very severe disabilities are not social protection beneficiaries. Therefore, they are not entitled to government-paid social work services. However, there are no legal regulations on the price schedule of social work services.

5.4. Financing for home-based care services

Home-based care services for older persons are growing rapidly in big cities, with relatively high prices. Payment for these services come from household financial resources [109]. A comparison of the prices of home-based care services for older persons of some companies in HCMC, shows that the average price is approximately 7 million VND/month (8 hours/day for 30 days/month). If the service requires medical expertise or 24-hour care/day,
the price is higher. This price of home-based care services for older persons is unaffordable to most families, and the social assistance payments from the State are inadequate to reduce the financial burden of (or barrier to) these services. Only families with good economic conditions can rely on these services as the main care option for older persons in the family. Families without economic conditions can use these services only for a short time or a few hours per day.

The opportunity cost of volunteer care of older persons is the lost income of such volunteers as they spend time on caring for older persons instead of working to make money. Although there are many volunteer-based care models, when the workload is heavy (e.g. older persons with dementia or who are bedridden) and volunteer caregivers sacrifice their income to care for older persons, it is difficult to maintain their activities at a large scale and for a long term. To overcome this problem, the ISHC model is piloting the use of paid care assistants, at a cost lower than that of companies providing home-based caregivers of older persons. In terms of service delivery, it would be easier to mobilize caregivers of older persons with this approach while keeping the service price lower than that of private services, facilitating the use of services by households with limited economic conditions.

5.5. Long-term care insurance for older persons

Long-term care insurance has been developed in high-income countries, while community-based financial solutions are still the main solution applied in middle-income countries. Not all older persons need long-term care services to deal with dementia or inability to take care of themselves. However, in case they need these services, it is difficult to pay for them with the social assistance, retirement pension, savings or income of family members, and health insurance does not cover non-medical services. Long-term care insurance is one policy solution to aide older persons to finance long-term care. Some Asian countries have introduced this type of insurance, e.g. South Korea. However, other countries still apply a community-based risk pooling mechanism like in Thailand.

In 2008, Korea introduced long-term care insurance, applied unconditionally for all people 65 years and older and conditionally for people less than 65 years of age who have age-related diseases such as dementia or paralysis. This type of insurance covers: (i) community-based services such as home care, home nursing, day care, short-term respite care, and (ii) residential care services, e.g. nursing homes that care for older persons. To be eligible for these services, older persons are assessed through a standardized assessment using a 52-item questionnaire to classify them into five levels. About 6% of older persons are eligible for these services. Funding for this program comes from insurance premiums, government taxes and user co-payments. The role of the National Health Insurance Corporation (at central and local levels) is to determine and collect contributions, manage financial resources, assess and determine the level of entitlement, and monitor services. As a result, the number of participants in long-term care insurance has increased significantly from 1% in 2003 to 6% (i.e. 320 000 older persons) in 2014, but still represents a small proportion of all older persons.

In Thailand, long-term care risk pooling is done through charitable contributions and volunteers in the community. The cost of social care is paid by local governments, charity funds or contributions by volunteers, for example carpenters may donate devices or home repair to assist older people to age in place. Thailand’s long-term care policy focuses on the community-based care system in which caregivers in families and volunteers are expected to care for dependent older persons. Lam Sonthi is the only district providing community-based care through paid care assistants to fill the gap of the shortage of family caregivers.
In summary, the Vietnamese elder care system, although it has made some important achievements, has nevertheless been slow to adapt to meet the intensifying needs of population aging. Families are the primary source of long-term care for most older persons in Vietnam, as in most other nations. However, as the average number of working age individuals per older person diminishes, and as longevity increases, the number of households that will be facing difficulties in caring for their older members will increase. At that point, society can no longer rely solely on family members to provide long-term care for older people facing difficulties in performing ADLs, and it will become necessary to mobilize the entire community and society to help families implement that responsibility.

Vietnam’s societal response aimed at supporting families to provide long-term care for their older members is so far very limited. Institutional residential care facilities in the public sector and charitable sector only serve an extremely small number of older persons classified as social protection beneficiaries. Private nursing homes, although they are developing, have rather high prices, which many families cannot afford to pay. The need for care in the community and family is predominant. Diverse services to support families to care for their older members, such as the ISHCs, will have to become the main solution, but have so far received inadequate attention. Recommendations on solutions for long-term care of older persons aimed at achieving healthy aging in Vietnam are synthesized in Chapter VIII.
Chapter VII. Social environment to support healthy aging in Vietnam

1. Framework for analyzing the relationship between social environment and health among older persons

According to WHO, a living environment that is friendly towards older persons helps achieve healthy aging through support to maintain and develop intrinsic capacity throughout the life course for each individual and promotes functional ability so individuals, with varying intrinsic capacities, can all achieve their own value. A healthy aging environment requires 5 basic domains of functional ability:

1. Meeting the basic needs of older persons, including food, clothing, housing, health care and long-term care.
2. Learning, to improve knowledge and decision making.
3. Mobility.
4. Building and maintaining relationships and being respected.
5. Contributing to society.

In Vietnam, Article 10 of the Law on the Elderly states: “Care of older persons involves taking care of spiritual and material life in order to meet the basic needs of food, clothing, housing, transportation and need for entertainment, recreation, information, communication, and learning of older persons. Moreover, in the current reality, tourism, sports and spiritual life are becoming important needs of the population and have important effects on health of older persons. As a result, compared to the contents of the social environment for healthy aging conceptualized by WHO, this chapter has added additional contents about meeting needs for tourism, recreation, sports, information and spirituality. This chapter does not discuss issues of health care and long-term care, which were already covered in Chapters V and VI.

The social environment affects health of older persons through 10 key components that can be divided into two groups: (i) material (4 first components) and (ii) non-material (remaining 6 components) as presented in Figure 79. Accordingly, these elements affect health of older persons at four levels: (i) society (culture, law, policy, ...), (ii) community (iii) the family (responsibility, attention), and (iv) the individual (habit and effort).

Figure 79. Social environment and health of older persons

![Social Environment Diagram](image-url)
The social environment for older persons in Vietnam is analyzed on the basis of customs, habits, policies and methods that the Government, community, family and older persons themselves implement in order to ensure their material and non-material life conditions.

2. Social environment to ensure material conditions for older persons

2.1. Ensuring adequate nutrition and food security

Vietnamese people always consider eating is an important issue: “It’s no use preaching to a hungry man”. On April 24, 1956, in the closing words of the ninth plenum of the Central Committee of the Vietnam Workers’ Party, President Ho Chi Minh emphasized: “If the people are hungry, the Party and Government are at fault; if the people are ignorant, the Party and Government are at fault; if the people are sick, the Party and Government at fault. “[110]

For several decades, Vietnam has resolved the problem of adequate food sustainably for the entire population, including older persons. Annual grain output per capita reached over 500 kg, specifically in 2015 it reached 550.6 kg per person. For many years, Vietnam has been the second largest exporter of rice in the world, with exports reaching over 6 million tons a year, or even reaching 8.0 million tons in 2012 [111]. Results from the 2003 survey in Ha Tay show that only 1.19% of older persons in urban areas and 6.34% in rural areas suffer from hunger [112]. With rapid socio-economic development over the past few years, this situation has continued to improve.

However, food shortages may still occur among some population groups, such as the poor and older persons, particularly among poor older persons without family to support them, or when they face natural disasters or catastrophes. To further improve the policy response to these situations, the Government issued Decree 136/2013/ND-CP dated 21 October 2013, stipulating the following:

- Social assistance payments: older persons in poor households and all older persons aged 80 and older who are not yet receiving pensions or other government support payments, are entitled to regular social assistance payments of 270,000 VND (equivalent to over 27 kg of plain rice at Hanoi prices on 29/10/2016). Some older persons receive social assistance payments that are 1.5 times or 2 times the regular amount.

- Care and nurture in the community or at social protection centers and social housing: older persons living in poor households with no obligatory and supporting person can live in the community if there are recipients. Social assistance payments (3 times the social assistance norm) or admitted to a social protection center (paid at a rate of 4 times the social assistance norm).

- Emergency support: Food support policy for all members of the household during and after famine, fire, crop failure, or other unforeseen events. Specifically, assistance of 15 kg of rice per person per month for no more than 3 months for each round of assistance and assistance of 15 kg of rice per person for all members of the hungry household during the Lunar New Year. “Do not let people go hungry” is always the order from the authorities when disaster strikes.

With the achievements of agricultural development and policy as above, Vietnam has eliminated food shortages for the general population, including older persons. In addition, food preparation in Vietnam is also very diversified and mostly in soft form, such as rice, rice porridge, noodles, and nutrition powder which are very suitable for older persons.
Chapter VII. Social environment to support healthy aging in Vietnam

In addition, proper nutrition for the general public, and older persons in particular, is also a concern. The MOH has issued recommendations for “Ten Good Nutrition Tips for 2015 - 2020” which focus on healthy diets, low salt, low fat, low sugar, and increased calcium, and fiber in food. However, in addition to supporting policies and mechanisms promoting a healthy diet for the general population, there is a need for specific nutritional advice that is easy for older persons to implement.

The ISHC model described in Chapter VI includes activities aimed at supporting older persons facing sudden difficulties through community self-help activities. Every month, during regular club activities, a discussion is held about helping at least one case facing especially difficult circumstances in the community. Forms of assistance, besides contributing time, include also cash or in-kind support like rice. Besides mobilizing members to contribute, the clubs also mobilize resources in the localities to provide additional support, helping to ensure that needs for food are met among older people facing difficulties.

2.2. Meeting clothing needs

The clothing needs of older people are not simply to ensure adequate warm clothes for winter and cool clothing for summer, but also to ensure that the materials and design are appropriate for age, and are convenient for older people in performing ADLs. Currently, production and imports of textiles and clothing are adequate for Vietnam’s needs, and include supply of items needed by older persons, such as adult diapers and soft fabric clothing. A 2004 study found that only 0.6% of the older persons in urban areas and 4.75% of the older persons in rural areas in 2003 had unmet need for clothing [112]. Thus, in general, one could say that the need for clothing among older persons in Vietnam are met.

During emergencies, such as natural disasters, or in poor areas, clothing is always an essential good to be provided, with older people being a priority group to receive such assistance. For example in 2009, the VAE collaborated with the VNCA and several sectoral agencies to successfully organize a campaign for “One million warm jackets for poor older persons” with the objective that every poor older person, would be given a warm jacket with priority given to 61 poor districts, [113]. In addition, annually at the Tet holiday, on Vietnamese National Older persons day (6 June), the President and leaders traditionally give gifts of silk fabric to people aged 100 years and older and older persons with meritorious service to the country.

2.3. Meeting housing needs

The demand for housing is one of the essential needs and a minimum human right. Vietnamese people attach importance to housing, with the traditional saying “one must have a stable residence before one’s career can take off”. The Constitution of 2013 contains three articles concerning citizens’ housing: “Citizens have the right to a legal domicile” (Article 22); “Everyone has the right to ownership of legally earned income, savings, housing, means of production and daily activities, capital contributions to an enterprise or other economic organization” (Article 32); and “The state has a policy of housing development, creating conditions for people to have an accommodation” (Article 59).

