Vietnam insights

The right to health and access to universal health coverage for older people

Global AgeWatch
Data and analysis on population ageing

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The right to health and access to universal health coverage for older people

Older person from an intergenerational self-help club in Hai Phong, Vietnam

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Abbreviations

COPD	chronic obstructive pulmonary disease
ISHC	intergenerational self-help club
LTC	long-term care and support
NCD	non-communicable disease
UHC	universal health coverage
WHO	World Health Organization

Executive summary

Vietnam's population is ageing rapidly and, alongside this demographic transition, the country is undergoing an epidemiological transition with a major shift in patterns of disease and health. The prevalence of non-communicable diseases (NCDs) has risen, and conditions such as cardiovascular disease, cancer, diabetes and chronic respiratory disease have a disproportionate impact on older people.

The health system in Vietnam needs to adapt to these demographic and epidemiological changes to ensure older people's right to health is realised. Access to universal health coverage (UHC), a global priority under the United Nations 2030 Agenda, is a key part of the realignment of health systems required to ensure older people's right to health is met.

This report is a companion to the Global AgeWatch Insights report, *The right to health for older people, the right to be counted* (globalagewatch.org). It assesses the extent to which older people can realise their right to health and are included in UHC efforts in Vietnam. The findings are a result of literature and data reviews, as well as in-depth interviews and focus group discussions with older people and stakeholders in Vietnam.

Health insurance coverage

Overall insurance coverage among the older population has expanded rapidly in Vietnam, from 54 per cent in 2006 to 96 per cent in 2018 for people aged 60 and over. In-depth analysis of the data, however, reveals differences in coverage based on age, education and income.

Over 60 per cent of older people in Vietnam have low levels of educational attainment, either never having gone to school, completed primary school only, or being without any formal qualifications or certificates. Despite the aims of social health insurance, its coverage was higher among older people with university degrees (94 per cent) and those living in high-income households (80 per cent) than among those with only primary education (66 per cent) or in the second-lowest income quintile (65 per cent).

Some people who are not eligible for social insurance might be covered by private health protection, but the older people interviewed in our survey said they could not afford it, while others decided not to buy coverage due to a lack of awareness of its benefits. Some local governments have schemes that address the gaps in social insurance coverage, but these are constrained by local priorities and finances.

The law in Vietnam obligates families to provide support to older members of the household, and family support is often needed to cover shortfalls in the health system.

The data shows that households providing care to an older member of the family are more likely to suffer from catastrophic health expenditure than households with no older person, and the poorest households with people aged 50 and over are the most at risk. Family caregivers may also lack sufficient knowledge and training to provide appropriate support.

Older people's access to NCD services

Overall, older people's access to services for NCDs remains low: 68 per cent of survey respondents aged 50 to 69 who have NCDs reported not receiving treatment at a health facility. Access to prevention and treatment varies widely for individual NCDs. For example, among older people with diabetes, only 42 per cent had been screened, compared with an 80 per cent rate for those with high blood pressure.

In our qualitative research findings, health providers confirmed that the problems reported by older people about difficulty accessing NCD screening, diagnosis and treatment are partly due to the patchy provision of services, medication and expertise at different health facility levels. Providers said this also depends on what services are reimbursed by Vietnam Social Security.

Health services

The findings also highlight inequalities within the older population in relation to access to services. Older people are generally more likely to be excluded if they have low levels of education or income, live in rural areas or belong to ethnic minority groups.

Reported levels of satisfaction with health services accessed by older people visiting a health facility vary. Satisfaction with services is higher at community health facilities (86 per cent) compared with district hospitals (74 per cent). In contrast, many older people complained about the quality of services at the primary healthcare level in relation to NCDs, which can be attributed to a lack of specialist facilities and training for the care of older people.

Various arrangements in Vietnam, such as mobile healthcare teams, older people's associations and intergenerational self-help clubs, aim to address some of the gaps in service identified in this report. Some of these measures, such as donor-supported projects, are potentially not sustainable in the long term, however, or are constrained by resources.

Action is needed

We recommend the following actions to ensure the right to health and UHC includes older people from all backgrounds in Vietnam.

- The Ministry of Health in Vietnam should explicitly include older people in health policies and in the monitoring, evaluation and reporting of progress on these policies.
- Social health insurance coverage must be extended to all, especially those who are at risk of exclusion: the 'near poor', those who do not have access to social protection and those aged between 60 and 80 years. These are the groups typically without the capacity to pay for health insurance.
- Basic diagnostic and prescription services for the prevention and treatment of the NCDs that are common in older age, such as hypertension and diabetes, need to be available and accessible, in all districts and communities.
- The Ministry of Health and primary healthcare facilities must focus on finding and managing cases of diabetes among older people, especially those with lower educational attainment or wealth, in ethnic minority groups, and those living in rural areas.
- The Ministry of Health must address gaps in mental health service provision; wide availability of mental health services is needed.
- Local health providers – with support from civil society and local government – should improve their outreach services to groups at risk of exclusion, including providing regular NCD screening, prevention and management.
- The Ministry of Health and primary healthcare providers must ensure better access to NCD medications, particularly for disadvantaged groups.
- Health information systems must be improved, with age caps removed to ensure data is collected on older people. The General Statistical Office of Vietnam should give open access to micro-data.
- Every level of government in Vietnam must protect all older people from catastrophic health expenditure and from impoverishment caused by payments for health services.

- The Ministry of Health should develop education programmes on geriatric care for health practitioners and, with support from academia and civil society, strengthen training both on-the-job and in curricula for all healthcare workers.

- Public education and sensitisation efforts are needed to reduce the risks of NCDs and improve their management, again with a special focus on the identified groups of older people who face further barriers to the realisation of their right to health.

Older person and a volunteer from an intergenerational self-help club in Chu village, Vietnam

Older person from Kim Son district, Vietnam

1. Introduction

Vietnam's population is ageing rapidly. The proportion of the population aged 60 and over has almost doubled, from 6.9 per cent in 1979[1] to 12 per cent in 2018.[2]

In addition to a demographic transition, Vietnam is going through an epidemiological transition as the pattern of disease shifts towards non-communicable diseases (NCDs). The prevalence of NCDs has increased while the prevalence of communicable diseases has declined from 18.6 per cent in 2000 to 11 per cent in 2016.[3] NCDs such as cardiovascular disease, cancer, diabetes and chronic respiratory disease have a disproportionate impact on older people.

This report also explores inequalities in access to healthcare among older people based on their level of education or income, and where they live. While the proportion of older people living in urban areas has grown, the majority continue to live in rural areas.[2] The breakdown is 33 per cent in cities compared with 66 per cent in rural areas.[2] Estimates of the proportion of people aged 65 and over with disabilities range between 28.4 per cent and 40.7 per cent, with variation in reported rates due to survey measurement differences.[4] Over 60 per cent of older people in Vietnam have low levels of educational attainment, having never gone to school, having completed primary school only, or being without any formal qualifications or certificates.[2]

The health system in Vietnam, as in other countries, needs to adapt to the country's ageing population and the growth in NCDs to ensure the right to health of older people is met. The global push towards universal health coverage (UHC), given increased momentum by the United Nations 2030 Agenda and Sustainable Development Goals, provides opportunities to drive this health services transition. UHC is defined by the World Health Organization as ensuring that all people and communities receive the quality services they need, and are protected from health threats, without financial hardship.[5]

This report is a companion to the Global AgeWatch Insights report, *The right to health for older people, the right to be counted*, published in 2018.[6] *Tanzania Insights* is also being published as a sister report to the present case study.

Global AgeWatch Insights analysed the realisation of older people's right to health in low- and middle-income countries according to four components: availability, accessibility, acceptability and quality. The report found that the realisation of older people's right to health remains deeply unequal and often limited, and that gaps in data for policy planning remain a significant barrier to progress.

In this report, we aim to explore in greater depth in a specific national context some of the key issues identified in Global AgeWatch Insights that affect older people's enjoyment of the right to health. We assess progress towards older people's inclusion in UHC in Vietnam in order to identify issues of coverage and access, and to give national stakeholders recommendations for action to advance older people's right to health.

The methodology is given in detail in the Appendix. It involved a review of the literature, including academic, policy and targeted literature, an analysis of secondary data in Vietnam, and in-depth interviews and focus groups with stakeholders and older people about their respective experiences of providing and accessing health services.

2. Policy environment

In Vietnam, some important steps have been taken to advance older people's right to healthcare. An overview of the relevant provisions in the constitution, as well as legal and policy provisions, is presented here. The sections that then follow will explore older people's experiences of healthcare within this policy environment.

The 1946 constitution of Vietnam stated that "all older people would receive assistance" (to access healthcare). The 1980 revision added the obligation of the state and society to assist older people who lacked family support: "the state shall care for the protection and improvement of the health of the people...combining prevention with treatment and taking prevention as the main priority" (article 47). The revised version in 1992 stipulated that children of older people should take the primary responsibility for the care of their parents while the state and wider society were responsible for taking care of older people who had no family support (the age range for older people has not been specified in the constitution).

The right to healthcare for older people was specified in more detail in the 2013 revision of the constitution, which stipulates the need to develop a social security system to assist older people: "the state shall create equal opportunities for the citizen to enjoy social welfare, develop a system of social security, exercise a policy assisting old people, disabled, poor people, and people with other difficult circumstances" (article 59).

The current constitution aims to ensure that all older people, regardless of their family situation, have support, and aims to facilitate the development of different forms of assistance for older people.

The 2009 Law on the Elderly stipulated the rights and obligations of older people.[A] It guarantees "basic food, clothing, lodging, movement and healthcare needs", gives older people "priority in the receipt of relief in cash or in kind, healthcare and lodgings". It sets out that:

- Older people are entitled to health insurance, monthly social assistance payments and payment of funeral and burial costs upon their death.
- All people aged 80 and older who are not pensioners or receiving other monthly social assistance payments, are entitled to health insurance paid from the state budget.

The 2009 Law on the Elderly remains the highest level of legal document to cover older people's issues, including healthcare service coverage. The law mentions some specific care services that shall be made available to certain groups of older people, including: "poor old people, 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, basic medicines, devices and equipment for functional rehabilitation". This law also regulated that all general hospitals with 50 or more planned beds must have inpatient beds and consultation rooms in the outpatient department that are designated for older patients, and stipulates the prioritisation of older people for receiving medical services.

The first government decree on social health insurance came in 1992[B] and the decree issuing the charter of health insurance was in 1998.[C] The government issued these policies to improve healthcare services for the poor and other groups deemed vulnerable, aiming to provide them with coverage either by exemption from paying user fees for services or by health insurance coverage. These policies were considered to have

equity implications for the healthcare received by older people – with those belonging to specific groups receiving better attention. These included older people without children or pension, poor people, people with disability, those living in remote or very poor communes. Another government decree in 1994 also named "a number of beneficiaries entitled to exemption from user fees: people with disabilities, orphans, elderly without support".[D]

According to the Health Insurance Law in 2016, older people in most of the above-mentioned groups participating in health insurance shall pay a co-payment rate of 20 per cent while the remaining 80 per cent is paid by health insurance.[E] Older people who are poor or beneficiaries of social policies shall get 100 per cent of their healthcare costs covered by health insurance.

Older people living alone in poor households and without any support must be included in one of 14 groups deemed vulnerable that participate in the mandatory social health insurance, and poor older people are included as a target group.[F] Additionally, local governments should allocate funding to cover travel costs, medical examination at home, and referral costs for older people without family support.[G]

All countries need to make some provision for long-term care and support (LTC) as part of their health and care systems. Vietnam is no exception. The purpose of LTC is to meet the needs and rights of the proportion of older people in the population who, due to frailty, impairment or illness, need additional support to age with dignity.

