JOINT ANNUAL HEALTH REVIEW 2016
Towards healthy aging in Vietnam

Executive summary

The Joint Annual Health Review 2016 is the 10th annual review implemented in a collaboration between the Ministry of Health (MOH) and the Health Partnership Group (HPG). The contents of the report this year aim to update the status of implementing the Five-year plan (2016 - 2020) and results of implementing the tasks of the 2016 Health sector plan following the structure of health system building blocks. In addition, the review focuses on in-depth analysis of the topic "Towards healthy aging in Vietnam" The report contains two parts with eight chapters.

PART ONE. UPDATE ON THE HEALTH SYSTEM

Chapter I. Health system management and health information systems

1. Implementation results

Reform health system organization reform: The decree on functions, tasks, authority and organizational structure of the MOH in the new term was drafted. The MOH issued and implemented circulars guiding functions, tasks, authority and organizational structure of the local health system (provincial health department, district health office, provincial and district health centers (DHC) and commune health stations (CHS)). The Centers for Disease Control (CDC) model in the provincial level and the dual function DHC (curative and preventive care), which is also responsible for management of CHS activities, were implemented.

Refine health sector legislation and regulations: The National Assembly passed the new Pharmaceutical Law while laws on blood and stem cells, population and alcohol control are being formulated. The Government issued 11 decrees and the MOH issued 18 circulars in various fields. The MOH is complying with regulations on issuing legal and regulatory documents, applying evidence-informed policy making and gathering feedback and comments to serve reforms.

Promote administrative procedure reforms and IT applications: The MOH has applied the TCVN 9001:2008 quality management system for managing documents on-line; has simplified 221/225 administrative procedures (98.2%); allows 100% of public administrative procedures to be performed on-line at level 2, with 37 services at level 4. From 30 June 2016, the information systems for health insurance claims processing were linked to the entire curative care system. The MOH Public Administrative Reform Index in 2015 improved notably, from 73.55 to 86.58 points, moving the MOH from 17th to 8th rank among government agencies.

Strengthen health sector inspections: The health sector has implemented the project to improve capacity of the health inspectorate to the year 2020 and issued 4 inspection procedures for food safety inspection. Inspectors in provinces and units have received

professional training. Inspection and checking teams have been organized to detect and deal with violations in food safety and curative care in a timely manner.

Enhance international cooperation, and global health sector integration. The MOH is implementing 34 ODA programs and projects; among these 17 are grants amounting to 1.53 billion USD. Vietnam is actively contributing to development of global and regional policies in the health sector in multi-lateral forums such as WHO, APEC, and ASEAN.

Consolidate the health information system: The MOH has implemented measures in the Statistical Law on information gathering and administrative data on the health sector. Information and statistical data dissemination is becoming diversified. The MOH has issued the Action plan and Plan for application and development of information technology in the health sector for the period 2016–2020.

2. Difficulties and shortcomings

Health sector organization: There is no national health sector development master plan. Provincial level CDCs lack regulations on their functions, tasks and activities. No detailed regulations are available on organizational arrangements, physical facilities, human resources, operational and financial mechanisms to serve reforms in health facility organization and operations.

Policy making: The participation of stakeholders for implementing policies remains limited; there is inadequate response to comments and feedback on policy drafts. Some policies face implementation difficulties due to lack of regulatory impact assessment to work out problems during policy formulation. Seven out of 105 tasks assigned to the health sector during the period January to October 2016 were late compared to the deadline.

Administrative reforms and information technology (IT) application: Many medical facilities are not using IT tools or are using many different systems on different platforms. There is not yet a system for integration, archiving and interoperability for patient databases and electronic patient records among medical facilities. The uniform code lists continue to change and contain inconsistencies.

Health sector inspections: The scope and need for inspections is substantial while the number and capacity of inspectors remain limited. The participation of local authorities and intersectoral collaboration in inspections in some localities are not yet effective.

International cooperation and integration: The pace of implementing some ODA projects is slow, with low disbursement rates due to inconsistencies in regulations, procedures, and guidelines for implementation. Activities of technical working groups are irregular, with limited sharing of information and coordination of resources.

Health information system: Statistical data are still primarily gathered through periodic reporting, leading to long delays and low accuracy. Processing and dissemination of data are still largely done manually. Information remains fragmented, and difficult to synthesize and manage. There is limited ability to use data for analysis and forecasting. Regulations on replacing the paper-based system by electronic reporting are not yet in place.

3. Priority issues

- Lack of national master plan for health system development; lack of detailed guidelines for reforming the organization and activities of health facilities, particularly the CDCs.

- Still limited role of important stakeholders in policy formulation; mechanisms to respond to feedback lacks timeliness and transparency; and regulatory impact assessments not being performed adequately.
- Lack of an IT platform and stable and scientific common set of codes to serve as a basis for data integration for management of curative care and ensuring effective use of the health insurance fund.
- Number and capacity of specialized health inspectors insufficient for implementing their tasks; intersectoral collaboration in inspections remains weak.
- Impediments in regulations and administrative procedures adversely affect the pace of implementing ODA projects. Technical working group activities are not meeting their potential.
- Data gathering and processing is still largely done manually; databases are fragmented and lack interlinkages. Lack of regulations on replacing paper with electronic records. Lack of a complete set of indicators to evaluate performance on Five-year plan targets and sustainable development goals (SDGs).

4. Recommendations

- An updated health system master plan, CDC guidelines and models, and health facility staffing norms should be developed and issued promptly by the MOH.
- Issue and implement a transparent feedback mechanism to respond to comments during policy formulation; implement regulatory impact assessments as a standard operating procedure for all policies; ensure they are done objectively and independently.
- Complete a common and scientific set of codes and develop a unified IT platform for the database integration center of curative care facilities.
- Strengthen communication (IEC) on inspection policies; strengthen training to improve quality of health inspectors; inspect actively and deal strictly with violations.
- Strengthen monitoring and supervision of activities of international cooperation projects in order to promptly detect and find solutions to resolve any impediments to implementation as they arise. Review TORs and strengthen the cooperation mechanism for technical working groups.
- Issue a concrete plan for implementing the Statistical Law in the field of health. Develop an information portal that integrates electronic data centrally at the MOH. Promptly issue regulations on use of electronic reports and databases to replace paper-based systems.

Chapter II: Inputs to health service delivery

1. Implementation results

1.1. Strengthen quality of training; improve service style and attitude of health workers

Undertake fundamental and comprehensive reforms for health worker training. Vietnam has developed a reform model for training health workers with research and practice tracks, which are appropriate with the national education system structural framework and national qualifications framework. The MOH is implementing the HPET project in order to reform pre-service medical training for doctors and nurses.

Develop standards to ensure health worker training quality. The MOH has recently issued basic competency standards for dentists and is building standards for other professionals including in public health and pharmaceuticals. The MOH is in the process of auditing and standardizing 25 continuing medical education (CME) curricula and related training materials, and is providing training to trainers. A decree on organization of practical training in the health sciences has been drafted. The MOH has collaborated with the Ministry of Education and Training (MOET) in health worker training quality management, including development of standards for instructors and practical training facilities inside and outside of training establishments.

Develop a health workforce of adequate size, appropriate structure and sufficient capacity and qualifications to implement their tasks. The MOH has implemented a Project on work positions in each government facility. Standardized regulations are being developed on job appointments and promotions for facility leaders and government health workers.

Reform the service style and attitude of health workers towards satisfying patients and creating an initial transformation in medical facilities. The health sector has strengthened monitoring in hospitals and independent evaluation of performance in different facilities. The results show that a positive transformation is taking place in many aspects, from the leadership to health workers and even to patients.

1.2. Reform policies on medical service prices, and financial autonomy; implement the roadmap towards universal health insurance

The roadmap for new medical service prices following Circular 37/2015 is being implemented in 3 phases with 36 fully autonomous hospitals and 441 private facilities in 32 provinces implementing service prices incorporating 5/7 cost components (including payroll) into new service prices, expanding further to national coverage in 2017. *Autonomy and accountability mechanisms in public health service facilities have been implemented*. A new draft decree on autonomy of public health service units in the health sector, including a proposal for a government hospital management board model has been submitted to the Government for consideration. *Further steps to implement the universal health insurance roadmap*. By December 2016, 81.7% of the population was covered by social health insurance, exceeding the National Assembly Target (76%) and the target set for 2020 (80%). Health insurance gatekeeping arrangements at the commune level and among district hospitals were eliminated to give patients more choice. The number of district medical care contacts increased 14.8% while commune medical care contacts fell 12.9%. Average costs per medical visit at the commune and district levels increased substantially (51.4% at commune and 34.2% at district levels). Arrangements were made to incorporate payment for TB and HIV/AIDS into the health insurance mechanism. A draft decree guiding implementation of some articles of the revised Health Insurance Law was developed and a circular on the basic service package to be paid by health insurance was issued in 2017. *Effectiveness in use of health financing resources has been strengthened*. Circular 35/2016/TT-BYT on conditions for payment of technical medical services by health insurance was issued. Capitation, diagnostic-related groups (DRG) payment policies continue to be refined and piloted, while data from Ninh Binh (DRG pilot province) are being standardized, coders are being trained and surveillance instruments are being developed. *Social mobilization for health, and public private partnerships (PPP) have been encouraged*. Nine service providers have signed contracts for loans in the amount of 1.944 trillion VND and taken

on the responsibility to pay back both principal and interest. Some 810 joint ventures and partnership arrangements for medical equipment have been implemented, with total capital of 3.882 trillion VND. A circular on organization of services and medical service prices for higher amenity services at public medical facilities has been drafted. *The health financing information system has improved*. The MOH has issued data output indicators for software to manage medical facilities and a fourth version of common code lists. Data have been linked between medical facilities and data portals of Vietnam Social Security (VSS) from 1 July 2016. National Health Accounts (NHA) were produced from 1998 - 2013; a plan has been approved for producing NHA for the period 2015 - 2020, and 5 pilot provinces have been instructed to produce provincial health accounts.