The Housing Law (2014) stipulates the beneficiaries of social housing support policies, including older persons, such as: (i) people with meritorious services to the revolution in accordance with the Law on people with meritorious service to the revolution; (ii) poor and near poor households in rural areas; (iii) households in rural areas regularly affected by natural disasters, and climate change; (iv) low-income, poor and near-poor households in urban areas. Although there are no specific regulations on the architecture of buildings appropriate for older persons, Article 20 of this Law stipulates that the architecture must be appropriate with the
historical and cultural traditions. With the culture of respect for older persons, certainly older people should be given a space that is appropriate for them.

The Vietnam National Action Program for the Elderly for the period 2012 - 2020 set the target for 2015 that “100% of older persons will not be living in dilapidated houses”. To implement this target, provinces have set the target of “eliminating temporary, dilapidated houses for older persons” or “eliminating temporary houses for families consisting of poor older persons without family support.” According to the Intercensal population and housing survey in 2014, 99.96% of families in Vietnam have housing. Besides owned or rented homes, older people also live in public or private social protection centers [114].

Thus, one can conclude that thanks to efforts of older people, their families, the community and the state, older people in Vietnam have been guaranteed housing. However, the appropriateness of design, interior arrangements, and amenities to facilitate ADLs of older persons have received little attention to date. Vietnam still does not have regulations on standards of housing design appropriate for families with older members. Few families have put in place measures to avoid falls among older persons. In addition, currently there is little research on the ability to meet needs for housing among older persons such as quality or housing arrangements appropriate for older persons.

2.4. Meeting transport needs

Vietnam has many legal documents regulating priority in support for meeting transport needs of older people in the community. Article 15 of the Law on the Elderly stipulates that “when using public transport, older people should be aided and convenient seating arranged for them.” The Law also stipulates that discounted fares should be offered to older persons. Article 4 of Decree No. 06/2011/ND-CP stipulates the details of priority seating and assistance for older persons using public transport. It also states that discounts on fares should be at least 15% for ships, trains, and airplanes. In addition, Ministry of Transport Circular No. 71/2011/TT-BGTVT also provides for additional priority for older people, such as priority counters for buying tickets, assistance with luggage and with getting on and off the means of transport.

Despite these policies, a 2015 study found that only 30.9% of older persons reported receiving discounts for transport fares when riding the city buses, 28% on long-distance buses, 21.5% on trains, 13.9% on airplanes and 7.3% on ships. Similarly over 38% of older people reported that they were given priority for convenient seating arrangements on the city bus, 35.9% on long-distance buses, 18.9% on trains, 10.1% on airplanes and 6.3% on ships [114]. This indicates that most enterprises have not paid attention to implementing the fare reduction policy, and monitoring and enforcement of the regulations are lax.

In addition, there are no detailed regulations on the design of transport infrastructure, vehicles, escalators/elevators, lighting, etc., in line with the needs of older persons. There is also no policy to ensure convenience and safety for older pedestrians as they walk along the road or cross the road. Measures are not in place to ensure that drivers or others assist older people to safely enter or exit means of transport. These shortcomings put older people at risk when participating in traffic, or when using means of transport, which could adversely affect older people’s health due to accidents, falls, or isolation, if shortcomings prevent them from getting around to participate in society.
3. Social environment to ensure non-material conditions for older persons

3.1. Meeting needs for life-long learning

Goal 4 of the WHO Global Strategy and Action Plan on Aging and Health 2016 states: “Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all”. In Vietnam, Article 39 of the Constitution states: “Citizens have the right and obligation to study”; Article 10 of the Education Law (2005) states: “The State shall exercise social justice in education, creating conditions for everyone to learn.” Article 3, paragraph 1 of the Law on the Elderly (2009) states that older persons shall be “facilitated to participate in cultural, educational, physical training, sports, recreation, tourism and leisure activities.”

Currently, about 2 million people (16.2%) between the ages of 60 and 64 have post-secondary education qualifications of elementary level or higher. In fact, some 4.4% of people in this age group have university or higher levels of education. Among people aged 65 and older, 7.3% have post-secondary education or training qualifications. These people are a valuable resource for the nation. However, a large share of older persons has low educational attainment due to decades of war that delayed socio-economic development. In 2009, about one third of people in the 60 - 64 age group and nearly two-thirds of the group 65 years and older had never completed primary school [24].

The low educational level and technical expertise of older persons adversely affects their quality of life in general and their ability to reason, analyze and make decisions, including in the field of health care. Efforts are therefore needed to improve knowledge of older persons, through literacy training, practical training on livelihoods or health care, through clubs and centers in the community. At the same time, it is important to facilitate participation of qualified older people to continue to contribute their technical expertise to the workforce.

3.2. Meeting the information needs of older persons

In addition to the need for life-long learning, older persons also have a high need to access information. One element of Article 25 of the Constitution of Vietnam relates to the citizen right to have “access to information”. Article 29 of the Law on the Elderly stipulates that “the Ministry of Information and Communications shall direct the mass media agencies to promptly and accurately disseminate information on policies and laws related to older people.” The Vietnam National Action Program for the Elderly 2012 - 2020 sets the target: “80% of central and local radio and television stations have a broadcast on issues related to older persons at least 1 time per week” by 2015, increasing to 100% by 2020.

Mass media in Vietnam is quite diverse, including newspapers, radio, television, mobile phones, internet and community loudspeakers. Older persons in Vietnam mainly live with the family, so the characteristics of older people’s access to information is linked to household access. Results of the Intercensal population and housing survey 2014 indicate that 93.9% of households have a television (93.5% in rural areas and 94.7% in urban areas); 85% of households use landline or mobile phones; and 25.1% of households use computers. These rates almost doubled compared to 2009, when nearly 5.1 million households, accounting for 22.5% of all households, had radios [26].

As of 25 December 2014, Vietnam had 838 print press agencies with 1111 press publications, including the newspaper and magazine entitled “Older people” [115]. The program “High ball”, game show “Fun, healthy, useful” on Vietnam Television, “Older person club” program of the Voice of Vietnam, the “Older person role model” section of the Older People
newspaper are all content and programs that have received investments and are of good quality and diversity of contents and well received by older persons contributing to their spiritual health. There are 9 provincial radio stations (Thai Nguyen, Long An, Vinh Phuc, Hanoi, Cao Bang, Dak Lak, Lang Son, Ha Tinh, Hau Giang, Gia Lai) that have invested in and maintained several programs about older persons, with an average of about 50 articles or reports per year or monthly broadcasts on older persons. Some provincial television stations such as in Son La, Gia Lai provinces have even created relevant contents in ethnic minority languages.

Survey results show that over 80% of older persons regularly read newspapers, watch television or listen to the radio “[28]. Television and newspaper articles are both “spiritual food” to help entertain older people and help them live happily, healthily and usefully, and are also a forum for older people to discuss issues and share their perspective. Opinions from older people on these programs is based on their life experience, and includes precious lessons for younger people, and at the same time, in this way, they can contribute and propose recommendations to the Party and Government to revise policies about care for older persons.

Besides the mass media, direct communication through many forms has been integrated into activities in villages and urban blocks so that older people in different population groups can access many diverse sources of information. The active and effective involvement of the Fatherland Front, VAE and other mass organizations and social organizations through campaigns and projects has developed a model of care and promoted the role of older persons in society, and contributed to communication about policies and laws about older persons, with 45.22% of older persons becoming aware of their rights through this channel, compared to only 28.77% learning about their rights through the mass media [28]. As a result, more than 78% of older persons and 72% of members of households caring for older persons know about the Law on the Elderly, the entitlements of older persons as well as how to ensure access to these entitlements. As a result of diverse information sources for older persons, about 80 - 90% of older people know about their individual rights and over 60% of older people know about their socio-economic rights [114].

Nevertheless, the communication policies and their implementation have not yet paid adequate attention to the specific characteristics of older persons, and inadequately distinguish between older persons and other people. In the market economy, older persons are not a strong player, so they may receive less attention. Thus, it is necessary to increase effectiveness of activities of mass organizations in localities to provide information and implement policies on older persons. Household members and the community must provide information to actively support older persons. This is also an appropriate way to improve awareness and knowledge of older persons about state policies as well as social life. Information for older persons must be provided with large-size lettering to make it easier to read, with many images that are appropriate for the ability of many older people to understand information.

Older persons not only need information related to the Law and their rights, but also on knowledge of disease prevention and health promotion. Currently the mass media has many programs providing knowledge about health care for older persons, such as “Live happy, live healthy” on Vietnam Television. The main source of information on health care for older people comes from health workers and activities of the VAE, the Red Cross, activities of the model on counselling and care of older persons in the community of the General Office of Population and Family Planning and activities of the ISHC. Counselling information on health for older persons is very important so they can care for their own health, but also to guide other family members in knowledge and skills to help provide health care to older persons.

The Older people help Older people clubs of the General Office of Population and Family Planning were initiated starting in 2011. By 2016, 1155 clubs had been sustained in 370
communes/wards of 32 provinces, with a total of 66,015 members facilitated by commune level population workers in collaboration with relevant sectors (the core agency being the VAE). These clubs organize activities once a quarter in the form of cultural activities, provision of information, knowledge about health care for older persons [106].

Among the 8 areas of activities of the ISHC model are information and communication activities organized through monthly club sessions aimed at improving awareness and knowledge of older persons about health care, laws, policies and activities to increase income and technology transfer. According to an evaluation of the model by UNFPA in 2015, 99.6% of club members participating in the survey indicated that they feel more confident since participating in the ISHC.

3.3. Meeting the needs of tourism, sports, and entertainment for older persons

Older persons are considered to have completed their duties to society and their family. During the period of rest after a long work life, they often have a desire to visit places they could not visit in the past. Older people often want to visit tourist spots of historical or spiritual significance.

Article 3, paragraph 1 of the Law on the Elderly (2009) states that older people “shall be facilitated in activities of culture, education, sports, exercise, entertainment, tourism and leisure.” Decree No. 06/2011/ND-CP stipulates: “Older persons are entitled to a minimum 20% reduction in entrance fees and service fees when visiting cultural and historical sites, museums, and other places of interest, when exercising or participating in sports at sports facilities that sell tickets or charge fees.” Ministry of Finance Circular No. 127/2011/TT-BTC stipulates that this discount shall be up to 50%. The government has also made many detailed regulations to publicize and effectively implement this policy. However, the proportion of older persons who travel for tourism is quite low. According to the “Visitor Survey Results 2009”, people aged 55 and older account for only 7.4% of participants in total domestic tourists [116], compared to their share in the population at 16.7% [22]. Only 32.4% of older people reported receiving a discount ticket for tours in 2015 [114].