Vietnam so far has no official policy on LTC. Arrangements in relation to the financing and training of caregivers, and quality standards for care provision, are not set out in legislation or directives. As detailed later in our findings on LTC, family members and others who voluntarily take on the role of primary caregiver are the foundation of community-based models of LTC, and Vietnam does not yet have an insurance scheme for LTC provision.

Members of an intergenerational self-help club practising a facial massage in Thai Binh, Vietnam

3. Health service provision

3.1 Network of healthcare services

Vietnam has an extensive healthcare network from the national down to the community level. Both preventive and curative services are provided at national, provincial, district and community health facilities. There are 1,451 public hospitals (39 national, 492 provincial, 645 district and 72 specialist) and about 11,100 community health facilities known as commune health stations with, in every village, at least one health worker supporting station activities.[7] There are also 219 private hospitals and 31,594 private clinics in Vietnam.[7]

The public facilities are where most healthcare services are provided under social health insurance coverage for older people in Vietnam.

The national geriatrics hospital is the only tertiary hospital completely dedicated to older people's healthcare. There are also dedicated geriatrics departments, or departments integrating geriatrics with other specialties in several other national hospitals.

At the provincial level, the number of hospitals with established geriatrics departments or units, or departments integrating geriatrics and other specialties, increased from 40 in 2015 to more than 70 in 2017.[8] Geriatric care is also provided by 36 provincial rehabilitation hospitals and 15 nursing centres of other sectors, as well as rehabilitation departments in general hospitals. There are 629 district hospitals (accounting for 30.7 per cent of all inpatient beds nationally), 544 regional polyclinics and 11,000 community health station, and a large workforce of village health workers across Vietnam, with a role in primary healthcare, particularly for older people.[8]

In 2018, some 97 hospitals had a dedicated geriatrics department and 918 examination departments had separate rooms or tables for older people.[9] In 2016, there were 37,622 inpatient beds dedicated to older people.[8] According to the Vietnam National Action Plan for the Elderly, all provincial general hospitals and specialised hospitals should have a geriatrics department by 2020.[8]

3.2 The role of older people's associations

Vietnam enjoys the active participation of older people in a network of groups known as older people's associations. These have included the Vietnam Association of the Elderly, which has been actively involved in healthcare activities with and for older people in all provinces, in collaboration with the health sector. Among its activities, the Association of the Elderly has organised annual health check-ups and health communication programmes. Other bodies include the Vietnam National Committee on Ageing, which coordinates multisectoral and mass organisations and has working groups in each province and district,[8] the Women's Union, the Farmers' Association, and the Veterans' Association.

Intergenerational self-help clubs (ISHCs) also serve an important function in Vietnam. These were established with help from HelpAge International. Each club has 50 to 70 members and a small group of volunteers delivering home-based care and social assistance, as well as learning and enterprise programmes.[8] Home volunteers care for sick older people, those with chronic illnesses, who live alone, lack caregivers or have financial difficulties. Once a week, volunteers go to homes to chat, give support for housework, help with personal hygiene, and mobilise care and community support as needed.

The ISHC model is being formally scaled up. The national action plan for older people for 2012-2020 set a target of at least half of communes

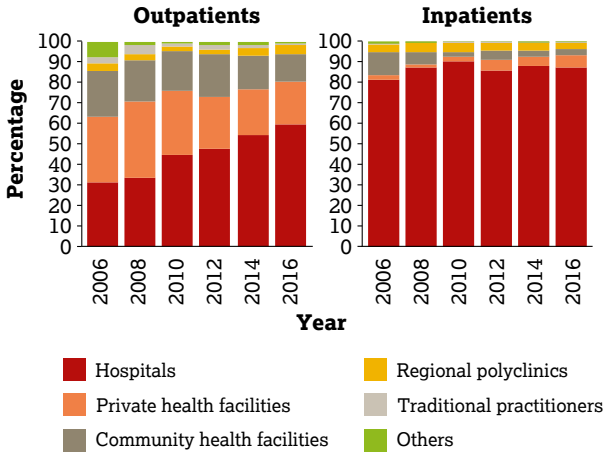
and towns having an ISHC, and in 2016, a prime ministerial decision also supported the model.[H] A target has been set for 3,200 ISHCs in 45 provinces, with at least 105,000 older people participating by 2020. The ISHCs also have a role in the Ministry of Health's counselling and care model for older people, to increase access to appropriate physical and mental health services, prevent risk factors for non-communicable diseases (NCDs) and help with maintaining independence in activities of daily living.[8]

3.3 Types of provider used by older people

The 2016 Vietnam Living Standard Survey shows that government hospitals are the primary providers of inpatient care for older people.[2] As seen in Figure 1, some 87.4 per cent of older people used public hospitals for inpatient services in 2016. The coverage of outpatient care for older people was more diversified. Public hospitals covered 60 per cent of the outpatient services used by older people in 2016, rising from 31 per cent in 2006; private health facilities followed at 21 per cent in 2016, and community health stations were at 14 per cent.

The limited use of inpatient services provided by private health facilities may reflect the fact that social health insurance does not cover these services. The doubling of outpatient access to older people by public hospitals may be due to a few factors including higher levels of insurance coverage among older people, an increase in the number of public hospitals registered to provide care under health insurance schemes and increased need for NCD services among older people.

Figure 1: Percentage of older people using healthcare services by type of provider



Source: Vietnam Living Standards Survey, 2016[2]

Notes:

Hospitals, community health facilities (commune health stations) and regional polyclinics are public facilities. Regional polyclinics provide primary care and some hospital services. Some private services are provided in public hospitals. Traditional practitioners provide services such as herbal medicine and acupuncture privately

Members of an intergenerational self-help club getting their blood pressure recorded by the club's manager in Thanh Hoa, Vietnam

4. Health insurance coverage

The number of older people benefitting from health insurance has risen steadily, leading to a dramatic difference in 2018 compared with 2006. As Figure 2 shows, coverage is now at 96 per cent, versus just 53.9 per cent in 2006. This rise is partially due to the Law on Health Insurance (2008, revised in 2013) and the Law on Older People (2009), and the government target to achieve complete coverage by 2025.[1]

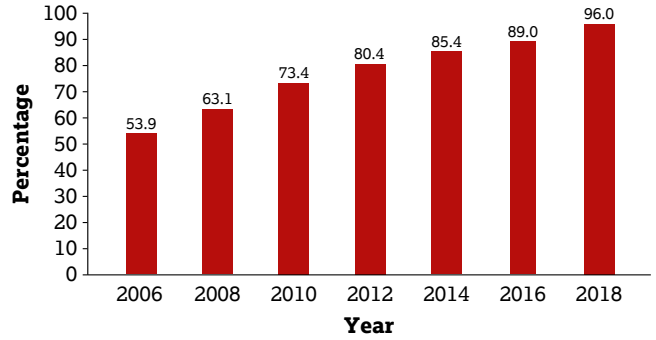
Overall coverage masks differences across ages and types of coverage, however. The 2016 data reveals that the share of uninsured older people was higher among the group aged 60 to 69 (15.5 per cent) than in the cohort aged 70 and over (7 per cent).[4]

For people aged 80 and over, entitlement is enabled by the Law on Health Insurance and Older People, with their health insurance premiums being paid from Vietnam's social security or state budgets. In the 60-to-79 age bracket, however, these national budgets provide for only some groups to get their health insurance premiums paid, namely:

- pensioners retired from work
- poor people who do not have family members obligated to provide support
- people with meritorious service
- older people with disabilities living on monthly social assistance payments.

Other people in the 60-to-79 age group must pay the health insurance premium by themselves unless they belong to a priority group, for example, poor, without a pension, with a parent or

Figure 2: Percentage of people aged 60 and over with health insurance in Vietnam



Sources: Vietnam Living Standard Surveys,[2] Vietnam National Committee on Ageing 2018[9]

children working in the army or police forces. While the majority in this age group fall into one of the priority groups, those who do not are unlikely to participate in social health insurance.

An analysis of data from the 2015 World Bank Group/Vietnam Ministry of Health survey of quality and equity in Vietnam's district and community health facilities shows that most older patients using health services at district hospitals and commune health stations are covered by health insurance.[10] Of the people in the survey aged over 50 who were inpatients at district hospitals, an average of 93 per cent had health insurance, and this status rose with age (86 per cent coverage for those aged 50 to 54, around 94 per cent in the groups between 60 and 74, and 98 per cent for people 80 and over). This health insurance status was consistently high across the older people who were outpatients at district hospitals, at between 97 per cent and 99 per cent. The proportions for outpatients at commune health stations were in the low 90s in the groups aged between 50 and 69, and above 95 per cent for all age groups over 70.

4.1 Patterns in social health insurance coverage

Social health insurance is considered the key to UHC in Vietnam, as in many countries. This section presents findings from the Vietnam Living Standard Survey for the years 2010, 2012 and 2014 on patterns of social health insurance coverage among older people (Table 1).[2]

Table 1: How social health insurance coverage varies by socio-economic factors for older people

	2010 (%)	2012 (%)	2014 (%)
Sex			
Male	62.2	65.4	71.7
Female	59.0	64.0	72.6
Age group			
50-59	51.7	54.7	63.5
60-69	66.9	69.2	76.7
70-79	69.8	74.9	81.4
80+	72.1	88.3	90.3
Marital status			
Single	54.3	62.0	73.2
Married	59.2	62.3	70.1
Widow or widower	66.2	73.6	80.1
Divorced	44.8	59.3	60.8
Education			
Less than primary	57.0	62.1	69.3
Primary	55.9	58.2	66.3
Secondary	70.0	75.9	77.6
College/University	92.5	93.2	93.7
Wealth quintile			
Lowest	68.3	73.5	78.7
Second	51.8	58.7	65.1
Third	55.1	57.5	65.0
Fourth	59.5	63.4	71.3
Highest	66.5	69.9	79.6
Living area			
Urban	64.4	71.3	75.9
Rural	58.5	61.7	70.3
Overall	**60.4**	**64.6**	**72.2**

Source: Vietnam Living Standard Surveys[2]

Notes:

Older people over 50: n=8,123 (2010), n=8,016 (2012), n=9,268 (2014)

While the level of coverage has improved in these years for all the older age groups, the youngest in the most recent figures are being left out compared with the oldest (63.5 per cent covered among those aged 50 to 59 in 2014, compared with 90.3 per cent of those aged 80 and over). The growth in coverage from 2010 and 2014 among those aged 80 and over, of almost 20 percentage points, was also about twice the growth for the 60 to 69 age group (10 percentage points).

To close gaps in access, the local government of Da Nang City in central Vietnam decided to use its own budget to expand the coverage given nationally beyond people aged 80 and over, by purchasing social health insurance for people aged 75 to 79. This point was illustrated in an in-depth interview with one of the key informants:

"The coverage of health insurance among the elderly in Da Nang was already 95 per cent since four or five years ago. To complement the national policy, we used our city budget to buy health insurance for people aged 75 years old and above."

Representative in the Da Nang social insurance office

Members of an intergenerational self-help club receive training in Tien Lang district, Vietnam

Disparities in coverage narrowed between 2010 and 2014, but a large gap remains for people with less education, especially when compared with those with a college or university education. In 2014, two thirds of older people with only primary education were covered, compared with more than three quarters of those with secondary education – and compared with 94 per cent of those with higher education. In terms of coverage gap by income, older people in the second and third wealth quintiles saw lower coverage (65.1 per cent and 65.0 per cent respectively) than those in the wealthier fourth and fifth quintiles (71.3 per cent and 79.6 per cent). (Coverage for people in the very lowest wealth quintile, though, was almost comparable to that in the wealthiest.)