1.3. Implement the 2016 Pharmaceutical Law

The regulatory system continues to be refined. The Government has issued Decree 54/2017/ND-CP guiding implementation of the Pharmaceutical Law and Decree 65/2017/ND-CP on special policy for seedstock, capital and technology to develop cultivation and exploitation of medicinal ingredients. *Sufficient supply of drugs has been assured*. Vietnam can produce almost all generic dosage forms of drugs; Vietnam produces 10/12 vaccines in the expanded program on immunization (EPI). Drugs produced domestically account for 36% of value and 74% of volume, ensuring about 50% of demand. The number of drug registrations for imported drugs is about the same as for domestically produced, but with double the number of active ingredients. The pharmaceutical supply network includes 40 thousand retailers and more than 2000 wholesalers. *Drug price management*. The pharmaceutical market is basically stable, without any major or irrational fluctuations in drug prices that could adversely affect health care for the population. The MOH has issued circulars (09/2016/TT-BYT and 10/2016/TT-BYT) to guide strengthening of competitive tendering for drug procurement in hospitals. *Drug quality management measures are being implemented*. The Drug Administration of Vietnam (DAV) has strengthened verification for issuing good practice (GMP) certificates. Cooperation and technology transfer have been promoted to continuously improve manufacturing technology and pharmaceutical preparation techniques. The DAV has updated and published lists of foreign manufacturing facilities whose drugs have violated quality standards and taken samples from 100% of their import shipments. Drug ingredients are being checked for quality control. *Safe and rational use of drugs*. Prescription drugs are being managed and a draft new list of non-prescription drugs is being developed. Adverse drug reactions (ADRs) are being monitored. Strong IEC on antibiotic resistance is being implemented. *Vaccine safety*. Vietnam is checking, certifying and monitoring vaccine production in domestic production facilities; vaccines that do not meet quality standards are being recalled. Vietnam has successfully produced the measles-rubella vaccine and has introduced, it into the EPI starting in 2017.

1.4. Reform medical equipment management and invest in infrastructure at the grassroots level

Infrastructure continues to receive investment: Efforts have been focused on central and tertiary hospitals to build new facilities outside of the central city and to build multi-story hospitals. Vietnam is implementing the Project to Build and Develop the Grassroots Health Network in the New Situation. *Medical waste treatment systems are being put into operation*: About 54.4% of hospitals have waste treatment facilities; over 95% of hospitals implement daily sorting and treatment of hazardous medical waste. *Management of medical*

equipment has been strengthened: Decree 36/2016/ND-CP on equipment management was issued and circulars are being developed to implement the decree. *Health technology assessment (HTA) performed*: The investment and use of some high cost medical imaging services are being evaluated. Medical equipment is being maintained and calibrated: technicians have been trained, equipment maintenance costs are being incorporated into the medical service user fees and new standards for medical equipment have been issued.

2. Difficulties and shortcomings

Human resources: Health worker training quality does not yet meet requirements. Education quality accreditation has not yet been implemented, and standards for graduates are not yet being used to manage training quality. Remuneration of health workers is still unreasonable (particularly starting salary and seniority raises). No sustainable policy is in place to attract health workers to disadvantaged areas. Distribution of health workers is imbalanced and quality varies across regions and facility levels. The quality of health human resources remains limited, especially at the grassroots level. Implementation of regulations to shift all junior college and secondary medical training to state management by MOLISA is causing major disruptions for students and training facilities. Collaboration with the MOET in directing the administration of health worker training that takes into account the special nature of this training has not yet been effective.

Health financing: Growth in state health spending has not been maintained: state budget allocations for national target programs (NTP) in health have been cut and funds have not been allocated for implementing the Project to Build and Develop the Grassroots Health Network. Expansion of health insurance coverage to informal sector workers is still facing difficulties. Strategic purchasing by the health insurance fund remains limited due to delays in reforming the contracting mechanism, quality control, determining the basic insurance service package and reforming payment methods. Medical service costs are escalating due to over servicing of unnecessary items by providers and overuse by insured users. Provider payments remain primarily fee-for-service, while new methods are not yet applied widely. A model for public hospital management appropriate with hospital autonomy policy has not yet been determined. Although out-of-pocket health spending is increasing, GDP is growing rapidly and government and health insurance spending are accounting for growing shares of total health expenditure, reducing the financial burden on households.

Drug and vaccine management: No mechanism for regular and effective drug price surveillance has yet been put in place. Pharmaceutical use does not yet ensure safety and rationality; antibiotics are being over-prescribed and over-used. Prescription drug sales without prescriptions are widespread while ADR reporting remains weak. Management of the quality of western pharmaceuticals, traditional medicinals, biologicals and blood services are not yet uniform and consistent.

Medical infrastructure and equipment: Funds for investing in grassroots health infrastructure are insufficient. Management of medical waste has shortcomings: some medical facilities continue to cause severe pollution, and there is a lack of funds for investing in waste treatment infrastructure, maintenance of operations and monitoring of compliance. Medical equipment management remains limited: HTA is not yet widely used, cost-effectiveness in high tech medical equipment is not being applied. Lists of

equipment and technical standards are not regularly updated, and there is no database system for equipment management while quality control of medical equipment is weak.

3. Priority issues

- Training quality does not yet meet requirements. Health worker competencies, particularly at the grassroots level are limited. Remuneration is inappropriate and fails to provide effective motivation or incentives.
- Growth in state budget investment for health and expanding health insurance coverage to the informal sector are facing difficulties; out-of-pocket spending of the population is likely to rise as medical service prices are raised.
- There are substantial impediments to implementing strategic purchasing and cost controls by the health insurance fund and implementing new provider payment mechanisms.
- An appropriate model for public hospital management to control cost escalation while implementing hospital autonomy has not yet been determined.
- A mechanism for regular and effective monitoring of drug prices is not yet in place. Drug use does not yet ensure safety and rational use, particularly for antibiotics.
- Funds for investment in grassroots health infrastructure are insufficient. Management of investment, operation and monitoring of medical waste treatment has been weak. Management of investment and use of medical equipment has not improved efficiency.

4. Recommendations

- Reform training curricula and apply medical education quality accreditation and output standards in managing training quality.
- Strengthen CME, training in place for health workers at the grassroots level appropriate with their competency needs, case mix and nature of their work.
- Reform the health worker training model following the national qualifications framework together with remuneration commensurate with qualifications of health workers. Study to develop financing mechanisms to attract and motivate health workers at the grassroots level.
- Strengthen IEC, simplify procedures for enrolling in health insurance, expand the value of benefits for insured individuals through increased service prices following the roadmap for full cost recovery.
- Develop a project to implement strategic purchasing by the health insurance fund; strengthen application of IT in management of medical services and health insurance reimbursement, control cost escalation of insurance reimbursements by reducing over-servicing by providers and excess demand from users. Expand implementation of capitation and DRG payments.
- Promptly issue a new decree on autonomy of public medical service units, pilot and draw experience from a hospital management board model.
- Guide and implement regulations on competitive tendering and price negotiation for pharmaceutical procurement along with centralized procurement. Develop a drug purchasing center and centralized procurement system.

- Strengthen IEC, combined with strengthened inspections and checking on drug prescriptions and use of antibiotics at health facilities and in the community. Strengthen monitoring activities and reporting on ADRs and errors in use of medicines.
- Increase state budget investment in developing infrastructure at the grassroots level; strengthen social mobilization for investments in physical infrastructure and equipment for provincial and central hospitals.
- Continue to control medical waste treatment, particularly in polluting facilities; monitor design and implementation of medical waste treatment in newly constructed facilities.
- Implement HTA when investing in expensive high tech medical equipment, control use and monitor quality and safety in use of medical equipment.