The VAE at all levels has collaborated with the Culture, Sports and Tourism sector to organize cultural, sports and recreational activities for older persons. The Central VAE has collaborated with the Vietnam Sports Administration (of the Ministry of Culture, Sports and Tourism) to organize sports competitions (national competition 1 to 2 times per year); provincial level 2 times per year; district level 1 time per year. According to statistical reports, over 900 sports competitions have been organized with more than 1 million older athletes. The fitness movement has developed strongly at the grassroots level. More than 55 provinces are widely disseminating Tai Chi exercises. It is estimated that 15 - 20% of older persons in rural areas and 60% of older persons in urban areas participate regularly in sports, cultural activities [117].

VAE at all levels focuses on developing clubs for older persons. Up to now, there are 58,099 clubs nationwide with diverse cultural, arts, physical training, sports, dancing, chess and other activities. These clubs have attracted nearly 2.6 million older persons (accounting for about 30% of all older persons nationwide), contributing to improving health and reducing illness, while preserving and developing the traditional cultural identity of the nation.

Physical exercise is also one regular activity of the ISHCs, with a target of at least 80% of club members participating in physical exercise and sports or Tai Chi on a regular basis (at least 3 times per week), appropriate with their health status. In many localities, the ISHCs have become a core force for developing physical exercise campaigns, attracting many older persons to participate.
Another activity area of ISHCs that should also be mentioned is cultural and performance activities (each ISHC has one core cultural team), entertainment, and social interaction. Along with the self-care and health care activities, these activities help the members substantially improve their material and spiritual lives. An evaluation of the ISHC model by UNFPA found that 84.58% of ISHC members surveyed reported that their health had improved and 12.5% indicated that they still maintain their good health.

Nevertheless, the proportion of older persons able to avail of the policy of discount prices when participating in sports activities only reached 12.5%, and in rural areas only 10% [114]. Reasons for this low performance from the older person’s side are due to lack of funds, inadequate health to participate and lack of understanding about the policy for older persons. Reasons for this low performance from a societal perspective is due to the low development of technical facilities for sports and physical exercise; insufficient number of cultural, historical sites, museums and scenic places of interest. Some agencies responsible for managing these facilities do not yet strictly implement government regulations; while government agencies do not implement inspections or surveillance or impose penalties for violations. On the other hand, the regulations on discounts do impose the same benefit for all people in all regions, even though needs may be very different.

Currently, information gathering and analysis about sports and tourism among older persons is quite limited. As a result, there is a need for communication to older persons about policies intended to assist them, particularly in cultural and sports activities. At the same time, the VAE, VNCA and relevant government agencies should increase their monitoring activities. There is a need for exemptions or discounts for older people to participate in cultural, educational, sports, physical exercise, entertainment, tourism and recreational activities. On the other hand, besides facilitating the participation of older persons in sports, tourism, and entertainment campaigns for spiritual well-being, there is also a need for advice and instruction about physical exercise, to encourage and support older persons to develop a healthy lifestyle, an appropriate recreational regime and participation in regular physical activity that is appropriate for each age to promote improved health.

Clubs have been very active in this area, such as the ISHC, and require increased investment to enable them to scale up activities with support from the culture, sports and tourism sector. The VAE should implement the tasks assigned by the Prime Minister in the Project to Scale up Clubs. The VAE should collaborate with the MOH, Ministry of Information and Communication and the Ministry of Culture, Sports and Tourism to support and facilitate health care activities, IEC on health promotion, sports, Tai Chi, and cultural activities for ISHCs.

### 3.4. Family relations of older persons

Family factors play an important role in protecting health, but also in inducing illness in general, but particularly for older persons. Besides genetic factors, lifestyle habits and behaviors, and relationships between members of the family are also related to many different ailments in older persons. Family members play the most important role in caring for and supporting older persons to meet material and spiritual needs, both when healthy and when ill.

In traditional Vietnamese families, children and grandchildren are taught gratitude and filial piety towards parents, grandparents and ancestors. Vietnamese law also contributes to strengthening these values. The Law on the Elderly (2009) stipulates the obligation of children and grandchildren to care for older persons (Article 10) and stipulates that older persons are entitled to make their own decisions about living with children or grandchildren (Article 3). The obligation to support older persons is also specified in Articles 70 and 104 of the Law on Marriage and the Family (2014).
According to the 2006 Nationwide Survey on the Family in Vietnam, 51.5% of older respondents indicated their expectation that they should live with their children. However, only 32.6% of all households actually had older person members (35.7% in urban areas and 31.4% in rural areas). The proportion of older persons living independently of their children is on the increase. Among older persons living on their own, 95% have been visited by children in the past 12 months. Some 39.3% of older persons reported that their main source of livelihood was provided by their children. In contrast, 90% of older persons still support children and grandchildren through help with housework or child care. Most older persons (87%) reported that their family, children and grandchildren have been good to them. Thus the traditional values and behaviors such as “younger people depend on their father while older people depend on their children” in modern Vietnamese society are still valid [118]. In life, older persons act as role models, taking the lead and playing a core role in campaigns to build cultural life, family and love of learning. Spiritual well-being of older persons does not solely depend on material goods. While Hanoi has higher material wealth than Thanh Hoa province, the proportion of older persons who feel discomfort is 5 times higher than in Thanh Hoa. In contrast, the proportion of older people feeling that they have a comfortable life in Thanh Hoa is 3 times higher than in Hanoi [119].

It should be emphasized that older persons in Vietnam have been raised in an extremely different socio-economic context compared to their children and grandchildren, in terms of awareness, attitudes, and behavior among the generations. Without knowledge and skills to resolve these differences amicably, conflicts can arise, to the point of generational clashes of different levels of severity. Elder abuse appears to be undergoing a clear decline, but still exists, with 4042 reported cases in 2011; 2232 cases in 2012, 2367 cases in 2013 and 1432 cases in 2014. A majority of domestic violence towards older persons has been resolved in a timely manner [120]. However, children and grandchildren do not confide in or interact much with their grandparents or parents, adversely affecting emotional well-being of older persons.

The risk of conflict between older persons and their children and grandchildren in the modern family is a major concern, because of the decline in the culture of the family. The state lacks plans or methods to provide cultural education to families, particularly ethics education. There is insufficient pressure from public opinion and inadequate penalties for people who are violent towards grandparents or parents in society. In addition, problems also arise due to difficulties facing the lives of children and grandchildren, sometimes placing them in dire straits and stress. In addition, the lack of moral education, and the rise of social vices and bad habits also contribute to the situation. Therefore, it is necessary to create a harmonious environment in the family and community where older people reside so that they can have peace, and share their feelings and thoughts with their relatives and friends. At the same time, there is a need to intensify moral education, and impose administrative regulations to compel children to comply with social values of filial piety. On the medical side, there is a need for strengthening counselling for family members about how to harmonize relations between the family and older members, and to provide guidance for family members to gain basic knowledge and skills to support health care for older persons.

3.5. Social relations of older persons

Vietnamese people have a tradition of respect for older persons. This tradition is supported by policies and laws. Article 37, paragraph 3 of the 2013 Constitution of Vietnam stipulates that “older persons shall be respected, cared for by the State, family and society, and their role promoted for the cause of national construction and defense.” The government also has policies for reputed leaders among ethnic minority groups according to Decision No. 18/2011/QD-TTg and Decision No. 56/2013/QD-TTg.
Thanks to traditions and policies respecting older persons, they are actively integrated and participate in community activities. By the end of 2014, nationally there were more than 8,469,000 members of the VAE, accounting for about 84% of total older persons in Vietnam. In the period 2009 - 2014, central government agencies and Communist Party organizations have received 60 delegations including 5000 village elders to give them advice and moral support [121]. In the localities, older persons have actively participated in patriotic movements like “Old age, role model”, participating in the building of the political system, strengthening basic culture, and protecting border and island security. They have been active in economic activities, poverty alleviation, contributed to maintaining political security, social safety and order, protecting the environment and building a new countryside. Currently there are 1.24 million older persons (13.2% of older persons) who participate in the Communist Party, local authorities and mass organizations. The VAE in 1000 communes of 44 provinces in border and coastal areas have signed a program to collaborate in actions with border protection units. In 4013 seminars to contribute ideas to revise the Constitution, more than 165 thousand comments were obtained from more than 2 million older person participants [117].

ISHCs have some activities aimed at promoting participation of older persons in the community. Many older persons have become volunteers providing home care for other older persons, helping with economic development or helping cases in severe difficulty in the community through monthly self-help, community-help activities. Due to their participation as a useful person in the community, many older people have gained better health and morale.

In the community, from 2010 to the present, local authorities and Party organizations celebrate the longevity of more than one million older persons each year. More than 900 thousand older persons have been visited when ill or disabled, and given gifts on traditional Vietnamese holidays [122]. In 2015, the President of the nation sent cards and gifts to 22,659 people aged 100 years and older.64 Some localities even organize celebrations for older people outside of the ages stipulated in policies [121].65 When an older person passes away, the family, local authorities, mass organizations, village leaders, organize a dignified but financially modest funeral appropriate with Vietnamese culture. For older people without family, a funeral is organized with the involvement of the commune-level people’s committee where the older person resided, in collaboration with the VAE and local mass organizations following existing policy regulations [121].

However, since many older persons do not have birth certificates or their documents were lost during the war, it is not clear in which year they were born, making it difficult to determine age to organize celebrations and give gifts on legally specified birthdays. Therefore, it is necessary to continue to pay attention to effective implementation of policy regulations on gifts for older people reaching threshold ages, particularly for older persons in disadvantaged regions and ethnic minority people. In addition, there is a need for concrete solutions to support older persons to integrate and expand their role in the community and to facilitate older people to continue contributing to society.

### 3.6. The spiritual life of older persons

All of Vietnam’s constitutions, from 1946 (Article 10); 1959 (Article 26); 1980 (Article 68); 1992 (Article 70) stipulate freedom of religion and belief of citizens. Article 24 of the Constitution of 2013 states that “Everyone has the right to freedom to believe or not believe

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64 Statistical data from the Department of Emulation and Reward. Office of the President.
65 Decree 06/2011/ND-CP guiding implementation of the Law on the Elderly stipulates that the President is to provide gifts when people reach 100 years of age; the provincial people’s committee should provide gifts when people reach age 90; and that local authorities, depending on their situation, should provide gifts and organize celebrations for older people reaching milestone ages of 70, 75, 80, 85, 95, and over 100.
in any religion. All religions are equal before the law” and “the State respects and protects freedom of belief and religion.”

Most Vietnamese families practice ancestor worship. Religions, such as Buddhism, Christianity, Protestantism, Cao Dai, Hoa Hao, etc. are also practiced in Vietnam, with long family traditions with specific religions. According to the 2009 Vietnam Population and Housing Census, 15 651 467 people nationwide have confirmed their belief in a particular religion [24]. In social protection centers for older persons, there is usually a place for older people to practice their religious rituals.

A survey in Hanoi reported that 12% of older persons aged 60 and older go to the pagoda for worship [123]. In addition to regular prayers and rituals at the pagoda, older persons often participate in special religious holiday celebrations, or even pilgrimages to other pagodas. Freedom of religion has contributed to moral life and spirituality of older persons. Stable moral and spiritual life contribute to improving health of older persons. As a result, local authorities, mass organizations in the localities and the family, and establishments providing long-term care to older persons create conditions for older persons to follow their spiritual beliefs and at the same time severely punish anyone who violates religious freedom policies of the Party and State.