Finally, while older people living in rural areas have seen a rise in social insurance coverage, from 58.9 per cent in 2010 to 70.3 per cent, this latter figure for 2014 compares with 75.9 per cent of urban dwellers.

A report by the Vietnam National Committee on Ageing in 2018 points out that most of the current social insurance schemes provide for employees in the formal sector.[9] The report calls for coverage to be extended to include retired people, older people who have spent all their lives in the informal sector or who have been self-employed, and older women in particular, who are more likely to have worked informally. The government should, the report says, either cover financial contributions or provide direct services for them.

While the findings shown in Figure 2 present a positive picture in terms of the increase in the overall coverage of health insurance, there are issues and gaps, as illustrated in evidence from interviews and focus group discussions. The Vietnam National Committee on Ageing has reported that there are 400,000 older people without any kind of health insurance.[9] Almost all the older people affected are aged under 80. The near-poor group also accounts for many of the older people without health insurance. These are the people who do not receive either national or local (provincial) government health insurance subsidies, as explained by this key informant:

"Many older people have no health insurance because they do not belong to the beneficiaries of the national social protection policies. It would be great if the local governments can also support these groups. However, many provinces, cities have no financial capacity to do so as there are many other things to do while government budget is limited."

Representative of the Vietnam Social Security*

Many of the older people in the qualitative study who had fallen through the safety net of social protection programmes to cover insurance costs could not afford to buy health insurance themselves. Some could not pay even though the government offered to provide them with 80 per cent of the health insurance premium (about US$28), and some did not buy cover because they were not aware of its importance:

"Some people have no health insurance because they don't want to pay for health insurance, just because they are not aware of benefits of having a health insurance card."

"Older people who live in rural areas have to depend on their children's support and they do not have money to pay for health insurance. Some people have no health insurance because they don't want to pay for health insurance and they do not have money."

Two participants in focus group discussions with older people in Hai Duong

* Vietnam Social Security (VSS) is the government agency responsible for the implementation of national social insurance programmes such as pension, sickness and maternity allowances, and health insurance programmes. Source: https://www.who.int/health_financing/documents/oasis_f_11-vietnam.pdf

5. Older people's access to NCD services

Together with the increase in the number of people in the older population, the prevalence of non-communicable diseases (NCDs) has increased significantly.[8] Services for the management of NCDs are crucial for older people, who often have multiple chronic conditions.

5.1 Government commitment to NCD control and prevention

Several NCD prevention and control programmes have been implemented in Vietnam, such as the NCD national strategy for 2012-2015. While these programmes target conditions that are common in older age, they do not specifically address older people. The current national strategy for 2015-2025 targets the prevention and control of cancer, cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD), asthma and other NCDs.[J] Two of the strategy's objectives are to reduce NCD risk behaviour, and to reduce rates of disability and "premature mortality" due to NCDs.[†] The targets refer to the adult population and are silent on older people. In fact, the targets on control of diabetes exclude older people aged 70 and older by focusing only on the population aged 30 to 69.

A health system study conducted in rural Vietnam in 2012 showed that NCD prevention activities have been implemented according to the NCD-specific national health target programme. These activities are implemented without proper collaboration and integration between the different levels of the healthcare system, which may reduce their effectiveness.[11] This study also found that not many treatment services for NCDs were available at primary healthcare facilities (district and community health facilities). There were no special wards for NCDs at the district hospitals, and doctors had no specialisation in NCD diagnosis and treatment.[11] A similar health system study conducted in 2014 in three provinces in Vietnam confirmed that, despite strong government support for NCD prevention and control, Vietnam's network of commune or community health stations had limited NCD service capacity.[12] Another Vietnamese study revealed that community health stations did not have enough autonomy to implement NCD services effectively.[13] A more recent study (2017) conducted in rural Vietnam also revealed that access to NCD services among older people remains limited.[14]

In many areas, medicines and equipment related to NCD prevention and treatment in the primary healthcare system (at district and community health facilities) do not meet World Health Organization (WHO) criteria, yet this is considered an important step for integrating NCD management into primary care. (The criteria are set out by WHO's Package of essential noncommunicable disease interventions for primary healthcare in low-resource settings – WHO PEN.[15])

5.2 Older people's access to NCD care

Table 2 reveals patterns of care for the management of NCDs among older people, using data from the 2015 national survey on NCD risk factors by the Vietnam Ministry of Health.[16] The survey, within WHO's STEPS approach to NCD surveillance,[17] was completed by 3,758 participants from across all the provinces of Vietnam. Among those aged 50 to 69 years, the proportion with NCDs (hypertension, diabetes, COPD, asthma) receiving treatment was low, at around one third overall. Around 30 per cent of people in the groups aged 50 to 54

† HelpAge International challenges the use of the term premature mortality, because it suggests that mortality is acceptable at an older age. HelpAge recommends the use of the term preventable mortality. See HelpAge International's response to the web-based consultation on the first report of the WHO Independent High Level Commission on NCDs (May 2018) at http://origin.who.int/ncds/governance/high-level-commission/Help-Age.pdf

Table 2: How NCD care varies by socio-economic factors for older people

	NCDs: hypertension, diabetes, COPD and asthma (%)	Hypertension (%)	Diabetes (%)
Sex			
Male	35.6	77.3	32.4
Female	28.5	75.2	39.7
Age group			
50-54	29.3	85.0	27.7
55-59	28.5	58.4	40.8
60-64	36.5	84.7	39.2
65-69	33.8	80.5	34.5
Education			
Primary	26.6	79.2	24.3
Secondary	24.4	75.8	46.1
High school	53.1	70.0	43.8
College/University	38.6	78.6	40.5
Wealth quintile			
Lowest	34.8	75.7	27.9
Second	28.0	80.2	18.1
Third	22.0	60.5	57.6
Fourth	35.8	78.5	38.6
Highest	36.5	77.7	48.0
Living area			
Urban	40.2	80.7	46.2
Rural	26.2	71.9	26.1
Ethnicity			
Kinh (population majority)	32.5	75.9	36.3
Other groups	24.3	80.9	32.2
Overall	**31.7**	**76.3**	**36.0**

years and 55 to 59 years were receiving treatment, and the proportion was 37 per cent in the 60 to 64 age group.

Levels for people receiving management for hypertension are higher than this average. In three of the age groups over 50, hypertension management was provided for over 80 per cent, although it was only 58.4 per cent for those aged 55 to 59. Diagnostic and treatment services for high blood pressure are available at both district and community health facilities – data from the same survey show that these health facilities accounted for 80.9 per cent of hypertension management, the remainder being provided by central, private or other health facilities. For diabetes, though, diagnosis and treatment are available only at district hospitals. This would explain why the proportions of people over 50 with diabetes and receiving care for the condition were low – between 27.7 per cent and 40.8 per cent.

Table 2 also shows disparities by gender, socio-economic status and location for the levels of care in the management of NCDs among older people.

Source: 2015 Vietnam national survey on NCD risk factors[16]

Notes:

The n numbers were 424, 153 and 153 for NCDs, hypertension and diabetes respectively – participants aged 50-69 self-reporting an NCD among the total participants completing the study (N=3,758). These participants were asked – after answering that they had received a health professional's diagnosis of hypertension, diabetes, COPD or asthma – if any of these was "being managed at health facilities". Management meant their medical record was kept at the health facility and they went there periodically to check the condition of their NCD and get a prescription

Of those people aged 50 to 69 who have an NCD, the proportion receiving care for their condition is low for people with a high-school level of education, at 53.1 per cent – but it is very low, at 26.6 per cent, for those with only a primary education. For diabetes, the age group's same comparison by level of education is 43.8 per cent versus 24.3 per cent. There is also a notable disparity in diabetes management between the second and third wealth quintiles (18.1 per cent versus 57.6 per cent) and between the lowest and highest quintiles (27.9 per cent versus 48.0 per cent). Finally, the rows of percentages for rural or urban living area also show large differences that are in line with general trends. Overall, older people residing in urban areas are more likely than rural residents to register their NCD conditions with a health facility: 40.2 per cent and 26.2 per cent respectively. The disparity is especially large for the management of diabetes, as older rural residents' access is 20 percentage points less than among urban dwellers (26.1 per cent and 46.2 per cent respectively).

5.3 How access to hypertension services and medication varies among older people

Socio-economic factors in Vietnam appear to affect older people's access to health services for the management of high blood pressure. This is seen in Table 3 against the question of whether, for those who have hypertension, the condition is controlled – and particularly in Table 4 on access to medication.

In Table 3, the prevalence of hypertension is seen rising with age, from 33.9 per cent in survey participants aged 50 to 54, to 48.7 per cent among those aged 65 to 69.[16] A consistently low level of successful treatment – blood pressure control – persists, however, through all the groups over 50. Even though nearly half of the people aged 65 to 69 have hypertension, the proportion in whom this is controlled is 15.5 per cent, hardly above the 13.5 per cent seen for the younger group aged 50 to 54, where just over a third of the people have hypertension.

Older person in Hai Phong, Vietnam

Table 3:
How control of hypertension varies by socio-economic factors for older people

	Hypertension prevalence[i] (%)	Hypertension controlled[ii] (%)
Sex		
Male	45.5	14.1
Female	35.4	14.7
Age group		
50-54	33.9	13.5
55-59	40.9	16.0
60-64	41.4	12.3
65-69	48.7	15.5
Education		
Primary	41.9	15.6
Secondary	34.0	10.5
High school	46.7	19.5
College/University	43.1	12.3
Wealth quintile		
Lowest	35.9	14.8
Second	39.3	11.0
Third	40.7	12.9
Fourth	40.8	17.4
Highest	45.4	18.2
Living area		
Urban	43.2	17.9
Rural	38.6	12.4
Ethnicity		
Kinh (population majority)	41.8	15.1
Other groups	29.2	7.1
Overall	**40.2**	**14.4**

Levels of education, income and urbanisation in Table 3 show variations in hypertension control. Again, as seen across the age groups, the levels are also low right across the socio-economic factors, but for education, people who were high-school educated fared better in the study. For wealth quintile, the proportion with managed hypertension was close to 18 per cent for both the fourth and highest quintiles, but down to 11.0 per cent and 12.9 per cent for the second and third quintiles. Against living area, urban-dwelling older people with hypertension were more likely to have blood pressure controlled than rural older people (17.9 per cent controlled versus 12.4 per cent). Within the overall picture in Table 3 of low rates of blood pressure control for all groups of older people (14.4 per cent overall), Kinh people, the ethnic majority in Vietnam, reported over twice the advantage compared with other ethnic groups (15.1 per cent versus 7.1 per cent getting control of blood pressure).