Chapter III: Healthcare service delivery

1. Implementation results

1.1. Preventive medicine

Prevent and control communicable disease: Communicable diseases have been actively surveilled, prevented and controlled across the nation, particularly dengue fever and Zika virus. Disease outbreaks have been halted, detected and controlled in a timely manner, preventing any large epidemics from occurring. The incidence and mortality from communicable diseases has fallen compared to 2015: 27.8% reduction in typhoid, 11.2% reduction in viral encephalitis, 16.8% reduction in hand-foot-mouth disease; 28% reduction in deaths from dengue and 80% reduction in deaths from hand-foot-mouth disease

EPI: Vietnam continues to maintain over 90% rate of full immunization in children. Vietnam is starting to use the bivalent polio vaccine (bOPV) following WHO advice since May 2016. A campaign for measles-rubella booster vaccine for 1.8 million people aged 16 - 17 years (94.9%) was implemented, polio vaccine was applied to 95.3% of children under age 5 in 120 at-risk districts in 19 provinces. Auditing and certification of full conditions for immunization was implemented in 96% of facilities; post-immunization adverse reactions were monitored, registered and reported. The incidence of measles fell 8-fold compared to 2015.

HIV, TB and malaria prevention and control: *HIV/AIDS prevention and control network expanded, capacity and access improved.* Services are provided in 63 provinces with 110 laboratories certified for confirming HIV infection (5 new facilities in 2016), 385 facilities are providing ARV treatment (111 700 patients), 275 facilities provide methadone replacement therapy (50 800 clients). A model for counselling and testing in the community is being piloted in 5 provinces. In the first 6 months of 2016, counselling and testing for HIV was provided to 985 000 people (0.9% detected as HIV+). Among pregnant women, 618 500 were tested for HIV (563 found HIV+), and ARV was provided to 873 pregnant women. ARV prevention was provided for 764 children and Co-trimoxazole prevention for 425 children. *Health insurance support for people living with HIV was implemented*. ARV treatment will be reimbursed by the health insurance fund starting in 2018; 35% of

hospitals/health centers have supplementary contracts with VSS for patients living with HIV. *Almost all HIV/AIDS prevention and control targets have been reached in 2016*: Prevalence of HIV in the community (< 0.3%), proportion of people aged 15 - 49 with full understanding of HIV/AIDS (80%), and the proportion of people living with HIV meeting criteria for treatment who receive ARV (80%). *TB and malaria prevention and control*: Screening and diagnosis of TB in HIV/AIDS patients is being implemented in nearly all ARV treatment facilities; patients with HIV and TB comorbidity are being managed, and INH preventive treatment is being applied. Activities were implemented to celebrate "the World day for malaria prevention", malaria monitoring, prevention and control activities have been strengthened.

Non-communicable disease (NCD) prevention and control: A diabetes prevention and control information campaign was implemented. The STEPS survey on risk factors for NCDs was implemented, data analyzed and a report written. Training materials on prevention and management of NCDs in the community were developed; NCD statistical reporting forms were drafted. A report providing an update on performance implementing the national policy on prevention and harm of alcohol use was completed; the draft Law on Alcohol Control continues to be refined and sent out for comments and feedback.

Other preventive medicine services: Food safety and hygiene training and IEC activities have been strengthened. Specialized food safety inspections are being piloted. Inspections and prevention have been strengthened. Timely warnings of food safety risks have been provided, food safety incidents have been effectively and rapidly resolved. Food poisoning has been controlled, with incidents falling 32.6% and number of people affected falling 20% compared to 2015. Collaboration has taken place in surveillance, control, monitoring, and evaluation of the food safety of seafood in Central regions. An environmental monitoring outline was appraised in 2016 for four central level institutes. A survey and response plan were implemented in relation to health effects associated with drought, salinization in focal provinces. Medical waste management and use of household disinfectants and insecticides have been checked and monitored. Health environmental impact assessments of hospital construction and renovation projects were implemented. National technical standards, IEC, training, checking, monitoring systems were developed in the field of occupational safety and health.

1.2. Grassroots health care, primary care and national health target programs

Strengthen grassroots health care: *Integrate family practice principles into CHS and regional polyclinic service provision*. By June 2016, 336 family practices were established in 8 provinces; 195 245 health records were set up; 500 919 people were screened and 246 049 medical conditions were detected, while 3600 cases were referred for care. *Rotate medical doctors to work in the CHS*: district hospital and health center doctors were sent on rotations to the CHS while CHS doctors were sent to the district hospitals on a rotation to contribute to improving their professional capacity.

Military-civilian health cooperation: The Ministry of Defense collaborated with the MOH to implement military civilian self-protection, national defense and security education in the health sector; The military-civilian health committees in the provinces organized strengthening of grassroots health care, strengthening of medical service capacity of military-civilian medical facilities.

Maritime health development: A medium term investment policy (2016 - 2020) was completed. A telemedicine system linking district military-civilian medical center on Bach Long Vi island was implemented. A national steering committee for maritime health was set up and a seminar organized.

1.3. Provision of medical services and rehabilitation

Strengthen capacity for medical service provision, reduce overcrowding of higher level hospitals: *The satellite hospital* network was expanded to 63 provinces with 22 hub hospitals and 98 satellites. *Technology* transfer was organized through mentoring and rotations; IT was applied to support training, advising and technology transfers. Some 386 training and technology transfer courses were organized for 7051 health workers in satellite hospitals. The share of medical service techniques implemented in satellite hospitals has increased through technology transfer, reducing specialist referrals in 37.5% of satellite hospitals; the referral rates have fallen 73% to 99% depending on the specialty. *Infrastructure development and capacity to provide medical services continue to receive investments*. The pace of investments including procurement of medical equipment and development of 5 central and tertiary hospitals has accelerated. In the period 2012 - 2015, 119 new hospitals were built/rebuilt; 1839 departments and offices were renovated or rebuilt adding 5129 patient rooms and examination tables. *The number of beds and services delivered have increased*. The number of beds per 10 000 population has reached 25.0 (target was 24.5); among those, private sector achieved 1.5 beds per 10 000 population. Targets for medical service delivery such as the number of examinations, number of inpatient admissions, outpatient examinations, number of inpatient days, number of surgeries and procedures have all increased compared to 2015. *Improve the medical delivery process*. For outpatient care, the medical examination process has been reduced from 12 - 14 steps to only 4 - 8 steps depending on the type of examination, with a reduction on average of 48.5 minutes per examination, saving 27.2 million working days per year for society. In the inpatient sector, 58% of central hospitals and 47% of provincial hospitals that previously had patients doubling up in beds have reduced the proportion of wards with patients doubling up.

Medical service quality improvement: *Medical service provision processes have improved*. Hospitals continue to improve their outpatient examination clinics and expand hours of operation, improve the fee collection and hospital reimbursement processes to improve quality of services. Average hospital quality score for 83 criteria used at the end of 2015 and the beginning of 2016 was 2.8/5 points, an improvement over 2013 and 2014. *Reform the service style and attituded*. According to an HSPI evaluation, 71% of patients reported that health worker instructions and attitude have become more friendly; over 61% of patients registered improvement in physical infrastructure, reception, reduced waiting time; 87.7% of patients were satisfied with hospital medical services. *Laboratory testing service quality has improved*. The capacity of 3 national laboratory quality control centers has been strengthened; technical assistance was provided to 5 provincial and central hospitals to reach ISO standards, to create a national reference laboratory network. Training on laboratory quality management has been organized for more than 2000 staff. External verification activities have been strengthened with the participation of 3839 laboratories, double the number in 2014 and 10 times higher than in 2010. *Medical professional management coverage has increased*, with 45 975 medical facilities issued

licenses (94.7%) and 309 768 health workers issued practice certification (96.17%). An increase in medical care service inspection has occurred, with 5707 missions covering 11 354 facilities.

Establish and improve the referral mechanism and health insurance reimbursement: Implementation of patient enrollment, referrals and removal of the gatekeeping system for insured patients have opened up more choices for patients to access medical services. An overall architectural model and database output indicators have been developed for the medical services management software with a set of common uniform codes aimed at more comprehensive management and precision in patient information and convenience for health insurance reimbursement of medical services. Currently about 99.5% of medical facilities nationally are linked with the VSS computerized claims processing information system. The MOH is collaborating with the VSS for supervision of health insurance use and reimbursements to avoid fraud in use of the health insurance fund.

Encourage private health sector development: The MOH has set up a public private partnership (PPP) working group and is reviewing the possibility of setting up a PPP steering committee; a circular on PPP in the health sector has been drafted. Many PPP projects have received investments and are operating successfully such as: Phu Tho provincial hospital (500/1300 hospitals are funded through social mobilization); Dong Nai general hospital (500/1000 beds are funded through social mobilization). Through this mechanism, hospitals are able to acquire more infrastructure, physical facilities and modern medical equipment and to expand the number of medical technologies they apply.