3.7. Economic activity of older persons contributing to society and family

According to the Intercensal population survey in mid-2014, men who have survived to age 60 years, on average, live another 18.2 years and women live an additional 20.6 years. Among these older persons, many remain healthy and have useful technical qualifications, especially those in the 60 - 64 age group, who are capable and desire to continue working.

Vietnam also has policies to facilitate older persons to contribute their efforts to the family and society. The Law on the Elderly states that older persons should be provided with conditions to work appropriate with their health, occupation and other conditions to promote the role of older persons. The Labor Code (2012) stipulates the same policy. Accordingly, older persons are prioritized by allowing them to shorten their working times or to work part-time. Article 166). Older persons should not be assigned heavy or hazardous work (Article 167). In addition, the retirement age for workers with high technical and managerial qualifications has been raised (Article 187).

On that basis, Article 9, Section 2 of Decree No. 141/2013/ND-CP provides for the extension of the working time for retirement age lecturers for no more than 5 years for lecturers with doctoral degrees; No more than 7 years for lecturers with the title of associate professor and no more than 10 years for professors with the title of professor.67 Article 2 of Decree No. 53/2015/ND-CP specifies 10 groups of people who can extend their working life in the public sector. Individuals at the deputy level or equivalent can extend their age of retirement to 65 for men or 60 for women. These legal regulations, although they only focus on a small group of working people, are the beginning of development of a policy that promotes continued working life for older persons, particularly older persons with high technical qualifications.

With facilitation from the state, agreement of families and efforts of older people, the proportion and number of older persons in the workforce nationwide have increased gradually.

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66 Data on life expectancy at age 60 years comes from the General Statistics Office. In Chapter IV we used data from the Global Health Observatory (WHO) to allow for international comparison of consistently defined indicators. That source indicated that on average men who reach age 60 will live another 19.5 years, while women who reach age 60 will live another 24.9 years on average.

67 Note in Vietnam professor designates someone who has high educational qualifications and additionally has made academic contributions through research. The title of professor or associate professor is only granted after rigorous review of their contributions.
over time. In 2015, more than 4.49 million older persons were employed, accounting for 8.4% of the total workforce [124]. In addition, more than 95 000 older persons are owners of farms, production facilities and service businesses. More than 300 000 older persons have been nominated and given awards for excellence in their occupation/business. Older persons have mobilized their families and relatives to contribute 3.48 trillion VND, to gift more than 12.4 million m² of land, more than 5.3 million working days for construction of rural roads and local infrastructure [117].

In addition to older persons working due to their preference to remain active and enjoyment of work activity, it is important to recognize also that many people must work for economic reasons, even if their health is inadequate to handle work. According to the National Survey on Aging, in 2011, only 16.1% of older persons had a pension; 9.4% were receiving some social assistance payments, while other sources of support were unstable and uncertain. More than 62% of older persons did not have enough income to cover their costs of care in the family. This may cause pressure on older people pushing them to be more economically active even when they are too weak to work [28]. This is also consistent with the results of the 2003 Ha Tay survey showing that: 25.6% of older persons in urban areas and 28.3% of older persons in rural areas have a need to work. Among these people, 15.5% in urban areas and 16.5% in rural areas reported that they needed to work to earn a living [112]. At the same time, employment by young people often reflects typical features of work among other vulnerable groups, self-employed, concentrated in agriculture with low productivity, and no contracts. With low and unstable incomes, families with older persons often face more difficulties when they are faced with NCDs, particularly fatal diseases, with high treatment costs, leading to higher rates of catastrophic spending or impoverishment due to health spending [125].

In addition to activities that directly contribute to society and the family in economic terms (i.e. income generation and production of goods and services), older persons also actively contribute to the family through daily work of caring for grandchildren and doing housework. Although this work is not directly income generating, 27.2% of older people take care of grandchildren to free up their children to go to work. Some 17.4% of older persons help out their children and grandchildren in household enterprises, 27.5% of older persons participate in housework and 7.6% of older persons still actively participate in charity or community service [114].

Among the areas of ISHC activities supporting older persons, the largest area is activities to increase incomes. Each club has an income generation fund to allow members to borrow (in cash or kind) to create livelihoods for older persons, helping older persons to continue participating in economic activity. In addition to providing loans, the ISHCs provide information on activities to increase incomes that are appropriate for older persons, transfer technologies, arrange study tours to learn experience of others and share economic models. The ISHCs also encourage and motivate members to actively participate in economic development, through recognition and pointing out good examples among older persons, as well as through activities of volunteers helping with economic development (people who know how to generate a livelihood encouraging and supporting those who want to follow them). An evaluation by UNFPA in 2015 on this model showed that average annual income of ISHC members increased 30.3%. Nevertheless, the Income generation fund of the ISHCs scaled up by localities remain somewhat limited, because of low investment by the state, since they are mainly reliant on mobilized funding.

Responding to the need of older people who want to work and participate in socio-economic activities in Vietnam is an essential requirement of society. Helping older people with employment will resolve many problems for society, such as promoting their role, and encouraging them to continue to participate in socio-economic activities, reducing the burden
on social security if older people younger than 80 can escape poverty, and at the same time improving health of older persons, contributing to resolving social security policy and reducing costs to society.

It is necessary to have specific policies to encourage government agencies, economic organizations and enterprises employing healthy older persons who wish to continue working, especially older persons with high technical qualifications or highly skilled craftsmen/women. This would allow Vietnam to take advantage of the skilled and highly qualified workforce to create material goods for society, and at the same time reduce pressure to increase retirement age. At the same time, reforms are needed to the social security policy for older persons to reduce participation in the labor force due to economic pressures. Models that support older people to participate in economic development in their communities such as the ISHC require some state investment in income generation funds. The VAE should promptly implement the task assigned to them in the Project to Scale up ISHCs: VAE, collaborating with the Ministry of Agricultural and Rural Development, Women’s Union, Peasant’s union should communicate and guide ISHCs with knowledge for production and integration of resources from the program on the new countryside.

In summary, an older person-friendly social environment should ensure the comprehensive material and spiritual needs of older persons, safety for older persons, and promote older persons, their families and communities to participate in maintaining, protecting and improving health, and at the same time create optimal conditions for older persons to participate in contributing to society to the greatest extent possible. From a macro perspective, Vietnam has many policies to strengthen the social environment that supports the health of older persons towards healthy aging. However, we lack an integrated strategy and program of action as well as specific solutions for bringing these policies to life. Many policies and solutions are still only targeted to the poor and vulnerable groups, among which are some older persons, but the policies are not really focused or pay attention to the specific needs/characteristics of older persons. The ISHC model, a community based model aims to satisfy the physical, health and spiritual needs of older persons, and has been incorporated into the Vietnam National Action Program for the Elderly, 2012 - 2020. A project to scale up this model has been approved by the Prime Minister. However, state budget investments remain small, resources for scaling up are primarily from local mobilization, with the consequence that scaling up nationwide is extremely slow. Recommendations on developing a social environment that is friendly to older persons in Vietnam are presented in Chapter VIII.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

1. Priorities for healthy aging in Vietnam

1.1. Health priorities associated with population aging

Challenges of population aging

- The pace of aging in Vietnam is rapid, the population structure is changing drastically with a sharp decrease in the proportion of the working-age population, the time for preparation to respond to population aging is short while the awareness of aging-related problems in policy formulation and planning is still limited.

- Feminization of aging and high rates of widowhood and living alone, along with the forecast of a super-aged population (65 years and older) in rural areas by 2049, have not been fully considered in health and social security policies.

Health priorities in older persons

- Many older persons are still healthy and are actively participating in social and family activities. This group needs measures to prevent injury, infectious disease and NCDs, as well as health promotion and periodic health checkups for early detection of disease.

- Among older persons with ailments, the burden of disease is mainly due to NCDs, especially cardiovascular diseases, hypertension, cancer, diabetes mellitus, and chronic lung diseases. Older persons with these diseases need screening for early detection, timely treatment and effective management. These diseases require long-term management, making access to effective care at nearby facilities at affordable prices an imperative.

- The burden of disease due to reduced intrinsic capacity and functional ability in older persons increases with age. The ability of older persons to recover from illnesses and injuries also declines with age. Thus, older persons should be provided with timely rehabilitation services to reduce or reverse impairments in daily functioning. At the same time, older persons with difficulties in ADLs should be helped to continue to participate in the community and family.

- Neurological and mental health problems have a great impact on the quality of life and the self-care ability of older persons. At the same time, other diseases, decline of the self-sufficiency and living alone increase the risk of mental illnesses. Mental and neurological disorders in general have received less attention than other NCDs.

- Behavioral (and metabolic) risk factors contribute heavily to the burden of disease and death in older persons, but control measures at an early age have not yet achieved their potential for achieving healthy aging for the next generation.

1.2. Priority issues in providing health care services for older persons

State management of health care for older persons

- The accountability mechanism for units involved in the Healthcare for the Elderly Project has not been established. There is no mechanism for annual reporting on indicators related to health care for older persons to serve monitoring and evaluation.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

- The role and responsibilities of the General Department of Preventive Medicine have not been clarified in the Healthcare for the Elderly Project.
- There is a lack of intersectoral collaboration in areas such as physical activity for older persons, and medical care components of long-term care for older persons.
- Existing policies have neglected certain tasks relating to health care for older persons, e.g. mental health care, prevention of disabilities, fall prevention, and palliative care.
- The devolution of responsibilities to localities to implement health care for older persons is necessary to ensure the accountability of local governments, however this also creates a challenge that threatens achievement of national objectives on health care for older persons.

Organization of health care delivery for older persons

**Health IEC**
- There is a lack of collaboration among various NCD prevention and control programs in health IEC and in training to improve comprehensive healthcare capacity.
- Many older persons and their families lack basic knowledge on early signs of disease, causes of disease, healthy diet, and physical activity suitable for older persons, other basic needs for health care for older persons and information about types of health facilities able to diagnose, treat and manage common diseases in older persons.

**Periodic health checkup, disease management and health management of older persons**
- No uniform routine health checkup package has been developed to meet the needs for early detection of disease (screening) among asymptomatic older persons despite widely available international evidence on cost-effectiveness of certain screening activities. While Ministry of Finance Circular 21 (2011) does stipulate that local budgets should be used for this, the provincial health departments may be unaware of this policy and it has not been widely implemented. Lack of guidance on content of checkups and on budgeting norms may also hinder widespread implementation.
- There is a lack of technical guidelines on disease screening for older persons and disease management, and rehabilitation at the commune level in accordance with the pattern of disease of older persons.