In Table 4, the rates of access to medication for high blood pressure are lower among poorer and lower-educated older people, and among those who

Source: 2015 Vietnam national survey on NCD risk factors[16]

Notes:

The n numbers were 1,247 and 430 for prevalence and control respectively – participants, aged 50-69, among the total sample completing the survey (N=3,758)

i Prevalence: participants were classed as having hypertension based on actual blood pressure measurements of over 140mmHg systolic and/or over 90mmHg diastolic, or if they were currently on medication for hypertension

ii Controlled: in people with hypertension, control was defined as measurements below the levels for both systolic and diastolic, that is below 140/90mmHg

Table 4:
How access to hypertension services varies by socio-economic factors for older people

	Had blood pressure measured before[i] (%)	Was diagnosed with high blood pressure before[ii] (%)	Had access to high blood pressure medicine during the last 2 weeks[iii] (%)
Sex			
Male	78.7	35.0	51.4
Female	80.5	35.6	49.1
Age group			
50-54	72.8	27.2	42.7
55-59	80.3	35.6	49.0
60-64	82.6	37.2	47.6
65-69	87.6	44.9	60.9
Education			
Primary	74.2	40.0	47.7
Secondary	80.3	27.3	46.7
High school	82.6	37.9	51.5
College/University	95.9	36.1	62.2
Wealth quintile			
Lowest	72.5	41.5	50.5
Second	76.2	34.7	40.9
Third	78.1	30.3	45.8
Fourth	85.9	35.4	54.8
Highest	88.7	35.5	61.9
Living area			
Urban	84.6	39.5	57.1
Rural	77.2	33.1	45.6
Ethnicity			
Kinh (population majority)	81.8	35.3	52.4
Other groups	65.0	36.0	31.4
Overall	**79.7**	**35.3**	**50.1**

are in ethnic minority groups or are rural dwellers. The proportions of hypertensive people receiving drug treatment were well under half for the second and third economic quintiles, but over half for the wealthier fourth and fifth quintiles. Among the four levels of education, almost all college/university-educated older people had ever had their blood pressure measured, but this was down to three quarters of those having only primary-school education. Within the overall picture across the age groups in Table 4, with just half (50.1 per cent) reporting access to hypertension treatment, both the high-school and college-educated groups indicated better chances of receiving medication. Of non-Kinh people, just 31.4 per cent reported access to medication, compared with 52.4 per cent of Kinh people and, finally, 45.6 per cent of rural dwellers compares with 57.1 per cent of urban having access to anti-hypertensives.

Source: 2015 Vietnam national survey on NCD risk factors[16]

Notes:

The n numbers were 1,247, 1,002 and 358 for measured, diagnosed and medicine access respectively – participants, aged 50-69, among the total sample completing the survey (N=3,758)

Participants were asked:

i "Have you ever had your blood pressure measured by a doctor or other health worker?"

ii "Have you ever been told by a doctor or other health worker that you have raised blood pressure or hypertension?"

iii "In the past two weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor or other health worker?" (this question only for those answering yes to both the above questions)

5.4 How access to diabetes services varies among older people

The data on NCD management for older people revealed in the 2015 national survey on risk factors also suggests variation in access to care for diabetes as well as to care for high blood pressure.[16] The rates of access to medicines for the condition, seen in Table 5, are lower among women, for example. While the sample size is small (71 respondents aged 50 to 69 who had a diabetes diagnosis from a healthcare professional and received medication for it), 82.3 per cent of diagnosed older men had access to drug treatment, compared with 69.7 per cent of females. This difference is stark given that the gender-based access to blood glucose measurement is similar (41.3 per cent male and 41.9 per cent female). Against levels of education, the numbers are generally larger across the three elements of diabetes care for those older people who had high-school and college/university education. Under a third of those with only a primary school education is compared with over two thirds of those who went to college/university against whether they had ever had a glucose measurement. This disparity is similar for level of income, too – well under a third in the lowest wealth quintile were ever measured, compared with over two thirds in the highest quintile. Finally, a clear disparity is also seen in the data in Table 5 for ethnicity, with lower levels of diabetes care among people outside the Kinh majority.

Getting access to diabetes care can be a challenge for older people in Vietnam. Older people who participated in focus group discussions explained that, while access to health services via community health stations is widespread, it is not comprehensive, and they face expense as a result of gaps in care locally for conditions.

"I have diabetes for about a year. First, I went to the commune health clinic but there was no equipment needed to diagnose it. I went to the district hospital but there was no doctor there. Recently, I went directly to the provincial hospital but I had to spend a lot of money on travelling."

Participant in focus group, Hai Duong province

Older person in Bac Ninh province, Vietnam

Managers of an intergenerational self-help club discuss activities before their monthly meeting in Hai Phong, Vietnam

Table 5: How access to diabetes services varies by socio-economic factors for older people

	Had blood glucose measured before[i] (%)	Was diagnosed with high blood glucose before[ii] (%)	Had access to high glucose medicine during the last 2 weeks[iii] (%)†
Sex			
Male	41.3	9.9	82.3
Female	41.9	13.0	69.7
Age group			
50-54	39.2	10.2	43.2
55-59	43.4	11.9	87.0
60-64	41.5	13.3	84.2
65-69	43.1	11.4	84.1
Education			
Primary	30.7	9.3	63.5
Secondary	41.0	10.6	59.9
High school	59.8	17.5	96.1
College/University	66.7	11.8	81.8
Wealth quintile			
Lowest	28.8	8.8	74.3
Second	31.5	6.3	80.2
Third	38.0	12.5	68.0
Fourth	51.3	11.8	88.3
Highest	66.7	16.3	68.6
Living area			
Urban	57.8	15.3	80.5
Rural	33.5	8.5	65.6
Ethnicity			
Kinh (population majority)	44.3	11.9	75.1
Other groups	23.5	7.5	53.1
Overall	**41.6**	**11.6**	**74.6**

Source: 2015 Vietnam national survey on NCD risk factors[16]

Notes:

The n numbers were 1,247, 548 and 71 for measured, diagnosed and medicine access respectively – participants, aged 50-69, among the total sample completing the survey (N=3,758)

Participants were asked:

i "Have you ever had your blood sugar measured by a doctor or other health worker?"

ii "Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?"

iii "In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor or other health worker?" (this question only for those answering yes to both the above questions)

† Small sample size

6. Financing healthcare – costs for older people and the role of health insurance

Under the Health Insurance Law, some services that are important to older people are not covered by health insurance in Vietnam – for example, the screening of chronic diseases such as hypertension, diabetes, and routine health check-ups. If an older person has symptoms of disease and visits a health facility, the charges will be reimbursed by health insurance; but if a healthy older person uses a health check-up service for early detection of non-symptomatic NCDs, the charges are not covered by health insurance.

Figures 3 and 4 show that in 2016 the healthcare expenditure for both inpatient and outpatient treatments was much higher for older people than it was for younger cohorts. Data also shows that the gap between the younger and older has grown since 2010. The rise in inpatient costs over this period has been steep for both 40- to 59-year-olds and people aged 60 and over.

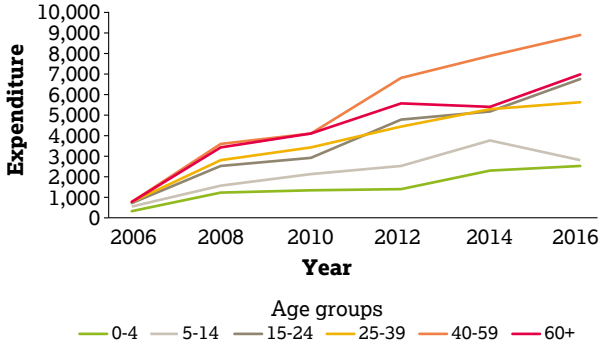
For the 40 to 59 group the costs more than doubled, from around 4,000,000 Vietnamese dong (VND) (about US$172 in March 2019) to around VND9,000,000 (US$388). For people 60 and over, expenditure increased 1.7 times, from around VND4,000,000 (US$172) to around VND7,000,000 (US$302). In comparison, costs for the 25 to 39 age cohort went up 1.6 times, from around VND3,500,000 (US$151) to around VND5,600,000 (US$241). In the case of outpatients (Figure 4), the 2010 figure of nearly VND1,000,000 (US$43) for those aged 40 to 59 increased to about VND1,558,000 (US$67) in 2016. For people aged 60 and over, the steepness of the rise was similar, as costs increased from VND1,079,000 (US$46) in 2010 to VND1,662,000 (US$72) in 2016.

The costs revealed by the Vietnam Living Standard Surveys[2] are borne out by the interviews with stakeholders:

"Healthcare costs for older people are much higher than those for younger ones. Many older people do not have an income and cannot afford to pay for the costs. Many of them rely on supports from their children. But there are also many older people who have to pay themselves. Some do not seek treatment because of healthcare costs. Some older people in rural areas have to sell their assets like pigs, buffalo. I know some older people with cancer have to borrow money from a relative to pay for healthcare costs."

Doctor from the national geriatrics hospital

Figure 3: How inpatient healthcare expenditure by varies by age group



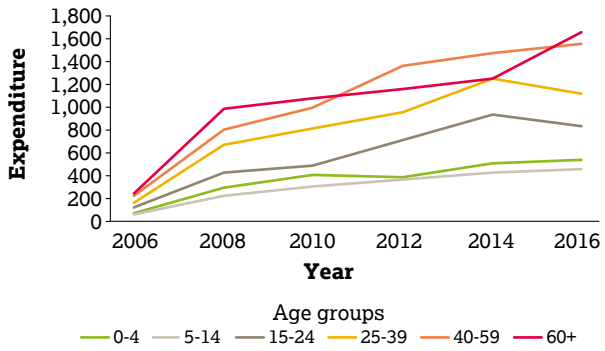
Source: Vietnam Living Standard Surveys[2]

Notes:

Expenditure: Vietnamese dong (VND) in thousands: i.e. 1,000 = VND1,000,000 (equivalent to US$43 in March 2019)

Average expenditure per person for inpatient treatment in the previous 12 months

Figure 4: How average outpatient healthcare expenditure varies by age group



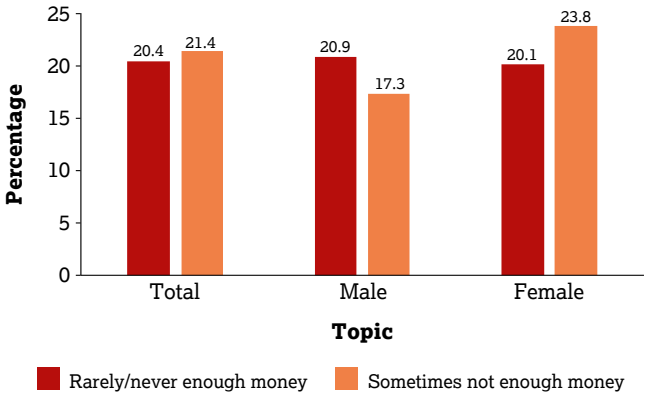
Source: Vietnam Living Standard Surveys[2]

Notes:

Expenditure: Vietnamese dong (VND) in thousands: i.e. 1,000 = VND1,000,000 (equivalent to US$43 in March 2019)

Average expenditure per person for outpatient treatment in the previous 12 months

Figure 5: Proportion of older people not able to pay for healthcare



Source: Ngoc Quynh for the United Nations Population Fund[19]

Notes:

Older people aged 60 and over; 2012 survey data of 852 older people in the provinces of Hai Duong and Ben Tre

As well as evidence from research informants, findings from the 2011 Vietnam ageing survey reflect concerns that many older people in Vietnam are simply going without care because they cannot pay for it themselves. This was a nationally representative survey of over 4,000 people aged 50 and over and has enumerated the problem in some detail.[18] Half of the older people asked said they could not afford treatment and medication fees (51 per cent within the previous 12 months of the survey).[18] The report concluded that one of the main reasons why older people did not treat illness or injury was that "they did not have enough money to pay for it". The results of the Vietnam ageing survey also revealed that when payments were made, only one in three were made by the older people themselves. In two thirds of cases, costs were covered, in decreasing order, by sons, daughters, spouses, daughters-in-law or sons-in-law.