Develop highly specialized medical services, apply high technology in medical services: Vietnam is implementing advanced medical technologies such as organ transplant, stem cell therapies, and laparoscopic surgeries. By September 2016, nationwide 1281 kidney transplants, 54 liver transplants and 16 heart transplants had been performed. In 2016, the health sector received 3 Ho Chi Minh prizes, 1 government prize on science and technology and 3 Vietnamese talent prizes.

1.4. Traditional medicine services

Some 57/63 provincial people's committees have approved plans for developing traditional medicine in their localities; 41 traditional medicine hospitals have registered investment projects for the medium term (2016 - 2020). The traditional medicine network has expanded with 63 public traditional medicine hospitals (58 at provincial level), and 3 private hospitals; 92.7% of general hospitals have a traditional medicine department or cluster (increased 2.7% compared to 2015); 84.8% of CHS have organized traditional medicine services (increased 10.5% compared to 2015). The share of patients receiving treatment using traditional medicine reached 4.1% at central facilities, 11.7% at provincial facilities, 13.4% at district facilities and 28.5% at the commune level. The quality of traditional medicine services has increased gradually through management of traditional medicine practice and quality control on medicinals.

1.5. Population, family planning (FP), reproductive health (RH) and maternal and child health (MCH) services

Population and FP services: Vietnam continues to implement projects to improve quality of population. The project to control imbalance in the sex ratio for the period 2016 - 2025 being prepared for implementation. Community-based health care for older

persons in the community is being implemented, a program for cooperation with WHO on care of older persons is being developed, the Health Care for the Elderly Project, 2017 - 2025 is being implemented. Activities for behavior change communication (BCC) on population and FP are being effectively implemented. Logistics for FP services are being assured through diversification of contraceptive methods and expansion of service provision models. Inspections and monitoring to detect violations in fetal sex selection are being implemented. Electronic database, management software and data storage on population and FP continues to be refined, updated and upgraded. Almost all population and FP targets have been achieved or exceeded such as total fertility rate (2.09 children per woman) and crude birth rate (15.74‰).

RH and MCH services: The action plan for prevention and control of cervical cancer is being implemented. The MOH is guiding and collaborating on measures to prevent and control Zika in pregnant women. Measures to limit obstetric complications in medical facilities are being strengthened. A maternal mortality audit was implemented in 2014 - 2015. Training has been implemented to strengthen capacity of health workers at all levels for implementing professional tasks in RH and MCH. The health sector is providing guidance and surveillance on the organization of assisted reproduction and surrogate motherhood for humanitarian reasons in 3 central hospitals (200 cases have been approved and 30 children already born). Many targets have been achieved for 2016: The malnutrition rate (underweight) in children under age five has fallen to 13.5%; the proportion of women with at least 3 antenatal visits reached over 90%, the proportion of women who were assisted at birth by a trained assistant reached 98%.

2. Difficulties and shortcomings

2.1. Preventive medicine services

Endemic communicable diseases such as dengue fever, hand-food-mouth disease continue to have high incidence and there is a latent risk of outbreaks. Newly emerging diseases (Zika, MERS-CoV, H7N9 influenza) present a threat of major pandemics if they enter Vietnam.

EPI is still facing many difficulties. The full immunization rate in many localities in the northern mountains was less than 50%; hepatitis B vaccination in the first 24 hours of life reached less than 70%. The preference for private vaccinations, combined with delays in obtaining imported supplies led to incomplete or delayed vaccination of children, increasing the risk of disease or epidemics. *Communicable diseases in the EPI (measles, diphtheria, pertussis, hepatitis B) could re-emerge* due to a high cumulative number of susceptible children who have not been vaccinated, or are incompletely vaccinated. In 2016, an outbreak of pertussis and diphtheria occurred in some localities like Cao Bang, Binh Phuoc and Quang Nam provinces.

HIV, TB and malaria prevention and control: The level of reduction in the HIV/AIDS epidemic is shallow and unstable, while the epidemiologic patterns are complicated, making it difficult to design interventions. Access and use of HIV/AIDS prevention and control services face difficulties in terms of number and quality. Sustainability is not guaranteed due to state budget cost cutting, while only 40% of people living with HIV have health insurance. Integration and collaboration between HIV/AIDS, TB, and RH activities are weak, reducing effectiveness of activities in the context of limited

resources. The indicator on the proportion of children who were infected with HIV from their mothers was 2.96%, not yet meeting the goal set for 2016 (below 2%). Control of resistance to ARV, and drugs for treatment of TB and malaria is a major problem due to low compliance with treatment regimes, and ineffective supervision.

NCD control and prevention: Investments in NCD prevention and control are disproportionately small compared to the burden of disease and need for health care services. The capacity of the health system, especially at the grassroots level of prevention, screening for early detection and management of NCDs remains limited. There is a lack of linkage between prevention and treatment, between levels in the hierarchy, constraining the capacity for continuous, comprehensive care for NCDs. Control of behavioral NCD risk factors remains ineffective.

Other preventive medicine services: Food safety violations in production, processing and sales of food remain widespread, increasing risk of food poisoning incidents. The capacity of the food safety management network is limited; intersectoral collaboration remains ineffective; sanctions are insufficiently strong. Food poisoning remains complicated, difficult to control, especially in the family and in industrial zones and street food vendors. The risk of environmental pollution is high due to the effects of industrialization, climate change, particularly drought, salinization and flooding and cyclones, which are intensifying and hard to forecast, while investments have been very modest. The coastal environmental disaster in the Central Region continues to pose challenges in coordination of surveillance, management and environmental treatment. Community awareness and attention towards investments in localities to achieve environmental sanitation, waste management, prevention of occupational disease and accidents remain limited.

2.2. Primary health care (PHC), grassroots health care

Investments and resource allocations for the Project to Build and Develop the Grassroots Health Network, national health target programs, military medical cooperation and maritime health are facing difficulties and not yet meeting needs. Capacity and quality of service delivery of the grassroots level remain limited, especially health management, detection and treatment of disease and common illnesses, particularly in mountainous, highland, border and maritime areas. There are inadequate professional guidelines and policy mechanisms to support service delivery of the family medicine model in different types of facilities.

2.3. Medical examination and treatment, rehabilitation

Organization of the network and operational mechanism of health facilities does not yet ensure comprehensiveness, continuity or quality of services. Overcrowding in higher level hospitals, especially tertiary specialist hospitals has not noticeably improved. The service quality management system is incomplete, lacking sanctions to support and encourage quality service provision. The quality of medical services has many shortcomings that need to be improved, both in terms of organization of provision, administrative procedures, and professional activities. Development of the private health care network has not met its potential. Quality management of private health services faces many difficulties. Capacity of health workers, particularly at the grassroots level, does not yet meet requirements for health care of older persons in the context of rapid population aging. Rehabilitation services have not met their potential or exploited their strength.

2.4. Traditional medicine services

Vietnam is still dependent on imports of medicinal materials for traditional medicine. The capacity for quality control is limited and quality of medicinal materials and traditional medicine has not yet been controlled effectively. Adoption of traditional medicine techniques in medical care has been slow. The proportion of services applying traditional medicines in medical facilities remains low. There are many shortcomings in state management of private traditional medicine practice. The regulatory system and professional guidelines are inconsistent, slow to be issued and do not yet encourage or support development of traditional medicine. The pace of implementing the Project to invest in building, upgrading the traditional medicine system for the period 2014 - 2025 and master plan for development of medicinal materials to the year 2020 and orientation to 2030 has been slow.

2.5. Population- FP, RH and MCH services

The scope of prenatal and postnatal screening remains limited. The risk of imbalance in the sex ratio at birth remains high. Investment and capacity of the health system to care for the health of older persons is incommensurate with need. The share of people who access services remains low and unmet need remains high in highland areas, areas with a high proportion of ethnic minority people, among adolescents, migrants, and workers in industrial zones. Physical facilities, equipment and human resources in district hospitals in many localities do not yet meet requirements for responding to obstetric and neonatal emergencies. Maternal and child mortality remain high and are declining slowly, especially in mountainous areas, while further reductions will be more difficult. Child stunting rates are high, especially in rural mountainous areas, while overweight rates in children are increasing in urban areas. The statistical system relying on reports is not precise, timely or complete, thus it is not able to effectively serve the needs of planning, policy formulation and design of interventions.

3. Priority issues

Preventive medicine

- The burden of disease due to communicable disease (endemic diseases, vaccine preventable diseases, newly emerging diseases) remains high and risk of outbreaks is always present.
- Surveillance and control of NCD risk factors has been ineffective; capacity of the grassroots level for detection and management of NCDs remains limited.
- Access to and use of HIV/AIDS control services among high risk groups remains limited and unsustainable, while integration of activities is not yet effective.
- Food safety violations in production, processing, and sales of foodstuffs remain widespread; the risk of food poisoning in institutional or commercial kitchens and street food remains high.
- Effects of environmental pollution and climate change are intensifying while little attention is being paid by sectoral agencies or localities for an appropriate level of investment.