**Geriatric medical examination and treatment**
- There is a lack of legal documents on functions and duties of the geriatric department in hospitals, causing difficulties for health facilities to organize and run a geriatric department that meets the needs of older persons. Specifically, older patients often stay in the specialist departments appropriate for their main disease rather than a geriatric department. There is a need to have staff of the geriatric department assigned to manage and coordinate care for every older patient regardless of department to avoid drug interactions and ensure the discharge plan includes rehabilitation and/or home-based and community-based care.
- There is a lack of regulations on downward referral of patients from hospitals to CHSs for continued treatment of patients with chronic diseases who have achieved a stable treatment regime at a higher-level facility, and who can be safely monitored and given medications at the CHS based on the prescription given by higher levels.
Other health services for older persons

- Home-based medical care is an essential need of older persons with serious illnesses, disabilities, or impaired mobility. Up to now the Law on Medical Examination and Treatment provides inadequate regulatory guidance for this type of service, currently only permitting home health services to basically implement simple doctor orders, or home-based care to be provided by family doctors, yet failing to provide a concrete list of approved scope of service that meets needs of older patients.

- Community-based rehabilitation has neglected people who became disabled due to old age, or older patients requiring rehabilitation after surgery, hospitalization, stroke, or onset of dementia (Alzheimer’s). There is a need for physical and occupational therapy to assist them to cope with disabilities and regain the ability to independently perform ADLs.

- The delivery of palliative care and end-of-life care for older persons with advanced chronic diseases is very limited, currently palliative care is mostly provided for patients with terminal cancer. There are still many older patients unnecessarily suffering from pain because health service providers or physicians are reluctant to prescribe adequate opioid pain relief due to lack of understanding of regulations on management of these addictive substances and protocols for pain relief at end of life.

Inputs into health care for older persons

Personnel to provide healthcare for older persons

- There is a lack of legal documents stipulating required competencies for health workers working with older persons (general doctors, family doctors, doctors in specialist departments with a high share of elderly patients such as internal medicine, cardiology, rheumatology, endocrinology, and psychiatry). A competency list is required to revise the training curricula of pre-service, postgraduate and CME training programs on care of older patients.

- The existing training curricula for general doctors, family doctors and nurses has not fully integrated competencies needed to provide medical care for older persons.

- The MOET has not yet assigned a level IV code for geriatric medicine in the list of postgraduate training programs of the national education system, although three schools are training level-II specialist doctors and one is training level-I specialist doctors, masters and doctorates in geriatrics.

- There is no National Geriatric Medicine Association to facilitate exchange of experience among professionals charged with health care for older patients, and to allow for greater sharing of knowledge to contribute more actively to development of up-to-date treatment guidelines, technical training and policy formulation.

- There are no incentives to motivate health workers to spend time counselling patients on disease prevention, medical interventions, risk factors and side effects during treatment as part of the basic package of healthcare, medical examination and treatment for older persons.

- Community-based rehabilitation guidelines, capacity and skills are not suitable with the rehabilitation needs for older persons, especially rehabilitation after hospitalization or surgery and rehabilitation to recover the ability to perform ADLs independently.

- Health personnel lack training and skills to advise on options such as continuation of treatment or shift to palliative care when older persons suffer from incurable diseases or can no longer tolerate treatment due to frailty. Very few health workers are trained adequately in pain management.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

**Health financing for healthcare for older persons**

- No sustainable and feasible financial solution has been found to ensure routine health checkups for the entire older population. Health insurance is not a solution because the Health Insurance Law does not include screening services and routine health checkups in the service package to be covered by health insurance. The Ministry of Finance has not been provided with a geriatric health checkup package that is backed up by cost-effectiveness evidence to be able to consider allocation of state budget for this purpose.

- Health insurance does not cover hearing aids and prescription glasses so the poor older persons have great difficulty in accessing such services to increase their functional ability to perform ADLs.

- Many older persons do not understand the health insurance benefits to which they are entitled. There is still a large proportion of older persons aged 80 years and older not covered by health insurance, although according to law, they are entitled to full subsidy of premiums.

- CHSs have very limited budget, low salaries and salary supplements which do not encourage them to effectively and actively manage health of older persons.

**Pharmaceutical management**

- Pharmaceutical management (i.e. procurement, guarantee of availability, prescription, medication information for older persons, etc.) has not paid attention to the special needs of older persons, who often have comorbidities and are at risk of taking medication incorrectly, or being prescribed drugs with interactions, or experiencing ADRs due to prolonged use or frailty (e.g. weakened liver, kidney).

- According to regulations, drugs can be prescribed for a maximum of 30 days. Regulations on health insurance inspection in some localities only allow patients to receive medicines every 2 weeks. Consequently, for older persons with mobility difficulties, the management of their disease is likely to be interrupted and the effectiveness of their treatment reduced.

**1.3. Priorities in long-term care for older persons**

**State management of long-term care for older persons**

- Some documents related to social assistance still do not consider the needs of older persons who are vulnerable and in need of special attention. One of the objectives of the Target Program on Social Assistance System Development for the period 2016 - 2020 is to develop and improve the quality of social assistance services for vulnerable groups towards international integration, however this Program does not refer to older persons as a beneficiary group (Decision No. 565/QD-TTg in 2017). Policies on disability assessment do not specify the characteristics of disabilities due to aging. Health insurance does not take into account the need for home-based medical care for disabled older persons with physical difficulty accessing health care facilities.

- Intersectoral collaboration in the development and implementation of policies on long-term care for older persons remains weak and unsystematic. MOLISA is responsible for state management of social protection establishments and the profession of personal care worker for older persons, while MOH is responsible for granting operating licenses for medical facilities and practice certificates for health workers. Long-term care for older persons requires both social care and medical care at older persons’ home or at...
residential care settings such as social protection centers. There is currently a lack of inter-ministerial documents to harmonize standards, scope of activities and collaboration between personal caregivers and health care workers, and mechanisms for monitoring home-based (community-based) care services. The Vietnam National Action Program for the Elderly has an activity “to standardize care settings for older persons”, however the implementation responsibility has not been assigned to any state agency.

- Ministry of Planning and Investment regulations on conditions for business registration have not yet added the condition of a license required to provide care services to older persons as stipulated in legal documents under the Law on the Elderly. Many care settings which provide residential care for older persons have completed business registration and begun operations, but do not have a license for provision of care services for older persons.

- The number of older persons entitled to social assistance and social work services is very small compared to actual need in society. Social work services such as interventions in case of violence or counseling on and search for necessary services when older persons have declines in functional capacity and are cared for at home are currently only provided for social protection beneficiaries (i.e. older persons who are poor and have no close family members to take care of them). Many older persons have reduced intrinsic capacity so they are unable to take care of themselves, but regulations on assessment of the degree of disability were designed primarily to serve assessment of disability payments for workers with decreased/lost work ability instead of older persons whose degree of disability should be determined in order to receive necessary social assistance. Older persons with severely disabilities and in need of assistance to perform ADLs are not entitled to a higher rate of social assistance to be able to hire caregivers or compensate for the loss of income of family caregivers who must leave work to care for them.

- Legal obligations of family members to care for older persons have not considered actual difficulties faced by middle-income and low-income families, or families having members employed during fixed administrative working hours. Failure to perform the obligations to care for older persons is considered an administrative violation and is subject to penalties. However, this violation is mainly due to the lack of economic conditions or limited available time of family members to spend on this duty, or the needs of older persons with very severe disabilities exceeding family members’ ability to respond. Support to families to fulfil their obligation is currently available only in localities where volunteers (such as from ISHC) are involved in care of older persons.

### Care models

**Home-based (community-based) care**

- **Families have the legal** obligation to care for older members, but in some cases the care needs of older persons exceed the family’s ability. Social workers only have the function of assessing needs and making assistance plans for older persons who are social protection beneficiaries, not for other subjects such as non-poor older persons without family members obligated to care for them, or poor older persons with non-poor family members, who are nevertheless facing economic difficulties. In such cases, ISHCs can provide support (e.g. help with cooking, buying foods, etc.), but this model has not been scaled up nationwide due to the lack of funding and human resources.

- For older persons with disabilities or severe diseases, in addition to assistance with ADLs, they often also require daily medical care. At present, the scope of home-based healthcare services is very narrow, service providers are allowed to implement physicians’ orders
only, not to provide IV drips or prescribe medications if needed. If older persons need medical examination/treatment, blood sample collection, changing of wound dressings, medications, they have to use services provided by a family doctor clinic. Currently many localities in Vietnam have no family doctor clinics. There are no regulations allowing the provision of home-based family doctor services without the physical existence of a family doctor clinic.

- There is a lack of legal documents for an institutional day care model for older persons. Many older persons are still able to take care of themselves and just need support in certain aspects, or are suffering from mild dementia thus should not be left home alone (e.g. people with Alzheimer’s disease). However, the community-based institutional day care model has not been developed to support families to accomplish their care-giving obligations while still engaging in economic activities to generate income for the family.

- Contracts or commitments on provision of care services for older persons are not standardized so it is difficult to protect older persons’ interests. Legal documents do provide for contracts, but do not specify care services to be provided by voluntary primary caregivers for older persons in the community, volunteers or paid home-based caregivers.

_Institutional (residential) care_

- Although there is a new regulation allowing private social protection centers to register as social enterprises and to receive preferential treatment in land allocation, taxes and loans, the policy has not yet been widely applied. Many owners of social protection centers are not aware that they can register as social enterprises. There is no mechanism for monitoring the implementation of the commitment to achieving the social goal relating to care of older persons.

- The standards of care at social protection centers currently focus mainly on infrastructure but not on processes of caring, ensuring safety, respecting and effectively meeting the needs of older persons, which can be applied at home and at social protection centers. There are no regulations on healthcare packages for older persons at social protection centers, where many of the residents have severe functional impairments and high needs for medical care.

- There is no legal basis for “Center for long-term health care service for older persons” mentioned in the Healthcare for Older Persons Project. Hospitals do not have the function of providing long-term care while social protection centers do not have the function of providing medical services.

_Human resources for long-term care_

- Family members with the obligations to care for older persons often lack necessary knowledge and skills. The main caregivers of older persons are their family members who assist with ADLs and sometimes medical care. However, they are often not trained so they lack knowledge and care skills. There is a lack of quality assurance mechanism and no electronic library which can provide video clips, lectures and materials to guide family caregivers on how to care for older persons.

- Competency requirements for caregivers of older persons have not been clearly defined to develop training materials. Caregivers of older persons are required to have experience (Decree No. 136/2013/ND-CP) or skills (Decree No. 06/2011/ND-CP) in caring for older persons, but the lack of specific competencies makes it difficult to develop training programs for different personnel involved in care of older persons. There is also a lack of ethical standards of personal care workers.
There is a lack of legal basis on volunteer or paid caregivers of older persons. Although some community-based care models are based on volunteers or paid caregivers, there are no standardized training programs that equip such volunteers or paid caregivers with necessary knowledge and skills to perform their tasks. The scope of work of volunteer and paid caregivers is not specified, nor is the form of service provision contract/commitment to protect the interests of older persons being cared for as well as of caregivers. There are no regulations on responsibilities and mechanisms for monitoring the quality of home-based care (safety, hygiene, health management, etc.) provided for older persons.

**Long-term care financing**

- **The regulation defining older persons entitled to social protection is not based on actual needs.** All older persons 80 years old and older not receiving retirement pension or other social assistance payments are entitled to social assistance, but at a very low rate, regardless of whether they come from rich or poor families. There are also other vulnerable groups that are not financially supported, for example older persons with severe disabilities (i.e. who are able to take care of themselves if assisted by another person, older persons who do not come from poor households but have no close family members to care for them while their income is not enough to hire caregivers.