Another study, this time conducted in two provinces in Vietnam in 2012, also revealed older people not being able to pay for healthcare expenses. As the totals in Figure 5 show, 41.8 per cent of older people reported, with a half–half split, either "sometimes" or "rarely/never" having enough money to cover the care.[19]

The Vietnam Living Standard Surveys show that rates of catastrophic health expenditure and impoverishment are higher among households with older people.[2] The proportions of older people suffering catastrophic expenditure seen in Table 6 have dropped since 2010 (when, for households with at least one person aged 60 or over, the percentage was 8.1; for people 50 to 59, it was 6.1), but a disparity has remained for older people in 2014. For households with no members aged 50 or over, just 1.8 per cent suffered catastrophic out-of-pocket costs for healthcare, whereas the figure was 3.2 per

Table 6: Catastrophic health expenditure and impoverishment among households with and without older people

	Out-of-pocket health costs					
	Catastrophic expenditure[i]			Impoverishment[ii]		
	2010	2012	2014	2010	2012	2014
Overall percentages by age group						
All household members <50	2.6	1.9	1.8	1.9	1.7	1.6
At least one person 50-59	6.1	6.1	3.2	3.3	3.2	2.0
At least one person 60 or over	8.1	7.8	3.7	4.2	4.2	2.4
Percentages by socio-economics: households with at least one person aged 50 or over						
Wealth quintile						
Lowest	8.5	8.0	4.1	6.6	2.5	7.0
Second	6.7	6.3	4.0	8.0	11.5	2.6
Third	5.7	5.8	2.5	1.2	1.5	0.6
Fourth	5.9	5.2	3.3	0.6	0.3	0.1
Highest	3.5	5.2	2.2	0.3	0.2	0.1
Living area						
Urban	4.5	4.1	2.3	1.5	1.3	0.9
Rural	6.8	7.0	3.7	4.2	4.0	2.7

Source: Vietnam Living Standard Surveys[2]

Notes:

i Catastrophic expenditure occurs when a household's total out-of-pocket health payments equal or exceed 40 per cent of the household's capacity to pay after meeting the costs of the basic standard of living (World Health Organization, WHO, definition given at https://apps.who.int/iris/handle/10665/69030)

ii Impoverishment is when a household not already poor becomes poor after paying for health services (also the WHO definition)

cent for households with at least one person aged 50 to 59, and 3.7 per cent for 60 or over. Table 6 also shows catastrophic health expenditure and impoverishment rates being higher for households with older people of poorer economic status or living in rural areas. For example, in 2014, some 7.0 per cent were impoverished by healthcare costs in the lowest wealth quintile, whereas for the third, fourth and highest wealth quintiles, this proportion was very small indeed.

A number of studies of different designs and in both rural and urban areas have added to this evidence of households with older people in Vietnam being pushed into poverty by healthcare costs. One study of a rural area, where there

are more older people compared with urban areas in Vietnam,[8] found that the catastrophic health expenditure rate was 14.6 per cent, and impoverishment was 7.6 per cent, among households with at least one member having a chronic non-communicable disease.[20] These rates are significantly higher than were found in households whose members were free from the diseases more common in later life. The cross-sectional survey of 800 randomly selected households also found that the presence of people aged 60 or over was significantly associated with catastrophic health expenditure and impoverishment – the likelihoods of these were, respectively, 1.2 and 1.1 times greater (odds ratios).[20] Similarly, two other studies have found higher risks of these financial burdens for households with at least one member aged 60 or over. One was a survey of 1,530 rural and 2,216 urban households,[21] and the other was of 492 slum and 528 non-slum households in the capital city Hanoi.[22] The latter found that the risk of catastrophic health expenditure was strongly associated with households in slums with an older person and households in the lowest wealth quintile. Finally, data on household financial burden and poverty over 12 months in 10,000 cancer patients in Vietnam, revealed statistically significantly higher odds of impoverishment for patients over 60 compared with those aged 44 to 60 (1.75 times higher odds).[23]

Older person receives health advice by trained members of an intergenerational self-help club in Hai Phong, Vietnam

7. Health services – perceptions and experiences

The health system of Vietnam has been developing and implementing some solutions to improve the quality of healthcare services in recent years. Consequently, people's satisfaction with services has also increased. Analysis of data from the 2015 World Bank Group/Vietnam Ministry of Health survey of quality and equity in district and community health facilities shows that consistently over 90 per cent of older inpatients aged 50 and over gave positive comments about aspects of quality after using general health services at district hospitals.[10] Table 7 below provides further data from the survey.

Figure 6 opposite, from the same survey, shows that about 74 per cent of patients aged 50 and over were satisfied in general with the outpatient services they used at district hospitals, while satisfaction among outpatients under 50 was lower, at 69.8 per cent. The survey also revealed some differences across gender, ethnicity and socio-economic status (Table 8). Slightly more female than male people aged 50 and over were satisfied with outpatient services (74.3 per cent versus 72.8 per cent), and ethnic minorities were slightly more satisfied than the majority Kinh. Finally, being poor versus near poor led to lower satisfaction (74.4 per cent versus 78.7 per cent) (Table 8 opposite).

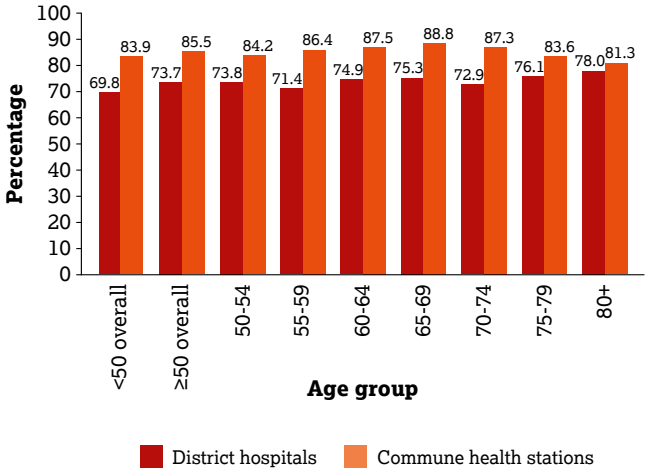
Table 7: How inpatient experience at district hospitals varies by age

Age	Received daily check-ups (%)	Received explanation about diagnosis (%)	Received physician advice on what to do (%)	Treated with disrespect (%)	Confirmed facility was clean (%)	Confirmed facility had sufficient equipment (%)	Confirmed facility equipment functioned well (%)
<50	97.8	94.4	94.8	1.8	93.6	95.1	96.6
50-54	100.0	93.1	94.8	3.4	96.6	92.0	89.8
55-59	97.7	97.7	97.7	0.0	97.7	92.7	92.1
60-64	100.0	93.5	95.7	4.3	97.8	93.2	92.1
65-69	98.0	98.0	93.9	0.0	98.0	94.7	97.1
70-74	97.8	95.7	93.5	4.3	97.8	100.0	100.0
75-79	97.4	94.9	97.4	2.6	89.7	93.3	100.0
80+	98.2	83.6	87.3	0.0	96.4	95.2	97.3
Overall	**98.1**	**94.0**	**94.5**	**1.9**	**94.7**	**94.8**	**96.0**

Source: World Bank Group/Vietnam Ministry of Health, 2015[10]

Notes: n=952

Figure 6: Satisfaction with outpatient services by type of health provider



Source: World Bank Group and Vietnam Ministry of Health, 2015[10]

Notes:

n=4,989, district hospitals; n=1,759, commune health stations (community health facilities)

Table 8: How satisfaction with outpatient services varies by type of health facility and socio-economic factors for older people

	District hospitals* (%)	Commune health stations** (%)
Sex		
Male	72.8	86.9
Female	74.3	84.8
Economic status		
Poor	74.4	85.5
Near poor	78.7	83.3
Not classified	73.3	85.8
Ethnicity		
Kinh (population majority)	73.6	85.8
Other groups	75.6	82.3
Overall	**73.7**	**85.5**

Source: World Bank Group/Vietnam Ministry of Health, 2015[10]

Notes:

*n=2,405, **n=907

Overall satisfaction with outpatient services at the community level (commune health stations) was higher than at district hospitals, as seen in Figure 6. For people aged 50 and over, this figure was 85.5 per cent, more than 10 percentage points higher than for hospitals. The satisfaction rates were lower among patients aged 80 and over compared with the younger groups. Across all patients aged 50 and over, female satisfaction was a little lower (84.8 per cent versus males, 86.9 per cent), as was that among ethnic minority groups (82.3 per cent versus Kinh, 85.8 per cent). Poor people aged 50 and over were slightly more satisfied (85.5 per cent) than the near poor (83.3 per cent) (Table 8). These figures represent general satisfaction with a visit to a health facility among those individuals who were able to access it. It might not capture the experiences of those who either chose not to seek treatment or could not access it. The next section aims to broaden this discussion by examining specific issues in the provision of NCD services and in the access to them.

Members of an intergenerational self-help club cleaning public areas as part of their activities to keep the local environment clean in Hai Phong, Vietnam

8. Issues in healthcare systems

8.1 Gaps in services for non-communicable diseases

While the levels of general satisfaction with the quality of both inpatient and outpatient healthcare are high among older people in Vietnam, the focus group discussions highlighted a number of specific issues. Many complaints focus on services p rovided at primary healthcare facilities, especially services for non-communicable diseases (NCDs). The quality of this provision has driven many participants to provincial or national hospitals for the diagnosis and treatment of their conditions. As a result, many older people and their relatives have to incur the costs of transport, food and accommodation as well as bear high co-payments for services that are not fully covered by social health insurance.

Several studies of the health system in Vietnam have found that not many treatment services for NCDs are available at primary healthcare facilities at the district and community levels. There are no special departments for NCDs at district hospitals, for example, and doctors have no specialisation in the diagnosis and treatment of these conditions commonly affecting older people.[11,14] Only 43 per cent of community/ commune health stations conduct screening for type 2 diabetes and just 16 per cent of community health stations dispense medication for it. The situation is marginally better in relation to hypertension, with 48 per cent of community health stations performing screening and 35 per cent dispensing medication for high blood pressure.[10]

As noted earlier, some groups within the older population (for example, rural residents, ethnic minorities, older people living in poverty, and those without education) face even higher barriers to quality services. The latest data (2016) shows that only 12.6 per cent of professional staff at community health stations have training on the rehabilitation of people with disabilities, and just 16.9 per cent of community health stations are designed in line with disability standards.[3]

While community access to services via community stations is widespread, older people cannot always get the care they need for their conditions at these facilities:

"My neighbour had chronic bronchitis but in the commune and district [they] could not treat it, so she had to go to a central hospital. Every time she went to treatment, there was a follower [carer] and a lot of costs for followers. She said, health insurance does not cover some expensive drugs, so it is expensive to buy outside."

Participant in focus group discussion, Dong Thap

In-depth interviews with stakeholders also clarified that the unavailability of NCD services is also related to social health insurance regulation. For example, hypertension services are included in the package of health insurance benefits for community health stations, but diabetes services are not.

"Each level of health facility is allowed to provide certain services, medicines and medical materials (technical capacity). A health facility will not receive reimbursement from Vietnam social security for the services that are beyond its technical capacity."

Representative of Vietnam Social Security

"Currently, most of services for hypertension, diabetes, bronchial asthma, chronic pneumonia are covered by the health insurance scheme at district health facilities or at a higher level of health system."

Representative of Hai Duong
centre for disease control and prevention

"We can provide diagnosis and treatment services for diabetes, but the costs of that service are not covered by health insurance."

Community health station representative in Dong Thap

"We want to serve elderly more, but the grassroots level can only supply drugs on a regular basis, but can't diagnose or prescribe because we can't perform blood biochemical tests, while to diagnose and monitor diabetes, biochemical testing is essential."

Community health station representative in Da Nang

In-depth interviews with stakeholders discussed how NCD preventive activities have been implemented under the framework of national programmes. In some areas, mobile healthcare teams have been established and do health check-ups for older people. These can help to detect some conditions such as high blood pressure, asthma and pneumonia, but they are not able to screen for disease such as cancer. This type of activity could only partly meet the needs of older people:

"We have been regularly implementing different national NCD programmes, such as prevention and control of hypertension, diabetes and COPD. However, the budgets for these programmes are very limited and we mainly do intervention activities such as health education, screening for hypertension…"

Representative of the provincial health office in Hai Duong

"Each year we conduct a general check-up for older people. We establish healthcare teams with doctors and staff from hospital and preventive medicine centre. These teams move around the province and provide medical check-up for the elderly. We do physical examinations, measure blood pressure, weigh, check eyesight and provide some vitamins and supplements. We cannot provide X-ray, blood tests to screen for cancer, since it is very costly and time-consuming."