Grassroots health care, primary health care and national health target programs

- Funds for investment in grassroots health care, PHC, health NTPs remain limited. Health sector capacity is inadequate to meet needs for health care.

- Policy on financing and professional technical assistance for service delivery following the family doctor model are inadequate.

Medical examination and treatment, rehabilitation

- Overcrowding in some specialties and tertiary hospitals has not yet noticeably improved.
- Capacity for medical service delivery in lower level facilities remains limited; organization and operational mechanisms do not yet encourage facilities to provide comprehensive, continuous care to satisfy need. The lack of mutual recognition of laboratory test results among health facilities is widespread.
- Management and organization of service provision and control of service quality have many shortcomings; medical service quality has improved, but does not yet meet expectations.
- Capacity of the private health network to deliver services remains modest and quality control is facing substantial difficulties.

Traditional medicine

- Domestic sources of medicinal materials remain limited, quality management of drug ingredients and traditional medicine practice is weak, and the master plan for medicinal materials production has been implemented too slowly.
- Research to apply traditional medicine treatment methods in medical care is insufficient. The proportion of patients using traditional medicine in medical facilities remains low compared to potential.

Population, FP, RH and MCH services

- Major regional disparities persist in health, disease and access to services. Maternal and child mortality in remote and isolated areas remain elevated and decline slowly. Unmet need for services among some demographic groups is above acceptable levels.
- The risk of imbalance in the sex ratio at birth remains high; projects for improving quality of the population have only been implemented at a small scale; population aging is occurring rapidly and has not been adequately taken into account in policy formulation.
- Investment and capacity of the health system to provide RH and MCH care and health care for older persons are not yet commensurate with need.

4. Recommendations

General solutions

- Complete and unify the model of the medical service delivery system organization at all levels towards strengthening linkages between treatment and prevention and across levels of the hierarchy.
- Develop, amend and refine policies and professional guidelines in the area of service delivery.
- Strengthen investment in grassroots and primary health care; reform the financial mechanism to ensure the rights of patients and incentives for health workers.

- Strengthen training and technology transfer for the grassroots level for health management, development and resolution of common health problems, with a focus on NCDs.

Preventive medicine

- Create a plan for active surveillance, forecasting and early detection, to control endemic disease outbreaks in a timely fashion; strengthen epidemiological surveillance at border crossing points.
- Strengthen IEC, ensure the supply of adequate vaccines, strengthen surveillance of the organization of immunizations to maintain the high full immunization rates, strengthen quality and safety.
- Strengthen IEC and BCC activities, actively implement measures to prevent disease and promote health. Train and supervise technical assistance to improve capacities for activities in prevention and control of NCDs at the grassroots level.
- Expand HIV prevention and control service facilities (counselling and testing, ARV treatment, methadone replacement therapy) down to the commune level; integrate counselling services with ARV, methadone replacement therapy, TB treatment and RH services at the grassroots level.
- Promote measures to get people living with HIV to enroll in health insurance; ensure health insurance entitlements of people living with HIV. Develop a plan to ensure quality ARV drugs with appropriate prices; step-by-step implement ARV provision paid by health insurance.
- Strengthen supportive supervision for compliance with treatment regimens for HIV, TB and malaria; develop prevention plans and monitor risks of drug resistance.
- Continue to implement the Project to invest in building waste treatment systems for health facilities and strengthen monitoring of medical waste treatment and management.
- Boost intersectoral collaboration in state management of food safety, inspections, surveillance, strict penalties for food safety violations; develop a model and surveil activities of clean food manufacturing enterprises and businesses.
- Continue to pilot, evaluate and scale up specialized inspections in food safety and hygiene; train and boost capacity in the food safety surveillance system of the health sector to actively check, prevent and warn of food safety risks.
- Organize and guide implementation of policies on environmental protection, occupational safety and health and accident and injury prevention; strengthen intersectoral collaboration in monitoring and enforcement of environmental protection regulations.

Grassroots health care and primary health services

- Mobilize resources to strengthen investments in PHC; implement the Project to Build and Develop the Grassroots Health Network in the New Situation.
- Develop mechanisms, strengthen training, attract human resources, reform and improve effectiveness of activities and integrate implementation of NTPs at the grassroots level.

- Apply the family doctor principles in PHC at the grassroots level; complete the policy mechanisms on finance, technical professional guidelines to support family doctor activities; expand the model of family practice clinics following an appropriate roadmap.

Medical examination and treatment, rehabilitation

- Promote measures to reduce hospital overcrowding: increase the pace of focal projects to develop new health facilities; expand the hub and satellite hospital network; continue to implement rotations of doctors, strengthen training and technology transfer to lower level hospitals and implement telemedicine.
- Issue regulations and professional guidelines and complete the medical service quality management system. Develop and implement a model for independent assessment and scoring of hospital quality; develop a financial and management mechanism to encourage service providers to improve quality.
- Strengthen quality management and calibration of medical testing, complete the mechanism to ensure mutual recognition of lab test results between medical facilities.
- Boost administrative procedure reforms in medical services, implement regulations on health insurance enrollment at primary care facilities and referrals in order to create convenient conditions for the people to access and use services, particularly for people with health insurance.
- Develop financial mechanisms to encourage lower level facilities to upgrade their capacity and quality of service provision, and resolve all common medical conditions.
- Strengthen management in issuing practice licenses; set up a system of examinations prior to issuing medical practice certificates to professionals, limit the duration of practice certificates and link renewals to CME.
- Encourage implementation of PPPs to invest in construction of medical facilities and diversification of health service forms.

Traditional medicine

- Strengthen implementation of the Project to develop traditional medicine. Implement the master plan, strengthen investments, preferential treatment, and ensure a market for outputs of concentrated medicinal ingredient cultivation.
- Issue technical and professional guidelines for traditional medicine, strengthen application of traditional medicine in medical services, expand the scope of traditional medicine practice, increase the proportion of curative care patients using traditional medicine.
- Strengthen capacity and promote quality control and quality monitoring of drugs and medicinal ingredients of traditional medicine manufacturing facilities, sales enterprises and treatment facilities.

Population, FP, RH and MCH services

- Study to develop a new strategy for population and FP, shift the focus from FP towards population and development to more comprehensively resolve population issues.
- Strengthen population and FP service delivery, RH care, MCH care in disadvantaged regions, focus on groups with unmet need.

- Train birth attendants, obstetric surgeons, post-surgical care teams in hospitals, assist the district hospitals in disadvantaged regions to implement comprehensive obstetric emergency services.
- Actively control and resolve underlying causes of imbalance in the sex ratio at birth. Strengthen IEC combined with inspections and punishment for violations.
- Integrate population, FP, RH, MCH services with preventive services at the grassroots level; expand scope of the prenatal and postnatal screening project.
- Implement effectively the Health Care for the Elderly Project; expand and diversify health services for older persons; cooperate inter-sectorally on prevention and control of accidents and injuries, particularly drownings among children.

PART TWO. TOWARDS HEALTHY AGING IN VIETNAM

Chapter IV. Population aging, health status of older people in Vietnam

1. Specific features of population aging in Vietnam

Situation: In the period 1979 - 2015, the number of older persons (aged 60 and older) in Vietnam increased from below 4 million (6.9% of the population) to 10.35 million (11.3% of the population). Vietnam has entered a period of population aging starting in 2012 (when older persons accounted for 10.2% of the population) and will become a country with an aged population by 2038 (20.1% of population in older ages). By 2049, population projections indicate that older persons will account for about 25% of the population, while people in working ages (15 - 59) will account for only 57%.

Vietnam has one of the most rapidly aging populations in the world, with the aging process occurring over 26 years (2011 - 2037), 2.6 times faster than in the United States (68 years) and 4.4 times faster than in France (115 years). This creates huge pressure for ensuring social security and meeting the rapidly growing health care needs of older persons.

The aging index is rising rapidly and the old age dependency ratio is starting to increase: The aging index (number of older persons per 100 people aged <15 years) in Vietnam has increased from 17 in 1979 to 47 in 2015 and is expected to increase to 138 by 2049. The old age dependency ratio has recently begun to rise, with 1 older person per 9 working age people in 2015, and projected increases to 1 older person per 6.2 working age people in 2029, and 1 older person per 3.5 working age people in 2049.

Population aging is the most rapid in the oldest age group: Population aging is occurring even among older persons and is fastest in the oldest group. The number of people aged 80 and older increased from 0.33 million (9% of all older persons) in 1979 to 1.95 million in 2015 (18.8%) and is projected to account for 4.3 million (nearly 16%) of the older population by 2049.