- **In case older persons have severe disabilities (e.g. bedridden) or suffer from diseases that require continuous care (e.g. Alzheimer’s disease), care needs are likely to exceed the ability of the family to meet them.** The fulfillment of family’s care-taking obligations through hiring a caregiver or leaving work to stay at home and care for older persons can cause financial burdens to the family lead to poverty. There are no insurance policies applicable to long-term care at home or at social protection centers.

- Health insurance does not cover services needed by older persons such as medical care and rehabilitation at home or in nursing homes because there are no mechanisms to control the abuse of these services.

- **Remuneration for caregivers with elementary qualifications such as volunteers or VHWs** is insufficient to ensure their income in case they spend adequate time to provide day-to-day care for older persons with severe disabilities or in need of medical services to manage their chronic diseases in the community.

- There is a lack of funding to expand the ISHC model nationwide, although this model meets many of the long-term care needs of older persons at low cost.

- Sickness benefits do not allow sick leave in case workers have to care for sick older persons, it is because there is a lack of budget in the social insurance fund and it is difficult to control the abuse of this policy (if allowed).

**1.4. Priorities for developing an environment conducive to healthy aging**

- Knowledge and practice of older persons in the areas of nutrition/diet, rest, and physical exercise aimed at disease prevention and control and health promotion remain limited. Access to information remains somewhat limited. The contents and method of communication are not yet appropriate for different age groups or health status of older persons.

- Most older persons have housing and are given priority in the use of public transport. However, the physical conditions and the design, arrangement, comfort of the house, the design of infrastructure, means of transport and transport equipment have not really met the needs of older persons, Ensure the convenience and safety of older persons in daily activities and when participating in traffic, travel.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

- Older persons have difficulty in traveling to seek health care, while care for NCDs usually requires the use of services in district hospitals and above, however, transport of patients from clinics to the hospital is generally only covered for severe illness.

- Poor income security for older persons leads to low living standards and pressure to continue economic activity. The mental health of older persons is influenced by financial concerns, especially in terms of health care costs, and the financial burden of children. Older person households are at increased risk of catastrophic spending and poverty due to higher medical expenses, especially for people with serious diseases such as cancer, cerebrovascular disease, or need for heart surgery or hemodialysis.

- Source of information and access to information on health care of older persons and families with older persons is still limited. Older persons and their family members need to be provided with information on the prevention of NCDs, self-care and support for care of older persons. There are no programs to guide rest, physical training and sport activities associated with prevention and improvement of health, suitable for each age and health status of older persons.

- Isolation, intergenerational tensions between families, such as conflicts with children, daughters-in-law, sons-in-law, or disorientation, also negatively impact mental health of older persons. Meanwhile, the practice of sending older persons to live in nursing homes for social care has not been widely adopted.

- There are policies to encourage older persons to work, contribute to the family and society. However, there is still a lack of specific mechanisms and solutions that will enable older persons to participate in social inclusion and adaptation activities in line with the capacities and circumstances of each group.

- ISHCs have been incorporated into the Vietnam National Action Program for the Elderly 2012 - 2020 and the Prime Minister has approved the project to scale up the model, but has not invested adequate state budget for these purposes.

2. Recommendations for health and related sector response to achieve healthy aging

2.1. Orientation for general solutions to respond to health problems associated with population aging

Policy solutions for rapid population aging

- Communicate and raise awareness of the entire society - especially of leaders and managers of ministries, sectoral agencies and local authorities - about the needs of older persons and caregivers for older persons for successfully responding to healthy aging in Vietnam. Take population aging into account while developing annual local socio-economic development strategies, plans and policies.

- For older persons with ability and need to work: find a solution for older persons to continue to work which is suitable for their health and ability, helps increase income and avoids loneliness.

- Although many older persons still contribute to the national economy, earn a living, receive a retirement pension, or receive family support, there are also older persons who need medical care or long-term care that exceeds their financial ability to pay and older persons without family to support them. These groups should receive special
attention through provision of higher monthly assistance payments and free social work services, etc.

Solutions to ensure healthy lifestyle

- Create models for meeting chronic disease management of older persons in the community; ensure continuity of care with models that are appropriate for different environments.
- Increase awareness and knowledge of older persons and families about how to maintain and improve health of older persons. Facilitate health promotion through exercise, diet, smoking cessation or other public health interventions aimed at older persons.
- Increase efforts for occupational and physical therapy or other interventions (e.g. surgery for cataracts) to increase physical functioning and maintaining independence for older persons as their health deteriorates or after they face health problems such as hospitalization or injury after falling.
- Ensure that caregivers, social workers and health workers are adequately trained and supervised to deal with the specific needs of older persons.

2.2. Recommended response to priorities related to health care and provision of health services for healthy aging

Recommendations for state management

- MOH should continue to direct and examine the implementation of Circular No. 35/2011/TT-BYT on health care for older persons and prioritize medical examination and treatment for older persons in health facilities; implement the Healthcare for the Elderly Project 2017 - 2025 and the Strengthening the Grassroots Healthcare Network Project.
- MOH should strengthen its capacity of coordinating units responsible for health care for older persons at the central level, inside and outside of the health sector; consider the establishment of local steering committees for health care for older persons with the support and supervision of the MOH, geriatrics specialized organizations and VAE.
- Set up a system to record and report on health care for older persons; to strengthen the system of routine and ad-hoc (internal and external) monitoring, supervision and evaluation of the performance of health care for older persons at all levels; carry out periodic surveys on older persons to monitor and supervise the implementation of activities and output indicators in healthcare and other areas.

Recommendations for health service delivery

Health IEC

- Enhance the roles of the General Department of Preventive medicine in coordinating health IEC activities relating to NCD prevention and in developing integrated guidelines on cost-effective NCD screening.
- Strengthen IEC on health care for older persons through appropriate channels (e.g. direct counseling by health workers or club activities) with contents suitable with the needs for disease prevention, health promotion for older persons, early detection of diseases, and palliative care; provide older people information about health facilities capable of examining, treating or managing their diseases; promote collaboration among the health providers.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

Periodic health checkup, management of diseases and the health of older persons

- Unify guidance on establishment of health monitoring/management records for older persons at the grassroots level.

- Develop an essential health checkup package for older persons that meets the needs for health checkup for millions of older persons at CHSs annually within the limited local budget funding available to detect common risk factors in older persons, which can be managed, treated and rehabilitated to improve quality of life. Balance the need for geriatric services with the cost containment need of VSS and Ministry of Finance. Implement pilot models to assess the impact of early detection and management of diseases that can be managed effectively at the grassroots level, for example we can take the model of the UK health checkup package mentioned in Box 2 above as the foundation for a pilot health checkup package in Vietnam.

- After the development of an essential health checkup package for older persons to be piloted, we can consider expanding or narrowing down that package based on the criteria recommended by WHO for selecting screening options (Box 1). Contents of the package may be changed over time when funding is added, or when risks increase. We can even develop more comprehensive packages for the wealthy elderly who are willing to pay for less cost-effective services.

- District health workers need to collaborate with CHSs in directing activities, participate in routine health checkup, follow up elderly patients whose diseases have been detected and need further diagnosis or treatment.

- It is necessary to inform older persons and their families through various channels so that older persons know their right to routine health checkup and are informed promptly when routine health checkups are organized in the locality.

- Develop a health monitoring record for older persons in accordance with morbidity patterns of older persons in Vietnam, including contents of health IEC and sections/space to record information about the routine health checkup package. This record can help increase the continuity of information sharing and record when older persons use health services in different places. We should consider the revision of the template for the record for health management and monitoring of older persons in the template for individual health management profile in service of PHC issued by MOH Decision No. 831/QD-BYT 2017 if necessary. The Mother and Child Healthcare Book developed by the Department of Maternal and Child Health with the support of JICA is another model that combines information about medical examination and IEC information suitable for the target group.

Geriatric medical examination and treatment

- Strengthen functions of CHSs in medical examination and management of chronic diseases; to improve their ability to provide health care for older persons, health IEC, health management for older persons and implementation of health monitoring record.

- Medical Services Administration should develop documents defining the functions and tasks of the geriatric department or geriatric professionals at various types of health facilities in line with the needs, capacities and health care for older persons models in Vietnam in order to clarify the roles of the geriatric department in providing...
comprehensive health care for older persons. The geriatric department is a unit in a hospital, responsible for collaborating with other units in performing its functions. The geriatric department works with other departments to provide counseling, receive elderly patients after the acute phase for continued treatment at the geriatric department, and consult with other specialists during the treatment of patients in their department. Guidance should be given on the establishment of the geriatric department in hospitals with 50 beds or more (excluding pediatric hospitals)

- Develop regulations and criteria for referral of patients from hospitals to CHSs for management of chronic diseases or disabilities after inpatient treatment episodes, or after the higher levels have developed treatment protocols suitable with the needs of elderly patients in need of NCD management and community-based rehabilitation of disabilities.

- For older persons with specific diseases and disabilities who are detected through screening or symptoms, medical examination should be delivered in accordance with specific needs of such diseases. Examination of other diseases for asymptomatic individuals will probably lead to false-positive results and unnecessary medical intervention.

- Develop the National Geriatric Hospital according to the existing project approved by the MOH; invest in geriatrics research, including clinical geriatrics and social geriatrics, etc.; consider the establishment and development of geriatric hospitals representing the Center and the South of the country. Such new geriatric hospitals will serve patients, direct geriatric activities, provide continuous training and participate in research.

**Other health services particular to needs of older persons**

- MOH should develop legal document to support and facilitate the development of home-based health care for older persons.

- Supplement community-based rehabilitation guidelines and create favorable conditions (i.e. equipment) suitable for the rehabilitation needs of older people at the CHS or at home.

- Develop appropriate guidelines on palliative care for older persons in the community with contents to serve older persons, their caregivers and family members.

- Ensure older persons suffering from pain have access to necessary pain relief, including during palliative care at home.

**Recommendations on inputs to health service delivery**

**Health financing**

- Overcome obstacles to the goal of universal health insurance coverage for people aged 80 years and older; consider expanding the health insurance subsidy policy, and encourage family members and social organizations to buy health insurance for people aged 60 - 79 without health insurance.

- Work out financial solutions for health insurance, the state budget or other sources to allocate funding to routine health checkups for older persons. In order to determine a health checkup package, its cost effectiveness should be taken into account because of limited resources as explained above.

- Consider a financing mechanism for services to treat some disabilities in older persons such as eye operation, provision of prescription glasses or hearing aids for poor older persons to increase access to these services.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

- It is necessary to reconsider incentives and accountability in the delivery of healthcare to older persons at the commune level in order to motivate commune health workers and VHWs to be more active in managing and caring for health of older persons.

**Human resources**

- Develop geriatric competencies as the basis for modifying the training of general doctors, specialists with a high share of older persons in their patient load and nurses caring for elderly patients. We can consider the competencies mentioned at: https://www.pogoe.org/geriatrics-competencies.