Representative of the provincial health office in Da Nang

Older people themselves also told the qualitative researchers that more needed to be done to widen the reach of check-ups:

"Personally, I see that the coverage of healthcare for the elderly is still limited. Each year, the mobile team come to provide a health check one or two times. This commune has 850 elderly members but the health programme lasts only half a day, so how many people can they reach? Further, older people often depend on their children – those whose children have monthly income, they may receive some money from children, those who have pension, they have some money for healthcare – those who have no pension, they totally depend on their children, so it is very difficult for them to go to the district or province for health checks. In order to be able to take care regularly and detect the disease early, the government should organise health checks at the commune for all older people."

Focus group discussion with older people in Hai Duong

An in-depth interview with a representative of the Dong Thap centre for disease control and prevention said: "By doing annual health checks for the elderly, we could find several hypertension cases." The representative added, "That is good anyway". But the numbers cited by doctors do not show a high rate of screening:

"We really want to screen all older people. However, due to constraints of time, budget and human resources, we can serve [only] a part of the older population. For example, in Da Nang city, there are about three to four thousand people, but we can screen about 1,000 people per year, less than 25 per cent of the total of older people."

General hospital doctor in Da Nang

Although neurological diseases, particularly dementia, account for a large share of the burden of disease among older people, there are yet to be any official policies or programmes for these diseases, including Alzheimer's. According to information shared by the Deputy Minister of Health in the autumn of 2018 – at the very first national conference on dementia – up to 1.3 million people in Vietnam had dementia, and this number was set to rise.[24]

In-depth interviews with stakeholders confirmed that dementia services were still largely lacking, for example:

"In Vietnam, there are more and more people with dementia, about 10 per cent [of older people], but diagnostic and treatment services are still unavailable."

Doctor from the national geriatrics hospital

Stakeholders also mentioned that systems for NCD management and the rehabilitation of older people have not been well established and have not met their needs. Most NCD cases were not followed-up after intensive treatment. Schizophrenia and epilepsy patients have been managed at the community level under the national healthcare programme for several years. These patients regularly received drugs for free at the community health stations. However, community health stations do not have the capacity to provide further diagnosis or to revise treatment plans. Whenever the patient's status is not stable, the patient would be referred to a higher level of service – to the district hospital and then to provincial hospitals.

"For NCDs, we have the national programme for schizophrenia and epilepsy patients. Normally patients are diagnosed at the provincial hospital. When the patient's status gets stable, they will be sent back to their commune. Health staff at the CHS [commune health station] will regularly receive medicine and distribute to the patients. CHSs are not capable enough to give diagnosis as well as make decision on the treatment regime for patients. When patients have problems, they will be referred to a higher level."

Representative of the Ministry of Health (medical services administration)

"[There is] no specific disease management programme for older people. The current national programmes for schizophrenia and epilepsy are for all."

Representative of the Ministry of Health (medical services administration)

8.2 Specialist care for older people

Vietnam has not yet developed geriatric competency standards for general practitioners, internal medicine or geriatric physicians. Although there are three schools providing training in the specialism of geriatric medicine, the national education system does not yet have a code for geriatric medicine in the list of postgraduate education specialities. There is no framework or standard geriatric curriculum to be used in the training programmes of general practitioners or internal medicine specialists, or for continuing medical education and vocational geriatric training programmes. There is no provision of continuing medical education to improve the general knowledge of health workers on the special needs of older patients, such as on drug interactions, the psychology of both healthy and sick older people, falls risks, counselling for diet and disease self-management, and so on. Extending this education outside of geriatrics departments is important because most older patients with specific diseases are likely to be treated in a specialty department other than geriatrics.

Discussions with stakeholders in the qualitative research also identified barriers relating to the lack of doctors and nurses specialised in geriatric as well as NCD care, to the lack of qualified staff at community health stations, and to insufficient time given to the care of older people.

"There are no specific services such as nursing homes for the elderly. Rehabilitation is also important for older people because they have many problems that need to use rehabilitation services. However, the rehabilitation services are not available."

Representative of Hai Duong centre for disease control and prevention

There is a lack of policy documents guiding healthcare for older people at all levels of the healthcare service delivery hierarchy, to stipulate the organisation, staffing, target patient groups and physical facilities of the geriatrics department in general hospitals, as well as at the primary healthcare level. Integration and collaboration among disciplines such as curative care, rehabilitation, clinical pharmacy, preventive counselling, health promotion, social work and personal care services in Vietnam are still poor.[25]

Many hospitals in Vietnam still lack specialist facilities for the care of older people. While most have some beds for older people and do prioritise these groups for medical examination and treatment, clinics for outpatients and rooms for inpatients do not always have exclusive designations for older people. Despite the interdisciplinary nature of the care of older people, the knowledge of health workers on the policy, programmatic and inter-organisational aspects of their health and social care is limited.[26,27]

Interviews with stakeholders provided some insights on gaps in the provision of hospital-based geriatric services in Vietnam:

"There are too few hospitals with a geriatrics department. At the moment, almost all provincial hospitals do not have a geriatrics department."

Representative of the national geriatrics hospital

"Currently, less than 40 per cent provincial hospitals have a geriatrics department, most of the hospital integrated geriatrics are in other departments such as departments of urology, departments of cardiovascular disease or departments of internal medicine..."

Ministry of Health representative (admission for medical services)

"The need for geriatrics care has been remarkably increased since we have [more] older people nowadays. However, our health system has not been developed accordingly. MoH [Ministry of Health] has just issued the document number 2248 about the establishment of a department of geriatrics and healthcare for older people."

Ministry of Health representative (planning department)

Other interviews revealed how the capacities of established geriatrics departments have been limited in responding to the health needs of older people. Key stumbling blocks are the lack of trained medical and nursing staff, few specialist beds and insufficient equipment.

"Vietnam does not yet have enough human resource to care for older people. Too much pressure for our nurses. Family members often have to hire caregivers – that is expensive and low quality because they have no expertise, no training."

Representative of the national geriatrics hospital

"There have been very few doctors specialised in geriatric care. Each year there are about some dozen doctors trained on this specialty. Some hospitals established the geriatrics department, but the doctors are mostly from the internal medicine department or other specialties without any training on geriatric care yet."

Ministry of Health representative (admission for medical services)

8.3 Long-term care and support

As highlighted previously, in Vietnam, there is as yet no formal system of long-term care and support (LTC). Family members and others who voluntarily take on the role of primary caregiver are the foundation of community-based models of LTC, with the aim of increasing the older person's independence and quality of life in the long term. For older people aged 60 to 69 with health problems, spouses are the primary providers of support for activities of daily living (55.8 per cent), followed by children (32.6 per cent). For people aged 70 and over, children are the primary carers (74.8 per cent).[4] Care of older people by family members is regarded by many stakeholders as appropriate within Vietnam's legislation, economic conditions and cultural traditions, but this model faces challenges. Such care can be difficult to provide in smaller families, for example, and may be challenging for busy adult children and those working far from home. People taking up these roles may also lack sufficient knowledge to care for older people with complicated illnesses.[8]

The role of governments in creating and maintaining systems of long-term care, incorporating partnership working with families and communities, has been highlighted by WHO. Vietnam does not yet have an insurance scheme for the provision of LTC, and the policy on sick leave in the social insurance programme is not applied in the case of a worker taking time off to care for a sick older person.[8] In addition, in many areas in Vietnam, local governments have not allocated funding to help run the Association of the Elderly, which provides several of the components of LTC.[28] Older people in the discussion groups very much valued such help:

> *"Older people often live with their children, so their children must take them to healthcare services. Those who live alone may have difficulty, but people from elderly association in the community and others in the community can help."*
>
> Focus group discussion with older people in rural Dong Thap

The role and tasks as well as the professional knowledge and skills requirements for caregivers have not yet been clearly and consistently stipulated in regulations. Lay people are the predominant providers of LTC, and the roles are not currently considered a formal occupation in Vietnam. There are no regulations on training qualifications, professional standards or on the licensing of care services for older people. The number of training establishments is very modest, and they do not follow any standard, unified curriculum.[8]

The most comprehensive community-based source of LTC in Vietnam is the intergenerational self-help club (ISHC). First established over 10 years ago with some support from HelpAge International, Vietnam had nearly 1,300 ISHCs at the end of 2017.

Other models for LTC are also seen in Vietnam, although there are challenges with some of these:[8,29]

- Free home care by volunteers of mass organisations (such as older people's associations, women's associations, the Red Cross), sponsored by HelpAge Korea (2003-2012). The volunteers were given training and had good results, but the project came to an end.
- Paid home care by volunteers and assistants of mass organisations, sponsored by the Republic of Korea and the Association of Southeast Asian Nations (ASEAN). The volunteers and care assistants are given training and receive a small monthly allowance (equivalent to about US$22 a month). This model is easy to implement and inexpensive, and appropriate to conditions in Vietnam, but it faces challenges in sustainability, organisation and finance.
- The General Office of Population and Family Planning model for the counselling and care of older people based in the community is a programme with volunteers who are healthy older people trained in basic knowledge to support other older people, with priority given to those in financial difficulty or without family support.

- Government-run social protection centres provide limited LTC support to older people who have met means-testing criteria.
- Paid care in private nursing homes: the service in private nursing homes is good but the fee is very high for average incomes.
- Paid home care and palliative care for older people is being organised in the form of private or social enterprise. The main users are families of older people who have the financial ability to pay. Another challenge with this model is that there is no monitoring and support from authorities.
- Paid home care provided by home helpers, whether full- or part-time: in this model, the training and monitoring of caregivers is limited.

8.4 Home-based care

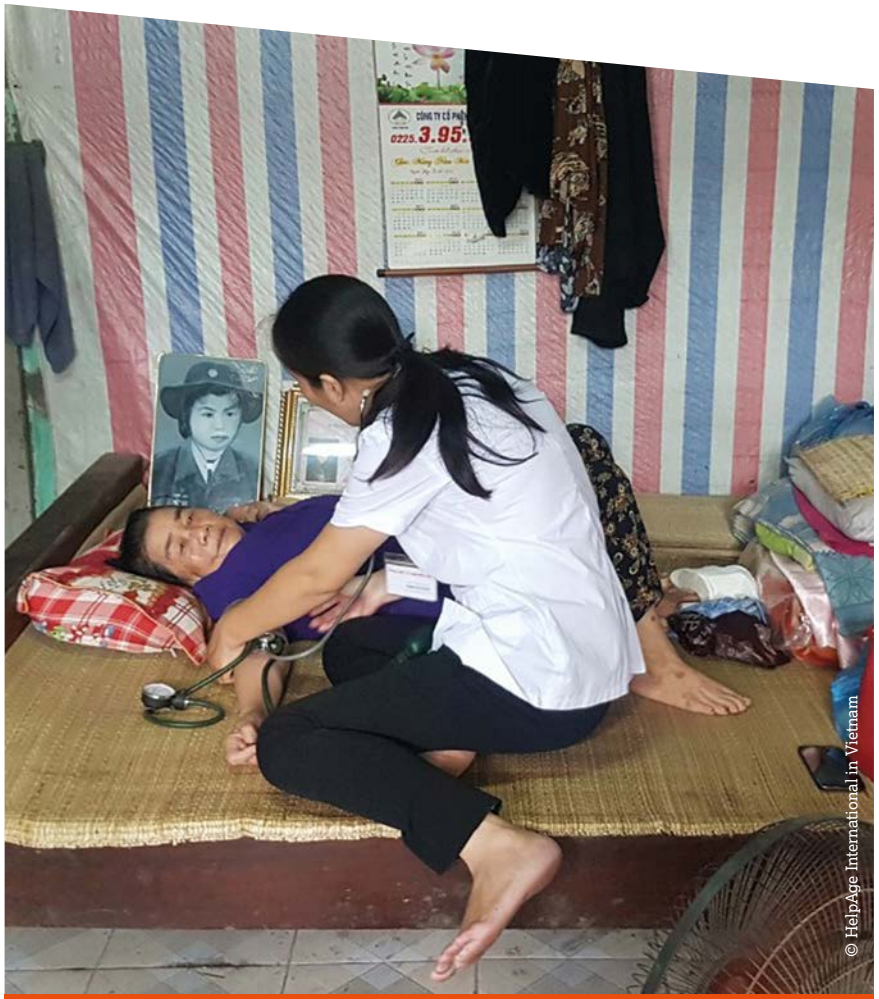
The concept of formal home-based healthcare services for older people is still a novel one in Vietnam. The existing law on examination and treatment does not provide any legal basis to set up the home-based healthcare services that older people may need.[K]

"Home-based healthcare services for older people have not been readily available in Vietnam. There has been no official regulation, guidelines and standards for these type of health services."