Feminization, increasing widowhood and growing share of older people living alone: The sex ratio indicates more women than men overall, and increases substantially with age. In 2014, the number of men per 100 women fell from 79 in the age group 60 - 69 years to 52 in the age group 80 years and older. The proportion of people widowed in 2011 was 36.1% (50.7% among women and 14% among men). The proportion of older persons living alone or only with an elderly spouse is increasing, and is higher for older age groups, and higher among women than men and in urban than in rural areas.

Older persons mainly live in rural areas; the rural share is increasing over time, and increases by age group: In 2015, about two-thirds of older persons lived in rural areas. As age increases, older persons become even more concentrated in rural areas and the sex ratio becomes even more imbalanced. Population projections to 2049 indicate that older persons in rural areas will increase threefold, and in urban areas will only double compared to the present. When older people are defined as those aged 65 and older, by nearly 2049, the rural population will have become a hyperaged population.

Older persons are more concentrated in the delta regions: Three delta regions hold a high share of older persons including the Red River Delta, North Central and Central Coast and Mekong River Delta. These also happen to be regions with net outmigration.

2. Health status of older persons in Vietnam

Life expectancy and healthy life expectancy (HALE): Life expectancy at birth in Vietnam in 2015 was 73.3 years (70.7 for men and 76.1 for women). HALE reached 63.2 years for men and 70.0 years for women. Life expectancy among those who have survived to 60 years of age is 19.5 for men and 24.9 years for women, while HALE at age 60 years is 14.7 for men and 18.4 for women.

Self-assessed health: According to the Vietnam National Aging Survey (VNAS) 2011, 65.4% of older persons assess their health as weak or very weak, 29.8% as average and 4.8% as good or very good. The proportion who assess their health as weak or very weak is considerably higher among the oldest old, elderly women and older persons living in rural areas.

Declines in functional capacity: In 2009, approximately 40% of male and 46% of female older persons faced difficulties with at least one of four basic functions (vision, hearing, mobility or cognition (concentration/memory)). Among these people, 24% of men and 31% of women reported difficulties with 2 or more of these functions. Among older persons facing functional difficulties, 10% live alone and 20% live with other older people. Currently health insurance does not pay for prosthetics, prescription eyeglasses, or hearing aids.

Synthesis of information on diminished functional capacities in older persons

	Population and Housing Census 2009	VNAS 2011
Impaired hearing (3.3% DALYs)	Male 21%; Female 25% 60 - 69 (10.40%); 70 - 79 (25.6%); 80+ (54.5%)	60 - 69 (19.5%); 70 - 79 (37.2%); 80+ (>50%)
Impaired vision (refraction disorders: 1.8% DALYs)	Male 28%. Female 34% 60 - 69 (19.45%); 70 - 79 (34.8%); 80+ (54.7%)	60% self-report poor vision; 76,7% poor vision diagnosed (60 - 74 years 70.3%; 75+ years 93%)
Impaired mobility	Male 22%; Female 29%	Overall: 71.6%
Impaired memory or concentration	Male 19%; Female 26%	47.9% indicate weak or very weak memory; (Female 51.1%; Male 42.9%)
Impaired performance of activities of daily living (ADLs)	No evaluation	37.6% have difficulty with at least one ADL (Female 39%; Male 35%); Age group 80+: 50%

Burden of disease measured in DALYs: The burden of disease among older persons is primarily caused by NCDs, accounting for 87 - 89% of lost DALYs and 86 - 88% of deaths depending on the age group. Among burden of disease, cardiovascular disease (mainly stroke and ischemic heart disease) accounts for the largest share among older persons, accounting for a rising share or burden of disease as age rises, from 26% in the group 60 - 69 years, to 38% in the group 80 years and older. The second largest disease group in terms of burden of disease is cancer (particularly lung, tracheal, liver, stomach, colon, with burden rising with age). The third largest group is other NCDs, such as COPD, mental and neurological illness, endocrinological disorders, urological disorders and musculoskeletal disorders. Cardiovascular disease is also the largest group in terms of deaths to older persons, mainly related to hemorrhagic stroke and ischemic heart disease. Cancer remains in second place, primarily lung/tracheal cancer.

Morbidity patterns: *In the community*, according to the VNAS 2011, joint pain, dizziness and headache are the most common symptoms reported by older persons, followed by cough, breathing difficulties and chest pain. Hypertension (46%), arthritis (34%) and respiratory problems are the most common ailments among older persons, with prevalence rising with age. According to the 2015 Health Survey, symptoms and disease most commonly reported by older persons included hypertension (30%), musculoskeletal disorders (10%) and respiratory disease (7.6%). *In medical facilities*, the two most common diseases presenting at health facilities among older persons are hypertension and acute bronchitis. Diabetes is only among the top 10 diseases among older patients at district or higher level hospitals. Other commonly found conditions include gastro-intestinal ulcers, cardio-vascular disease and musculoskeletal disorders. At the grassroots level, the 10 most common diseases presenting at health facilities accounted for 84% of all medical care contacts among older persons at the commune level; 52% of outpatient contacts and 45% of inpatient admissions among older persons at the district level. The most common diseases presenting for these services include hypertension (49.5%, 15.4%, 12.5% respectively at commune, district outpatient and district inpatient); communicable disease (22.1%, 16.4% and 15.4%); and musculoskeletal disorders (6.1%, 9.4% and 5.0%).

Burden of health risk factors: The three main categories of known risk factors cause 58% of the burden of disease among older persons as measured in DALYS in 2015. Behavioral risk factors contribute the most (40%), followed by metabolic risk factors (33%) and hygiene and the environment (14%). Among these risk factors, the most important ones are inappropriate diet (21.7% of DALYs: including excessive salt, fat and insufficient fruit, vegetables and seafood), high systolic blood pressure (20.2%), and exposure to tobacco smoke (18.7%, including passive smoking).

Chapter V. Health care to meet the needs of older persons in Vietnam

1. Network for health care of older persons

The healthcare network for older persons is currently integrated inside the general health system and there is substantial separation between curative and preventive care.

Central level: *The National Geriatrics Hospital* is the only tertiary hospital dedicated to the health care of older persons, while dedicated geriatrics departments or departments integrating geriatrics with other specialties have been established in several other central hospitals by 2016.

At the provincial level, by the beginning of 2017, more than 70 hospitals had established geriatrics departments or units, or departments integrating geriatrics and other specialties, although few of these operate as departments dedicated to the healthcare needs of older persons. In addition, geriatric care is also provided by 36 provincial rehabilitation hospitals and 15 nursing centers of other sectors, as well as rehabilitation departments in general hospitals.

Grassroots level, nationally there are 629 district hospitals (accounting for 30.7% of all inpatient beds nationally), 544 regional polyclinics and 11 000 CHSs and a large workforce of village health workers (VHWs), with an important role in PHC, particularly for older persons.

The provincial preventive medicine system collaborates with the district and commune level to achieve coverage down to the villages to effectively implement programs for NCD prevention and control for all patients, including older persons. The organizational model of the preventive medicine system is being rearranged to strengthen linkages and increase effectiveness in management of comprehensive and continuous health care services.

In addition, private hospitals and clinics are also involved in providing health care services for older persons. However, there is a lack of legal basis for services that specialized in home-based health care for older people.

2. Current hierarchical model of health care service delivery for older persons

Older persons account for 25% of total health care contacts overall, and at the provincial level. At the grassroots level, older persons account for 30% of health checkups at the CHS, and at the district hospital older persons account for 35% of outpatient contacts, 33% of health checkups and 30% of inpatient admissions. About 33% of inpatient admissions in private hospitals and 20 - 30% of all patients at provincial general hospitals. In 2012, there was a total of about 29 million contacts by older persons at medical services, including outpatient care (77%), health checkups (14%) and inpatient care (9%). The district hospital is the most heavily used by older persons, accounting for 33% of all health care contacts by older persons, followed by CHS (22%) and higher level hospitals (20%). Health checkups and inpatient care are primarily used in public health facilities. The private health sector primarily provides outpatient curative care.

3. Human resources and training for health care of older persons

Health workers at all levels of the health system provide health services to older persons, but their professional knowledge and understanding of the needs of older patients is currently very limited and uneven. Outside of the National Geriatrics Hospital, the geriatrics units in all other hospitals have insufficient doctors and most have not received specialized geriatric medicine training. Grassroots health facilities are used the most by older persons, but this is the level of care with the weakest capacity for providing health care to older persons, since most health workers at this level have not received training in care of older persons, and lack basic knowledge and skills to prevent and control NCDs in older persons. The preventive medicine system, was originally developed and staff trained to prevent and control communicable disease, but many of the preventive medicine staff have not yet been retrained appropriately to meet the needs of a changing case mix.