- Review, update, revise and amend undergraduate, junior college and secondary training curricula in the health sciences towards meeting health care needs of older persons according to geriatric care competency standards, from both the medical and psychosocial aspects for all health care workers who work with older persons.

- Enhance the contingent of geriatric specialists in localities through postgraduate training in geriatrics and supplementation of geriatric contents to the training of general physicians, internal medicine physicians, cardiologists and physicians of other specialties with a high proportion of elderly patients. It is recommended that MOET grant a code for geriatrics in the list of postgraduate training programs of the national education system.

- Continue to provide continuous training in geriatrics for health workers involved in medical care for older persons; place emphasis on contents of health counselling for older persons so that they can take care of themselves, improve their health and provide advice on end-of-life palliative care; strengthen the capacity of the National Geriatric Hospital, central and provincial hospitals, medical universities and other relevant agencies to deliver continuous training to health worker in health care for older persons, prevention and treatment of NCDs.

- Carry out procedures to establish the Vietnam Geriatrics Society and a Geriatric Association in the North; strengthen the role of geriatrics associations in the development of technical guidelines on preventive medicine, health promotion, diagnosis and treatment, health care, rehabilitation and palliative treatment in geriatrics; consider granting the certificate of eligibility to provide CME on geriatrics to HCMC Geriatrics Association.

- Develop the contingent of professionals involved in health care for older persons including doctors, nurses, rehabilitation technicians, social workers and caregivers (personal hygiene, dressing, feeding, etc.) in hospitals; formulate teamwork regulations and link with all departments with elderly patients in the entire hospital.

**Pharmaceutical management**

- Review the list of drugs covered by health insurance in relation to the special needs of older persons. Add specific prescription guidance to meet the particular pharmaceutical needs of older persons.

- Effectively communicate messages to older persons and their family so they understand that the medications prescribed and dispensed by the grassroots level have the same effects as those prescribed by higher levels so that they have trust in these medications, comply with their prescriptions, and do not bypass to higher levels, which helps reduce the overcrowding at higher levels.
• Consider the revision of regulations on drug prescription (Circular No. 05/2016/TT-BYT) and regulations on health insurance inspection of drugs for long-term and chronic disease treatment; balance the need for disease surveillance and funding against the need for older persons to access drugs to manage their chronic diseases.

2.3 Recommendations to respond to priorities in long-term care for older persons

Recommendations for state management

• Strengthen the roles of VNCA, VAE and the Social Protection Department (MOLISA) in developing, evaluating and revising policies related to older persons such as healthcare, health insurance, social work, care of people with disabilities, social assistance, human resources and facilities to care for older persons to make sure that special needs of older persons are taken into account.

• Develop a research program to accumulate evidence to support the development of appropriate policies on long-term care for older persons. Content of research includes care needs (medical and social care), capacity of family and community to respond to needs, current support from the state/local governments/charities; evaluate the healthcare needs of older persons at home and at social protection centers to adjust the scope of home-based healthcare services, home-based family doctor services and healthcare services at social protection centers (including public, charitable and private centers).

• Based on results of the research on the needs and families’ response capacity, review the definition of social protection beneficiaries towards expanding the beneficiaries of social assistance and care allowance due to their care needs exceeding the ability of family members with care-giving obligations, especially in case the older person has severe disabilities; review the process of assessing the degree of disability of older persons to ensure the interests of older persons with high social and medical care needs are satisfied.

• Develop a collaboration mechanism in developing and implementing policies related to care of older persons; ensure that MOLISA and MOH have common understanding and clear division of implementation responsibilities, especially in the management of human resources and care settings for older persons, meeting the needs for health care, disease management, rehabilitation and support for ADLs.

• Revise regulations on conditional business registration, ensuring consistency with provisions of the Law on the Elderly and sub-legal documents, especially in relation to the licensing of provision of care for older persons. Review and study regulations on organizing and providing health care services for older persons in long-term care facilities.

Recommendations on long-term care service provision

Community-based long-term care services

• Expand the group of older persons entitled to social work services covered by the state budget. In addition to older persons being social protection beneficiaries, there are other groups of older persons that need counseling and support to access assistance services or intervene in case of abuse or neglect. The group of beneficiaries should be expanded to: (i) older persons with social and medical care needs but those needs are not met by the persons with care obligation; (ii) older persons who are non-poor and have no close family members to care for them, with care needs exceeding their self-care ability and economic conditions to hire a personal care worker; (iii) older persons who are not social protection beneficiaries but who are suffering from abuse.
Chapter VIII. Priority issues and recommendations for solutions towards healthy aging in Vietnam

- Develop national standards of care and a clear monitoring system to strengthen the monitoring of care quality, quality of life and rights of older persons in community-based care models, suitable for Vietnam and accepted by the parties concerned.

- Mobilize social contributions to quickly expand the model of ISHCs to localities where no support is provided for long-term care for older persons; mobilize the participation of religious organizations, associations and charities in the development of community-based care models for older persons, support families with older persons having large needs for medical and social care; expand the operational scope of social protection centers to serve both older persons living in the centers and those living with the family in need of day care, short-term care, or support to ADLs (e.g. cooking, visiting doctors) and provide psychosocial care; strengthen communication so that the whole society understand better the care needs of older persons; encourage creativity in designing activities to support community-based long-term care.

- Study international experience in state management of home-based medical care services in order to revise policies and better meet the healthcare needs of older persons with disabilities and/or severe diseases who have difficulties in accessing health facilities; revise existing policies on the scope of healthcare license, health insurance payment for home-based services, and quality control of home-based healthcare services.

- Study international and domestic experience in day care services for older persons, develop and pilot models suitable for Vietnam, both in urban and rural areas; develop legal documents on care standards, financial regimes, quality control, etc. so that the day care model for older persons can be developed in Vietnam.

- Study international experience and relevant laws of Vietnam to develop standard contracts/commitments on provision of care services for older persons to ensure the rights of older persons in relation with volunteer and paid caregivers.

- Study policies on support to families of older persons who are poor or near poor, where the care of older persons affects employment and income earning.

Institutional (residential) care services

- **Disseminate the policies on registration of business as social enterprise and tax, land and loan incentives for investors who want to set up private social protection centers;** create a mechanism for monitoring activities of social enterprises working in the field of care of older persons to avoid the abuse of policies and protect the interests of older persons cared for in social protection centers; study the possibility to add care service for older persons with reduced functional capacity to the list of public services issued by Decree No. 130/2013/ND-CP because this service can be considered essential to socio-economic life, the provision of this service under the market mechanism is difficult as its full costs may not be recovered, this service can be provided in the following method: competent agencies or organizations order the service and organize tender following the price/fee as stipulated by the State. The advantage of this method is that subsidy is provided by the state for older persons who need the service but do not have enough resources to afford it.

- **Clarify the concept of “long-term healthcare center for older persons” in the Healthcare for the Elderly Project.** Before developing new models, consider alternative healthcare activities for older persons suitable with public, charitable and private social protection centers which care for older persons, so that these centers can provide both social care and medical care according to the actual needs of older persons with seriously decreased functional capacity living in social protection centers.
- Modify the standards of care at social protection centers to supplement standards related to care processes, safety, respect for human dignity, etc.; add standards related to healthcare services provided for older persons living in social protection centers. For facilities lacking conditions to provide medical services, specify contents of the service outsourcing contract to meet appropriate health care standards. For facilities able to provide medical services, the scope of services, conditions for service provision and eligibility for service provision licensing should be detailed.

- Collaborate with MOLISA and the Ministry of Defense to review organization, consolidation, strengthening of health care capacity of Centers that care for people who have contributed to the revolution following the model of military-civilian medical facilities to gradually participate in long-term care of older persons aimed at strengthening effectiveness of investments in the context of a declining number of war invalids and people who participated in the revolution.

**Recommendations on human resources**

- Develop competency standards for caregivers of older persons including family members, volunteers and professional care workers. The competency standards must cover both social care and medical care and must be developed for elementary, secondary and junior college training levels.

- VAE to collaborate with the health sector to collect or develop new printed materials and video clips to guide non-professionals on how to perform standardized care skills so that they can accumulate enough skills to care for older persons as required; control contents and disseminate these materials on the VAE website, through activities of mass organizations, ISHCs, self-help clubs of older persons, and mass media.

- Develop framework curricula for training of professional caregivers for older persons at elementary, secondary and junior college levels on the basis of the needs of social protection centers and paid home-based care service providers; organize examinations and certify people who want to become professional caregivers of older persons; consider the granting of certificates to volunteers and family caregivers upon completion of the training on care of older persons.

- Promote greater involvement of the health sector (CHSs, VHWs) in enhancing the capacity of family members and volunteers to care for older persons; in providing health counseling activities under the scope of the GOPFP health counseling and care model and in ISHCs; and in linking club activities to family doctors in localities where they exist.

- Supplement the roles/functions of VHWs with care of older persons in the community; provide VHWs with training in knowledge and skills relating to care of older persons.

**Recommendations on financing of long-term care**

- Consider the revision of the policy on provision of social assistance. It is proposed that social assistance should be provided based on the severity level of disabilities of people 60 years and older instead of providing it for all older persons 80 years and older. In order to implement this policy, it is necessary to renew the policy on assessment of disabilities in older persons as mentioned in the recommendation relating to state management.

- Consider the introduction of long-term care insurance in Vietnam in reference to long-term care insurance development experience of other countries like Korea. Insurance agencies can mobilize contributions from people who are not old and pay an amount based on the number of service days used by long-term care insurance participants with severe illnesses.
(certified by physicians), severe disabilities and very severe disabilities (assessed according to current regulations). The payments made by insurance agencies will be used by older persons’ families to cover the costs of residential care or home-based care.

- Consider the revision of the health service package to be covered by health insurance for older persons with difficulties in accessing health facilities for medical examination, treatment and rehabilitation. The revision should expand the scope of services provided at home or at social protection centers to be covered by health insurance, including measures to control over provision of services.

- In order to encourage volunteers and VHWs to improve their skills to care for older persons, it is necessary to develop a list of care services for older persons that are suitable for different levels of education, provide training for volunteers and VHWs to increase their capacity in meeting the needs for listed services, develop an appropriate financing mechanism to motivate caregivers of older persons and in line with the affordability of both wealthy families and disadvantaged families in the community.

- Mobilize funding to expand the ISHC model nationwide from different financial resources following Prime Ministerial Decision No. 1533/QD-TTG in 2016. Funds to scale up the model include initial investments to set up and stabilize activities of ISHCs such as funds for initial training (3 days per session), equipment and basic materials to start out. A recurrent budget is needed for refresher training, review meetings of the ISHC management and home caregiver volunteers, technical support and regular supervision by the VAE. Currently the MOF has provided a total of 700 million VND per year to the VAE (approximately 70 000 VND per older person). Sustainability of the ISHCs depends on the income augmentation fund, yet this lacks initial capital. Recommend mobilization of financial resources from the following sources: State budget (central and local); mechanism for the VAE to mobilize resources for scaling up the model (for example, Fund for Care and Promotion of Older Persons); prioritize mobilization of financial resources from contributions and other support (international organizations, enterprises, individuals).