Doctor from Dong Thap health department

A recent study collecting data from 713 people in a rural area of Vietnam reported that one in five older people (21.6 per cent) needed home-based healthcare services, including rehabilitation.[30] Another study in a rural area in Vietnam found that, although the majority of older people needing help did get enough support in their daily care, the demand for care was greater among disadvantaged groups, including those older people who were poor, had disabilities or lived in mountainous areas.[31]

In 2015, roughly 29,600 older people with serious illnesses who were unable to visit health facilities received home-based medical care from health workers in Vietnam.[32] This rose to 50,266 in just the first half of 2016.[33] In some provinces in Vietnam, home-based care projects have been implemented by community (commune) health stations that make use of log books to help monitor and follow up people with chronic



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A community health officer visiting an older person for a check up in Hai Phong, Vietnam

diseases[34] – but home-based services are not otherwise readily available in Vietnam.

8.5 Health information systems and data

The ability to make evidence-based decisions requires timely and quality data. Vietnam has a number of surveys to collect data on ageing and health but there are obstacles in terms of the timeliness, coverage and access to the data produced.

There are some sources of secondary data that can be used for an analysis of universal healthcare (UHC) for older people in Vietnam, but access to this data is challenging. Data from the Vietnam Living Standard Survey, a cross-sectional household survey conducted every two years by the General Statistical Office of Vietnam,[2] could be an important source for UHC analysis, but there is no official data-release policy for public use. Official reports are usually published a year later, and the micro-data, which is not published, can be obtained only by collaborators working with the office on special projects, and only a few years after the official report is published.

The *Joint annual health review 2016* touched on an assessment of health system capacity. It reported that health data has been gathered still primarily through periodic reporting, leading to long delays in access and reporting, and low accuracy.[8] The processing and dissemination of data are still done largely manually. Regulations on replacing the paper-based system by electronic reporting are not yet in place, and information remains fragmented – and difficult to synthesise and manage, with a limited ability to use data for analysis and forecasting. Databases are fragmented and lack interlinkages, and there is no complete set of indicators to evaluate performance against targets set by the national five-year plans or the United Nations Sustainable Development Goals.[8] Nor are there any focal points responsible for collecting and reporting annual monitoring and evaluation data about the implementation of the 'Health Care for the Elderly Project' for the period 2017-2025,[I] which aims for 100 per cent social health insurance coverage of older people; administrative data sources are not readily accessible and regular surveys are not in place. Wider data on the effectiveness, impacts and cost-effectiveness of intervention programmes targeting older people is still not available.

While the latest findings of the Vietnam Living Standard Survey do include data on older people, this data is often reported for a single cohort of people aged 60 years and over, or 65 years and over, and very few indicators are disaggregated for age, sex, disability and other relevant socio-economic indicators.[2] To build a deeper understanding of the health and care needs of older people, specialised surveys on health and ageing are needed – and access to results, and their timely publication, are vital to generating adequate data for policy planning and implementation. Very few such surveys have been completed. The only comprehensive national survey has been the Vietnam aging survey in 2011[18] with the next wave taking place in 2019. Another, the national survey on NCD risk factors (STEPS), was conducted by the Vietnam Ministry of Health with support from the World Health Organization in 2015 – but it had the narrow focus on NCDs and did not collect data on people aged over 69 years.[16]

9. Conclusions

Access to sufficient, good-quality and affordable health services is every person's right. The global commitment to achieve universal health coverage (UHC) for all aims to realise this. But governments in low- and middle-income countries are struggling to ensure this right as they undergo demographic and epidemiological changes.

This report has examined access to UHC for older people in Vietnam, measured progress and gaps in coverage and access, and highlighted the actions required to achieve UHC for older people.

We have seen that overall insurance coverage among the older population has expanded rapidly over the past 12 years, from about 54 per cent in 2006 to 96 per cent in 2018. The government made a commitment to prioritise better access to health for marginalised groups (that is, people with disabilities, people aged 80 and over, those living below the poverty line, and individuals without a family support), as well as for the retired and those with meritorious service. This has been done through the expansion of social health insurance coverage and a recognition, in policy and action plans, of the health-related needs and entitlements of these groups.

Social insurance coverage among the population aged 50 and over grew from 60 per cent in 2010 to 72 per cent in 2014. In-depth analysis of the 2014 secondary data, however, reveals differences in social insurance coverage based on age, education and income. Not unexpectedly, the social protection among people aged 80 and over was high (at 90 per cent), with much lower rates among younger cohorts (for example, 64 per cent and 77 per cent respectively among the cohorts 50 to 59 and 60 to 69).

Additionally, despite the progressive objectives of social health insurance, its coverage was higher among older people with university degrees (at 94 per cent) and those living in high-income households (80 per cent) than among those with only primary education (66 per cent) or in the second-lowest income quintile (65 per cent). This might indicate that some disadvantaged groups are falling through the safety net.

Some people who are not eligible for social insurance may be covered by an employer or voluntarily purchased health protection. However, older people interviewed for this report said that they could not afford to buy insurance themselves, while others decided not to buy coverage due to a lack of awareness of its benefits. In response to these barriers, the local government in Da Nang extended coverage to older people aged 75 to 79 by providing them with health insurance. Such moves strongly depend on local priorities and financial resources, though.

The law in Vietnam obligates families to provide support to older members of the household. Authors of the Vietnam technical report used as the basis for this report identified this as appropriate within the national context. However, several challenges may be associated with this arrangement (family support) if a household also has children who require care, or family members lack knowledge and training on care. The implications are increased burdens on caregivers and households. The data analysed shows that households providing care to an older member of the family are more likely to suffer from catastrophic health expenditure (as defined by the 40 per cent of household income or spending threshold) than households without an older person (with rates at 3.7 per cent and 1.8 per cent respectively). The poorest households with people aged 50 and over are the most at risk (households with an older person in the lowest quintile) – they are more likely to become impoverished than any other income group. As a result of paying for health services, these households are more likely to be pushed into impoverishment and to incur catastrophic costs (at rates of 7.0 per cent and 4.1 per cent respectively).

This report has found that overall access to services for non-communicable disease (NCDs) remains low: 68 per cent of people aged 50 to 69 with NCDs reported not receiving treatment at a health facility. Access varies widely according to specific NCDs: 24 per cent of hypertensive adults did not have a medical registration of their condition, compared with 64 per cent of those with diabetes. Similarly, the prevention rates are low and vary by disease. Among older people with diabetes, only 42 per cent had been screened, compared with an 80 per cent rate for older patients with high blood pressure. This gap can be partly attributed to the fact that diabetes diagnostics and management are not as widely available at a community level as they are for hypertension; older people require a referral to a higher-level facility. Health providers confirmed that each level of health facility is allowed to provide only specific services, medication and expertise. Facilities will not be reimbursed by Vietnam Social Security for services that are outside of their remit.

Vietnam has developed an extensive healthcare network that aims to reach the population at national, provincial, district and community levels. Various arrangements – such as mobile healthcare teams, older people's associations and intergenerational self-help clubs – aim to address some of the gaps in service. Some measures, however, are not sustainable in the long run (donor-supported programmes, for example), and some, such as mobile healthcare teams, are constrained by resources and therefore usually focus on intervention activities such as health education and screening for hypertension. And the diagnosis and treatment of certain conditions such as dementia is limited across the health system.

The findings show that when older people visit a health facility, more than 90 per cent are treated with respect, receive advice and explanation, and find facilities to be adequate in relation to cleanliness and the availability of medical equipment. The satisfaction is higher with services at community health facilities (86 per cent) compared with district hospitals (74 per cent). In contrast, many older people complained about the quality of services at the primary healthcare level in relation to NCDs. This can be attributed to a lack of specialist facilities for the care of older people, since less than 40 per cent of provincial hospitals had a geriatrics department, to the limited training on geriatric care among general physicians and family doctors, and to the lack of a standardised geriatrics curriculum.

Finally, this report has also highlighted a number of inequalities among the older population in relation to access to services. Generally, older people are less likely to be screened and treated for NCDs, and to access medication, if they have low levels of education, live in households in the lowest income quintile or in rural areas, or belong to ethnic minority groups.

10. Actions we can take together

Global AgeWatch Insights identified six building blocks that make a health system fit for purpose in an ageing world.[6] The health system in Vietnam must adapt to achieve universal health coverage (UHC) and to support older people to realise their right to health.

10.1 Leadership and governance

- The Ministry of Health in Vietnam must include older people in health policies, including policies on non-communicable diseases (NCDs), in targets, programmes, and in data gathering and reporting mechanisms. Such inclusion needs to monitor progress for the population aged 70 and over, who are currently excluded from World Health Organization (WHO) data, and needs to include NCD targets and the development of relevant indicators to measure progress on the health status of older people and their access to healthcare.

- Government at the national, provincial and municipal levels must continue efforts to extend social health insurance coverage to all, especially to reach older people with a low level of education or living in households in the second and third lowest income quintiles.

- The Ministry of Health and Vietnam Social Security must develop an appropriate health insurance benefit package that covers diagnostics and management, medication and assistive devices for NCDs across the different levels of health facility.

10.2 Service delivery

- The Ministry of Health and primary healthcare facilities must ensure that basic diagnostic and prescription services for the prevention and treatment of uncomplicated conditions such as hypertension and diabetes are available at district and community levels. Special attention should be paid to diagnosing and managing diabetes among older people with only primary levels of education or who belong to the lowest-income households, ethnic minorities or live in rural areas.

- The Ministry of Health must ensure that mental health services are widely available and target older people.

- Local health providers, with support from civil society and local government, must ensure the regular availability of outreach services, with a special focus on older people being served within their communities, including receiving regular screening for the prevention, early diagnosis and management of NCDs, again targeting older people with only primary-level education, belonging to the lowest-income households, ethnic minorities and residing in rural communities.

10.3 Health information systems

- The Ministry of Health and WHO must remove the upper age cap from the STEPS survey to enable the collection of evidence on prevalence, control and access to NCD treatment among the population aged 70 and over.

- The General Statistical Office of Vietnam needs to enable open access to the latest micro-data to facilitate the production of thematic and in-depth research and to stimulate the reuse of data for good causes.

10.4 Access to essential medicines

- The Ministry of Health and primary healthcare providers must ensure better access to NCD medications, especially for older people with hypertension who live in rural areas, belong to ethnic minority groups or household in the second-lowest income quintile, or with the lowest level of education.