Currently, geriatrics is not yet integrated into the contents of health sciences training curricula, there is no unified curriculum framework for a course on geriatrics for doctors or nurses. Some training curricula, such as for traditional medicine or nursing, do have contents related to health care for older persons, but the contents pays little attention to communication and psychology. There is still no IVth level code for geriatric medicine in the national education and training system for masters or PhD levels. The National Geriatrics Hospital has actively developed training materials and organized CME on geriatric medicine for doctors at all levels, but so far has only been able to meet a small part of the current training need.

4. Health financial protection for older persons

The proportion of older persons enrolled in health insurance has increased over time, from 43.5% in 2006 to 75% in 2014. It is highest among people aged 80 and older (80%), and lowest in the group aged 60 - 69 years (72%). By 2015, monthly social assistance payments and free health insurance cards have been provided to 1.5 million older persons aged 80 and older who don't benefit from a pension. According to household data, in 2014, 25% of people aged 80 and older did not yet have health insurance.

Health insurance aims to reduce financial barriers to use of health services and reduce health financial burden. Ideally, health service utilization of older persons should only depend on their need, and not on their ability to pay. However, research results on use of outpatient services among older persons suggests that there is moral hazard and adverse selection in the age group 60 - 69 years. With outpatient services, research results suggest that there are financial barriers that adversely affect ability to use health services among older persons without health insurance.

Variation in patterns of health care seeking at different levels appear to be affected by ability to pay and ability to access services, not only on the level of severity of the illness. Ability to pay is an important factor hindering older people from using health services, accounting for 43.5% of older persons foregoing medical services, followed by difficulties in transport (17.3% of older patients foregoing services). In order to treat NCDs, health insurance card holders still have to go to the district level, causing real difficulties for older persons living in poor households, disadvantaged, remote or isolated regions.

5. Health care service delivery for older persons

5.1. Implementation results

Health IEC, some localities have designed programs specifically for older persons on the television channels, through organizing activities for members of clubs for older persons, developing web pages to communicate about health for older persons. However, currently there is not yet a strategy or plan to support localities to implement health education to boost health of older persons.

Prevention of chronic NCDs, Vietnam has developed many policies to control risk factors for NCDs following WHO global recommendations. The main activities aimed at older persons involve health education, which has led to improvement in knowledge of the population on how to prevent NCDs.

Screening for early detection and timely treatment of disease. In 2016, 792 430 older persons (7.7% of total) received health checkups at the CHS. The number of older persons

without family support suffering from severe illness who received home medical care increased from 29 600 in 2015 to 50 266 older persons in the first 6 months of 2016. Many CHSs are managing lists of older persons in their locality, and some have even established health monitoring booklets for older persons, like the 20 communes in the Hoa Binh province project. ***For hypertension***: A model has begun to be developed for a hypertension control unit and a unit for treatment of hypertension at the district health center and district hospital. Approximately 12% of communes participates in managing hypertension through counselling and collaboration in providing pharmaceutical therapy at the CHS. By 2015, these activities had contributed to the detection and management of about 800 000 patients. ***For diabetes***: Commune level health services participate in detecting people with risk factors for disease, screening to detect pre-diabetes or diabetes in order to transfer them for confirmatory diagnosis and timely treatment, and follow-up management and monitoring of patients whose treatment has been stabilized at higher levels. These initial activities have contributed to detecting disease and management of 250 000 pre-diabetics and diabetics. ***For COPD and asthma***: Activities are primarily concentrated at the provincial level; initial pilots for managing COPD patients at the district level have begun. In 2015, 32 101 people were screened, and 2506 patients with asthma and 900 patients with COPD were detected. By 2016, 11 234 people with chronic respiratory disease were being managed in 115 clinics in all 63 provinces. ***For cancer***: The project on cancer control is focused on strengthening capacity, with the goals for the 2016 - 2020 period to strive to ensure that 80% of health workers working within the project have received training on prevention and early detection of common cancers and > 70% of provinces have a cancer control facility.

Rehabilitation: The MOH has a national plan for developing rehabilitation services for the period 2014 - 2020. It has issued technical guidelines and many professional materials on rehabilitation, including some with contents appropriate for rehabilitation among older persons. The list of technical services by designated level of provision was issued by the MOH (43/2013/TT-BYT) and includes many techniques that can be used in rehabilitation for older persons at the commune level, such as various forms of respiratory therapy. The project for community-based rehabilitation, in the first 6 months of 2016, has implemented rehabilitation for 114 198 older persons with disabilities, sequelae of injuries, adverse events, chronic disease and occupational disease.

Palliative and end-of-life care: This type of care is beginning to receive attention, particularly for cancer cases. Nationally there are 4 palliative care departments (all located in cancer hospitals). Some courses have been organized to train health workers in competencies for providing palliative care, end-of-life care and pain relief.

5.2. Difficulties, limitations

Health IEC for older persons has not yet been systematically provided; it remains limited in quantity and contents. Staff involved in IEC often lack regular training to update knowledge and skills. Resources for IEC remain low, hindering effectiveness. Many people lack basic knowledge on NCD risk factors.

Preventive care activities focused on NCDs are being implemented vertically, and tend to lack interlinkages. Some projects to control risk factors have not yet been approved. Important mental health problems among older persons, such as dementia, Alzheimer's disease and depression are not yet considered to be NCDs.

Periodic health checkup, screening to detect illness, and setting up of a health care record for older persons have not yet become routine because a basic health service package for older persons has not yet been developed to meet clear and appropriate standards and treatment guidelines. Prescribing and dispensing drugs to older persons is still inconvenient for patients, while supportive supervision to ensure compliance with treatment of NCDs has not yet received attention.

Lack of linkages between curative and preventive care, and between levels of the health system hierarchy and between facilities adversely affects continuity of care for older persons. Capacity to provide services for NCD management at the PHC level is very limited in terms of knowledge and skills, equipment and essential drugs. State budget funds for NCD prevention and control are not assured; the financial mechanism currently does not encourage early detection, counselling or management of NCDs at the commune level. The model of family doctor clinic is facing many policy difficulties. The system of statistical indicators to gather information to monitor and evaluate implementation of health care policies for older persons is incomplete.

Rehabilitation: Need for rehabilitation among older persons is high, yet there are no policy documents that focus on rehabilitation for older persons, and there is no orientation and leadership for development of health care for older persons based in the community. The list of rehabilitation services reimbursed by health insurance at the commune level is extremely limited, and to be paid, the CHS must have their service provision capacity approved by the local health authorities. Human resources and training in rehabilitation are very limited. The potential for rehabilitation in the community is very large, but it has not yet been adequately developed. Rehabilitation activities based on the community have been supported by the health and population target program, but no payment norms have yet been issued.

Palliative care and end-of-life care. The number of units providing these services is very limited, and palliative care services have not yet been provided in the home or in long-term care (LTC) facilities. Health workers have not yet been trained on these techniques and generally spend too little time on counselling. Services tend to focus primarily on pain relief, with little attention paid to providing other support services.

Chapter VI. Long-term care (LTC) for older persons

1. LTC needs of older persons

Older persons in Vietnam have a high need for LTC. Particularly in the community, because the number of older persons is large, the burden of chronic NCDs, disability and limitations in capacity among older persons tend to be substantial. This need is expected to grow as the number of older persons grows, particularly in the oldest age group requiring more care. In 2009, 2% of older persons had limitations in 4 basic functions (vision, hearing, mobility, concentration/memory) and 7% faced great difficulty in performing these functions. It is forecast that by 2019, 1 million people and by 2049, 2.5 million people will face these disabilities. Traditional care for older persons in the family is declining, because of demographic change, while income of the majority of families of older persons is low, insufficient to pay for institutional LTC services provided by the private sector. At the same time, some healthy older people with economic means prefer to live in a LTC facility despite lack of need.

2. Organization of LTC service provision for older persons

2.1. Models of LTC in the community

The foundation of community-based models is the family or someone who voluntarily takes on the primary caregiver role, and the aim is to increase independence and maximize quality of life in the long-term. Care of older persons by family members has many advantages and is appropriate with Vietnamese legislation, economic conditions and cultural traditions. However, this model faces many challenges with smaller families, busy children, working far from home, lack of knowledge on how to give care when older persons have complicated illnesses. The most comprehensive community-based LTC model in Vietnam is the Intergenerational Self-Help Clubs (ISHC).

ISHCs operate at the village level; they are established by the Commune People's Committee (PC), and administration is assigned to associations or mass organizations, with funding primarily from the rotating income generation fund of the club. This model has 8 areas of activities, including home care, health care and community support for older persons facing difficulties with ADLs. There are plans to expand to 3200 ISHCs in 45 provinces with at least 105 000 older persons participating by 2020. By the end of 2016, there were 1065 clubs in operation in 18 provinces with 55 000 older person members. Currently there is a lack of funding to scale up and create stronger linkages with the health sector and local authorities to ensure professional care and financial support.