- Consider the revision of VSS sick leave policy to cover the period which workers have to take leave to care for older persons if the number of leave days taken exceeds the number of allowed leave days during the year.

- Develop financing mechanisms for long-term care: integrate long-term care into the universal health care program, facilitate CHSs to not only provide facility-based health services but also send health workers to older persons’ home and care for them (it is necessary to determine eligibility criteria for entitlement to this policy, and care services to be provided), ensure policy implementation, cover nursing services by health insurance, provide treatment at registered care centers, add some rehabilitation techniques to the list of insured health services, develop insurance packages with long-term care services (including home-based care).

2.4. Recommendations for resolving priorities in development of an elderly-friendly environment.

- In addition to education and training to raise general knowledge, there is a need to strengthen counselling, and health education for older persons. Messages need to be designed specifically for the audience of older persons, and focused on healthy diet, reasonable rest and relaxation and physical fitness appropriate with different age groups, health statuses, and diseases among older persons.
- Propose concrete solutions to facilitate older people still able to work and desiring to work to continue participating in the workforce and participating in social activities, especially older people with high level qualifications.

- Consider expanding the groups of older persons entitled to social assistance payments and health insurance to people aged 75 and older who do not have stable income; mobilize older people with financial means to enroll in health insurance; study forms of support for health care of older persons such as support for transport to seek health care.

- Issue requirements and guidelines for standards to design and arrange amenities in dwellings appropriate for older people to ensure they are kept warm and safe, particularly paying attention to prevention of falls. Pay attention to the needs of older persons in designing and building public infrastructure, such as high rise buildings and public transportation.

- Combine effective communication with administrative measures to ensure development and maintenance of a harmonious environment in the family and community where older persons reside. Promote advising to family members on how to harmonize relations with older persons; guide families of older persons in knowledge and basic skills to provide health care for older persons and encourage and support their participation in health care of older persons in the family and community.

- The state should invest even more budget into scaling up ISHCs in order to implement the targets of the Vietnam National Action Program for the Elderly and the Project to scale up ISHCs according to Decision 1533/QD-TTg aimed at ensuring 8 areas of activities and quality of the model as initially designed, because this model contributes to creating a good social environment for older persons. It ensures their care but also promotes the role of older persons in the community. If the initial investment is effective, the ISHCs can be comprehensive and sustainable to help improve the physical and mental health of older persons in the long term.
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## APPENDIX. MONITORING AND EVALUATION INDICATORS, 2011-2015, TARGET TO 2020

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<tr>
<th>Monitoring indicator</th>
<th>Unit</th>
<th>Disaggregation</th>
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<th>Goal type</th>
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### Joint Annual Health Review 2016

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## Appendix: JAHR monitoring and evaluation indicators

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<td>Proportion of need for common medical equipment in medical facilities met by domestic production</td>
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<td>Pharmaceuticals, vaccines, blood products</td>
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<td>Number of retail drug outlets per 10 000 people</td>
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<td>Domestically produced share of value of drugs used</td>
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<td>Service delivery</td>
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<td>Implement universal health coverage</td>
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<td>Proportion of children under age 1 who are fully immunized (8 vaccines)</td>
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<td>Proportion of people living with HIV receiving ARV among those meeting eligibility criteria for treatment</td>
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<td>2012: 59.9</td>
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<td>Outpatient cases per 10 000 people</td>
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<td>2011: 1,374</td>
<td>2012: 1,485</td>
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<td>2011: 35.5</td>
<td>2012: 35.4</td>
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<td>Near poor</td>
<td>2011: 38.3</td>
<td>2012: 37.9</td>
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<td>Average</td>
<td>2011: 39.5</td>
<td>2012: 36.2</td>
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<td>Above average</td>
<td>2011: 39.6</td>
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<td>Proportion of patients using inpatient or outpatient services covered by insurance or exemptions</td>
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<td>2011: 72.1</td>
<td>2012: 77.3</td>
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<td>2012: 83.5</td>
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<td>2011: 67.7</td>
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<td>2011: 66.6</td>
<td>2012: 72.2</td>
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<td>Above average</td>
<td>2011: 69.4</td>
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<td>2012: 81.4</td>
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<td></td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
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<td>Proportion of households facing catastrophic health spending (out-of-pocket spending exceeds 40% of ability to pay)</td>
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<td>Prevent epidemics, infectious disease</td>
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<td>HIV/AIDS prevalence</td>
<td>Per 100 000 people</td>
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<td>Malaria incidence rate</td>
<td>Per 100 000 people</td>
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<td>51.90</td>
<td>49.25</td>
<td>39.47</td>
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<tr>
<td>Mother-to-child HIV transmission rate</td>
<td>%</td>
<td>&lt; 3%</td>
<td>2.96%</td>
<td>2</td>
<td>GARPR</td>
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<td>Proportion of people aged 15-49 years of age with comprehensive knowledge of HIV/AIDS</td>
<td>%</td>
<td>Female</td>
<td>45.1</td>
<td>43.4</td>
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<td>Reported number of people requiring intervention against NTDs (soil-transmitted helminths)</td>
<td>1000 people</td>
<td>National</td>
<td>8608</td>
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<td>Control health risk factors</td>
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<td>Proportion of households using improved toilets*68</td>
<td>%</td>
<td>National</td>
<td>77.4</td>
<td>83.4</td>
<td>78*</td>
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<td>Urban</td>
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<td>95.1</td>
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*68 Improved sanitation includes flush, semi-flush, double pit compost latrine, suilabh toilet, but excludes defecation into water bodies or other unspecified types.
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<td>Proportion of population using improved drinking water sources</td>
<td>%</td>
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<td>2011: 98</td>
<td>SDG 6.1</td>
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<td>Mortality rate attributed to exposure to unsafe WASH services</td>
<td>Per 100 000 people</td>
<td>National</td>
<td>2011: 2.0</td>
<td>SDG</td>
<td>UN SDG monitoring</td>
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<tr>
<td>Proportion of health facilities treating solid waste according to regulations</td>
<td>%</td>
<td>National</td>
<td>2011: 100</td>
<td>5YHSP</td>
<td>MOH</td>
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<tr>
<td>Proportion of population with primary reliance on clean fuels</td>
<td>%</td>
<td>National</td>
<td>2011: 51</td>
<td>SDG 7.1</td>
<td>UN SDG monitoring</td>
</tr>
<tr>
<td>Annual mean concentration of fine particulate matter (PM 2.5) in urban areas</td>
<td>μg/m³</td>
<td>Urban</td>
<td>2011: 27.6</td>
<td>SDG 11.6</td>
<td>UN SDG monitoring</td>
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<tr>
<td>Mortality rate attributed to household and ambient air pollution</td>
<td>Per 100 000 people</td>
<td>National</td>
<td>2011: 83.2</td>
<td>SDG 3.9</td>
<td>UN SDG Monitoring</td>
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<td>Acute food poisoning cases</td>
<td>Per 100 000 people</td>
<td>National</td>
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<td>5YHSP</td>
<td>MOH-HSYB</td>
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<td>Smoking prevalence rate</td>
<td>%</td>
<td>Youth (15-24 years of age)</td>
<td>2011: 12.6</td>
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<td>MOH-GATS</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>Male (15+)</td>
<td>2011: 45.3</td>
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<td>MOH-GATS[126]</td>
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<tr>
<td></td>
<td>%</td>
<td>Female (15+)</td>
<td>2011: 1.1</td>
<td>5YHSP</td>
<td>MOH-GATS</td>
</tr>
<tr>
<td>Age standardized prevalence of tobacco smoking</td>
<td>%</td>
<td>Male (15+)</td>
<td>2011: 47.1</td>
<td>SDG 3.a</td>
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<tr>
<td></td>
<td>%</td>
<td>Female (15+)</td>
<td>2011: 1.3</td>
<td>SDG 3.a</td>
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<td>Total alcohol per capita consumption projected estimates</td>
<td>(litres of pure alcohol)</td>
<td>National aged 15 and older</td>
<td>2011: 8.6 (2016)</td>
<td>SDG 3.5</td>
<td>UN SDG monitoring</td>
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<td>Diabetes prevalence in people aged 30-69 years of age</td>
<td>%</td>
<td>30-49 years</td>
<td>2011: 3.6</td>
<td>5YHSP</td>
<td>GDPM-DBPS</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>50-69 years of age</td>
<td>2011: 7.7</td>
<td>&lt;8.0</td>
<td>5YHSP</td>
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</table>

69 Raised blood glucose or currently on medication for diabetes
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<tr>
<td>Hypertension prevalence among adults(^{70})</td>
<td>%</td>
<td>18-69 years of age</td>
<td></td>
<td></td>
<td>18.9</td>
<td>30</td>
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<td>GDPM- STEPS</td>
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<td>Overweight rate in children (weight for height Z-score &gt;2)</td>
<td>%</td>
<td>Children &lt; 5 years of age</td>
<td>4.9</td>
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<td>5YHSP, SDG 2.2</td>
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<td>Overweight rate (BMI≥25)</td>
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<td>Adults (18-69 years of age)</td>
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<td>15</td>
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<td>Strengthen quality, effectiveness of the health service network</td>
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<td>Proportion of people diagnosed with diabetes who are being managed following guidelines</td>
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<td>28.9</td>
<td>50</td>
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<td>Proportion of people diagnosed with hypertension who are being managed following guidelines</td>
<td>%</td>
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<td>13.6</td>
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<td>Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic lung disease between age 30 and exact age 70</td>
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<td>10</td>
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<td>Malaria mortality rate</td>
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\(^{70}\) SBP ≥140 and/or DBP ≥ 90 mmHg, or on medication for raised blood pressure
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<td>Modernize and develop traditional medicine, combined modern and traditional medicine</td>
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<td>Proportion of pregnant women receiving antenatal screening</td>
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<td>%</td>
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<td>Folic acid supplementation during pregnancy</td>
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<td>Ethnic minority</td>
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## Appendix: JAHR monitoring and evaluation indicators

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## Appendix: JAHR monitoring and evaluation indicators

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Notes:
- Regions: RRD (Red River Delta); NMMA (Northern midlands and mountain areas); NCCCA (North central and central coastal areas); CH (Central Highlands); SE (Southeast); MRD (Mekong River Delta)
- 5YHSP-Five-year health sector plan 2016-2020
- DOP-Department of Organization and Personnel
- GARP-Global Aids Response Progress Report
- GDPM-General Administration of Preventive Medicine (MOH)
- GHE-Global health expenditure database
- GHO-Global health observatory database
- GSO-General Statistics Office
Appendix: JAHR monitoring and evaluation indicators

HSYB-Health Statistics Yearbook
MCH-Maternal and child health department
MICs-Multi-Indicator Cluster Survey (2011, 2013/14)
NHA-national health accounts
SDG-Sustainable development goal
STEPS-Stepwise Approach to Surveillance Survey (2015)
SYB-Statistical Yearbook (GSO)

Sources:

MMR- Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the United Nations Maternal Mortality Estimation Inter-Agency Group. The Lancet Published Online November 12, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00838-.


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