10.5 Financing

- Government at the national, provincial and municipal levels must ensure financial protection from catastrophic health expenditure for households with older people, especially households in the lowest income quintile.

10.6 Health workforce

- The Ministry of Health must develop education programmes on geriatric care for health practitioners (short courses or certificated training).

- The Ministry of Health, with support from academia and civil society, must strengthen regular training on geriatric care among all healthcare workers at district and community levels through reviews of training curricula and on-the-job training.

10.7 Public health information

- Local health providers, in partnership with civil society and academia and with support from local government, must continue with community or public education and sensitisation efforts related to the risks of NCDs and the need for prevention and treatment, with special focus on older people in rural areas, those with low levels of education, and belonging to ethnic minorities groups and households in the lowest income quintile.

Members of an intergenerational self-help club helping to build a volleyball yard for the village in Thanh Hoa, Vietnam

Glossary

Catastrophic health expenditure

Many families worldwide suffer undue financial hardship as a result of receiving the healthcare that they need. One of the issues universal health coverage (UHC) focuses on in this area is: "catastrophic spending on health", which is out-of-pocket spending (without reimbursement by a third party) exceeding a household's ability to pay.[35]

The authors of this report defined catastrophic spending as a household's total out-of-pocket health payments equal to or exceeding 40 per cent of its capacity to pay or of non-subsistence spending.[36] An alternative measure is based on out-of-pocket expenditures exceeding 10 per cent or 25 per cent of household total income or consumption. This is the approach adopted for the monitoring framework of the United Nations Sustainable Development Goals. Across countries, the mean incidence of catastrophic out-of-pocket payments at the 10 per cent threshold is 9.2 per cent. Incidence rates are inevitably lower at the 25 per cent threshold with a mean of 1.8 per cent.

Commune health stations

These are community health facilities delivering most primary care services in Vietnam, especially in rural and mountainous areas. They also take part in outreach through village health workers.[37]

Long-term care and support

Long-term care and support (LTC) refers to the activities undertaken by others to ensure that people with, or at risk of, a significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.[38]

Older people have the right to care and support services for independent living. These should be adapted to their individual needs, promote their wellbeing and maintain their autonomy and independence, without discrimination of any kind.[39]

Near poor

A rural household is defined as near poor if its monthly income per capita is between VND700,000 and VND1,000,000 and the household has access to fewer than three indicators of basic social services. An urban household is defined as near poor if its monthly income per capita is between VND900,000 and VND1,300,000 and the household has access to fewer than three indicators of basic social services.

Universal health coverage

UHC is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.[40]

Older people from an intergenerational self-help club playing games to increase cognitive skills an enhance social interaction in Hai Phong, Vietnam

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Appendix: Methodology

This appendix provides a copy of the authors' methodology section for the technical report on which the present report has been based. The literature, data analysis and qualitative research informing the report were conducted to address the following research questions.

Specific research questions, as set out in the terms of reference for the research

Frameworks, policies, strategies and plans for action

1a. What national frameworks, policies, strategies and plans for action exist to achieve universal health coverage (UHC) for older people in Vietnam (including health promotion, prevention, treatment, and provision of rehabilitation, long-term and palliative care of non-communicable diseases, NCDs)? What are the key contents of these frameworks, policies, strategies and plans for action?

1b. How do these national frameworks, policies, strategies and plans for action address the UHC dimensions of healthcare for older people (that is, population, service and cost coverage)? What services for health promotion, prevention, treatment, and provision of rehabilitation, long-term and palliative care of NCDs are covered by national health plans and what are still not covered?

1c. How do these national frameworks, policies, strategies and plans for action address the problems of inequity in healthcare for older people?

Progress towards equitable UHC for older people in Vietnam

2a. What proportions of the older people in Vietnam are able to access healthcare services when needed?

2b. What services for health promotion, prevention, treatment, rehabilitation, long-term and palliative care of NCDs are being provided to older people by types of service provider (public national, provincial, district and communal providers as well as private providers)?

2c. What are the sources of payment for health services used by older people (health insurance, out-of-pocket payment or others)? What is the level of individual/household expenditure on health, and how affordable are these services? Are older people incurring catastrophic health expenditure and/or being impoverished because of healthcare expenditure?

2d. To what extent are older people satisfied with the health services they receive?

2e. To what extent do inequities in UHC for older people (with regard to all above-mentioned UHC dimensions and service quality) exist in Vietnam (differences across different groups of older people stratified by gender, socio-economic characteristics, age, disability and location)?

2f. What are the enabling factors and barriers to achieving equitable UHC for older people's healthcare in Vietnam?

2g. What actions are being taken by relevant stakeholders (for example, government, healthcare providers, other public sectors, private sector, donors, civil society, academia) to ensure the furthest behind are reached first? What steps or programmes are there to: promote increased access to preventive, diagnostic, treatment management and follow-up services for NCDs; allocate funding and resources; collect new data and evidence to seek out missing older

men and women who are at risk of NCDs or currently have NCDs and to provide targeted services to them?

2h. What is the country progress on Sustainable Development Goal 3.8, the World Health Organization's (WHO) *Global strategy and plan of action on ageing and health (2016-2020)*,* and the national NCD strategy? What is the country progress towards UHC in relation to other countries in the region?

2i. What are the evidence gaps in relation to assessment of UHC for older men and women?

Solutions for improving equitable UHC for older people in Vietnam

3a. What are the suggestions from stakeholders on solutions for improving UHC for older people in Vietnam?

3b. What are the best practices regarding equitable UHC for older people in the Asia region?

3c. What are the feasible solutions to facilitate progress towards equitable UHC for older people in Vietnam?

Research methods

Multiple methods were employed, including literature reviews, secondary data analysis and a qualitative study to answer the above questions.

Literature review

A literature review was conducted to answer the research questions 1a to 1c, 2a to 2i and 3b.

A comprehensive literature review (of both published and grey literature in both English and Vietnamese) was conducted to gather literature on healthcare for older people in Vietnam.

The materials reviewed included relevant frameworks, policies, strategies and plans for action, published scientific journal articles, technical reports, evaluations, case studies, and others.

Both manual and electronic searches were conducted. Hand research was conducted at the national library, and libraries of relevant universities, research institutions and non-governmental organisations in Vietnam. Electronic searches for published papers were done mainly using the PubMed database. Websites and databases of the United Nations, other relevant international and national agencies, and others, were also examined. The WHO *Global strategy and plan of action on ageing and health* (2016-2020), and the national NCD strategy were also reviewed.

The following key terms and their combinations were used: older people, elderly, aging, ageing, universal health coverage, equity, inequity, health seeking behaviour, access, utilisation, effectiveness, health services, non-communicable disease, treatment, prevention, health promotion, prevention, treatment, and provision of rehabilitation, long-term and palliative care, universal, quality, financial protection, patient satisfaction, and Vietnam, Viet Nam.

Secondary data analysis

A secondary data analysis was conducted to answer research questions 2a to 2d and 2h.

A number of national-level data sources were identified and included in the analysis.

The Vietnam Household Living Standards Survey: a biannual cross-sectional household survey conducted by the General Statistical Office

* Geneva, World Health Organization, 2017, www.who.int/ageing/WHO-GSAP-2017.pdf (28 March 2019)

of Vietnam.[†] Heads of household are asked to provide information on variety of topics including:

- health insurance status
- health service use
- household out-of-pocket health expenditure
- other relevant characteristics (such as age, gender, socio-economic status).

Micro data from the Vietnam Household Living Standards Survey was not accessible for 2016. Aggregated figures that are presented in this report are taken from the survey's findings report.

Available micro data for earlier years, 2006-2014, was analysed.

WHO methods for estimation of financial protection were used to analyse catastrophic health expenditure.[‡,§]

The Vietnam NCD risk factors survey (STEPS) 2015:[**] This is a cross-sectional survey, conducted among 3,856 Vietnamese aged 18-69 years across all 63 provinces of Vietnam in 2015. Data was analysed for people aged 50 or over on selected NCDs and NCD risk factors, such as hypertension, diabetes, drinking, access to health services, and other relevant characteristics such as age, gender, socio-economic status.

The Vietnam district and commune health facility survey 2015:[††] The survey was conducted by the Health Strategy and Policy Institute of the Ministry of Health in partnership with the World Bank across six provinces in six regions. Information was collected from commune health stations and district hospitals as well as patients who use those facilities. Topics included the availability of key inputs (infrastructure and medicines) at the facility, patient experiences, the qualifications and experience of doctors, the knowledge of doctors, and the actual practice of doctors. Data was analysed for patients aged 50 and over and those under 50.

Qualitative study

Qualitative data was collected from 60 key informants and 46 older persons to address the research questions 1b to 3a. Short questionnaires were designed for each stakeholder group. The interviews were conducted in Vietnamese. The information was transcribed and later translated into English by a member of the research team.

Key informant interviews

Key informant interviews were conducted to better understand policy gaps on UHC, enabling factors and barriers to achieve UHC for older people, and actions taken by stakeholders to deliver equitable access to UHC for older people. Key informant interviews were administered at a national level and in three provinces from three regions of Vietnam: Hai Duong (north), Da Nang (central) and Dong Thap (south). In each of the

† General Statistics Office of Vietnam, *Vietnam Living Standard Surveys*, Hanoi, General Statistics Office of Vietnam, www.gso.gov.vn/default_en.aspx?tabid=483 (20 February 2019)

‡ Xu K et al, 'Household catastrophic health expenditure: a multicountry analysis', *The Lancet* 362:9378, 2003, pp.111-117, doi: 10.1016/S0140-6736(03)13861-5

§ Xu K, *Distribution of health payments and catastrophic expenditures methodology*, Geneva, World Health Organization, 2005, https://apps.who.int/iris/handle/10665/69030 (20 February 2019)

** General Department of Preventive Medicine, *National survey on the risk factors of non-communicable diseases (STEPS): Viet Nam, 2015*, Hanoi, Vietnam Ministry of Health, 2016, www.who.int/ncds/surveillance/steps/VietNam_2015_STEPS_Report.pdf (18 February 2019)

†† World Bank Group and Health Strategy and Policy Institute (HSPI) of the Vietnam Ministry of Health, *Quality and equity in basic health care services in Vietnam: findings from the 2015 Vietnam – district and commune health facility survey 2015* (report number AUS13083), Washington, World Bank Group, 2016, http://microdata.worldbank.org/index.php/catalog/2728 (20 February 2019)

three provinces, two districts (one urban and one rural) were selected, where typical urban and a rural commune wards were selected.

Respondents included representatives from key health system stakeholders across different levels of the system. They were selected and invited for an interview using a purposive sampling method.

The following is the list of institutions represented in the in-depth interviews:

National

- Medical Service Administration of the Ministry of Health (MoH)
- Planning Department of MoH
- Preventive Medicine Administration of MoH
- Vietnam Social Security
- National Geriatrics Hospital
- UNFPA
- Vietnam Elderly Association
- WHO

Provincial/city

- Provincial/City Department of Health
- Provincial/City Centre for Preventive Medicine
- Provincial/City Hospital
- Elderly Association

District

- District Health Centre
- District Hospitals
- Elderly Association
- Social Insurance Office

Community

- Commune Health Station
- Village Health Worker
- Elderly Association.

Focus group discussions with older people

Focus group discussions were organised to capture the experiences of older people in relation to the use of health and care services. Evidence and case studies were collected on quality of health services and the right to health of marginalised groups.

In each of the three provinces (Hai Duong, Da Nang and Dong Thap), two focus group discussions were held. The number of interviewed older people was 15 in Hai Duong, 16 in Da Nang and 15 in Dong Thap.

This older person used a loan from an intergenerational self-help club to invest in a duck-raising model in Hai Duong, Vietnam

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