Another model is free care for older persons in their home provided by volunteers, including the CASCD model (Red Cross), in which mass organization members, relatives and neighbors voluntarily come to the house 3 to 5 times per week to help older people with illness, loneliness, or facing difficulties with ADLs. Volunteers are given training and provide companionship, help with housework and link older persons with local authorities and mass organizations. In 2012, after 9 years of piloting and expanding, there are 1223 volunteers caring for 1094 older persons in 93 communes in 12 provinces. This model is easy to implement and inexpensive, appropriate with conditions in Vietnam, but faces sustainability challenges in organization and finance, so it is being integrated into the ISHCs. In addition, the model for Counseling and Care of older persons based in the community of the General Office of Population and Family Planning (GOPFP) also has volunteers consisting of healthy older persons who are trained in basic knowledge to support older persons, with priority given to older persons in financial difficulty and without family support. By 2016, almost all communes implementing the model (370 communes in 32 provinces) had established volunteer teams with a total of 4492 volunteers.

Paid home-care for older persons, is being organized as a charity activity of mass organizations, or as a private profit-making or social enterprise form. The main beneficiaries of this model are families of older persons who have the financial ability to pay, and may include quite diverse health care needs. A typical example of this is the CASCD model, which has received support from HelpAge International, or the center for home care of older persons organized by the Hai Phong Union of Science and Technology Associations. In major cities, private enterprises providing health care to older persons in the home are beginning to develop. In addition, many companies introduce helpers to care for older persons. They do not have professional qualifications but are usually trained to have basic

skills for care of older persons, to help with ADLs and housework. The biggest challenge with home-based care of older persons is the ability to retain a workforce, particularly when operating on a non-profit (charity) basis.

The social work services model is implemented by professionally trained social workers at various levels of administration. The main beneficiaries are older persons who are social protection beneficiaries. Care is focused on advising, treatment of psychological crises and physical rehabilitation, counselling and assistance to help older persons receive social assistance entitlements. By September 2016, 37 provinces had developed and approved a Project to establish a social work center. The need for social work services among older persons is rather high, however currently this model lacks coherence, is not clearly distinguished from services provided at social protection centers, and lacks a mechanism and source of funding to provide social work services to all older persons who need them.

CHS staff and VHWs also participate in some aspects of LTC for older persons in the community, with a clear role stipulated in the Health Care for the Elderly Project, 2017 - 2025. However, currently, no evaluation is available about their activities in providing LTC to older persons in the community.

2.2. Institutional (residential) model of LTC for older persons

The general feature of this model is that care is residential, long-term, including both personal care and health care. Some facilities also care for people with disabilities. There are both public and private centers with many different names, but for this report we use the term *'social protection establishments*' as used in legal documents. Almost all older persons residing in social protection establishments are people with severe disease or disabilities. Public and charity facilities prioritize social protection beneficiaries. Beneficiaries in private facilities that collect high fees are primarily older persons from better off families.

For social protection establishments with 10 or more residents, the Labor, invalids and social affairs sector (hereafter the labor sector) is responsible for issuing permits to operate in the field of care for older persons, while the provincial or district PC issues decisions for setting up these social protection establishments. For facilities operating as a business, a business registration is required from the provincial planning and investment department. In order to request a permit, social protection establishments must meet regulations on the environmental conditions and physical infrastructure (Decree 68/2008/ND-CP, Decree 81/2012/ND-CP and Circular 07/2009/TT-BLDTBXH). However, some non-public social protection establishments still operate even though they don't have permits to operate in the field of care for older persons because they do not yet meet these regulatory conditions. Service staff at social protection establishments are primarily personal caregivers; in addition there may be some medical, rehabilitation or nutrition staff depending on the facility. Currently there are no regulations on professional qualifications of caregivers, only some stipulations on their general capacity and character.

Social protection establishments can provide services to help with ADLs and nursing, administer oral medications, implement rehabilitation exercises following orders of a doctor, but cannot provide medical (curative care) services. Public social protection establishments are also supposed to provide counselling, assessment of mental health and psychosocial therapy. Up-market nursing homes (enterprise model) usually have

additional PHC, entertainment, recreation and other forms of assistance to meet needs of older persons, however the charges tend to be quite high compared to ability to pay of most older persons.

Currently insufficient information is available on the capacity and size of all social protection establishments caring for older persons. In 2015, nationally there were about 153 social protection establishments caring for older persons; among those 36% were public, 36% were on-public charities and 27% were private enterprises. About 18% of social protection establishments are operating without a permit to operate in the field of care for older persons, mainly charity facilities, but also some enterprises. The scale of establishments tends to be quite small, with 18% having fewer than 10 older persons, 42% having from 10 to 49 older persons and only 9% having 50 or more older persons as residents.

If one considers need only in terms of difficulties with ADLs (nearly 4 million older persons), or severe disability, the social protection establishments can only meet an extremely small share of need. The distribution of social protection establishments caring for older persons is uneven in terms of number and structure. Most non-public establishments were set up spontaneously, not according to any master plan, and are not yet tightly regulated. Most establishments only focus on residential care, and are not yet linked with providing services in the community, day care or short-term care. Physical facilities of many establishments are in a dilapidated state, and do not meet basic regulatory requirements. Collaboration between the labor sector and health sector in LTC remains quite loose.

3. Human resources for LTC of older persons

In Vietnam, there is little awareness among most people about the human resources providing LTC services to older persons. The role and tasks as well as professional knowledge and skill requirements for caregivers have not yet been clearly and consistently stipulated in regulations. Laypersons are the predominant provider of LTC for older persons, mostly family members, or volunteers. Family members usually lack any training, but have to help with instrumental activities of daily living (IADLS) and ADLs, as well as some aspects of medical care. Due to their lack of training, it is difficult for them to meet care needs for older persons, especially older persons with chronic disease or disabilities. Volunteer caregivers for older persons usually have some basic training, but not generally according to any standardized training program; they mainly provide psycho-social support, support with IADLs, but in many cases they are also mobilized to support ADLs.

Professional caregivers operate in residential facilities or act as paid caregivers in the home. In public and charity facilities, human resources are somewhat limited in number and skills, most have not yet had formal professional training in fields related to care for older persons, so it is difficult for them to meet the care needs of older persons. Private social protection establishments (enterprise model) tend to have a diverse staff that has been selected to meet needs for care of older persons, including health workers like secondary nurses, technicians, and personal caregivers. The role, tasks and participation of CHS staff and VHWS in LTC for older persons are not clear, while training on care of older persons has received insufficient attention and there are few enforcement or incentive mechanisms to ensure services are provided.

Provision of LTC services to older persons currently is not considered a formal occupation in Vietnam. There are no regulations on required training qualifications, professional standards, standard competencies for issuing professional licenses to provide care services for older persons. The number of training establishments providing training in LTC for older persons is very modest, and they do not follow any standard unified curriculum framework.

4. Financing of LTC for older persons

Currently, financing of LTC for older persons relies primarily on household budget. When older persons require assistance with ADLs on a daily basis for a prolonged period of time, families face a very large financial burden. In many cases, family members must leave work to care for older persons, adversely affecting family income. Relatives caring for older persons in the community do not receive any assistance payments. Support from the state budget or charity organizations for LTC of older persons is mainly reserved for social protection beneficiaries (the poor, older persons without family members to support them, or people with particularly severe disabilities) or people with meritorious service to the nation.

Within public social protection establishments, the state budget pays for care of older persons on a capitation basis, however, the current payment is rather low compared to need; mobilization of additional funding from the community and society remains limited. As a result, the material and spiritual life of older residents faces many difficulties. For social work service providers, funding follows the social mobilization model. The state budget supports construction and initial equipment during a pilot of this model, and also pays for some key services. For older persons who are not social protection beneficiaries, there is no regulation yet on a payment mechanism or service prices.

Elder care services provided on a business model are developing, but charges are very high compared to the ability of families to pay. Vietnam does not yet have LTC insurance. The policy on sick leave in the social insurance program is not applied in cases of workers taking time off from work to care for sick older persons.

Chapter VII. Social environment for healthy aging

1. Social environment to ensure material conditions for older persons

Meeting needs for food security of the population is among the priority tasks of the Vietnamese Government. Over many years, Vietnam has become a major global rice exporter, resolving food security in a sustainable way for the population, including older persons. When food shortages do occur in specific localities, older persons receive support to ensure food security in 3 forms: (i) regular assistance payments; (ii) care in the community or at a social protection establishment; and (iii) emergency assistance. Vietnam produces many soft foods that are appropriate for older persons. The Ministry of Health has laid out 10 recommendations on appropriate diet for the period 2015 - 2020 for the population, which are also relevant for encouraging healthy diet among older persons.

Meeting clothing needs: With the development of the socio-economy, currently the minimum needs for clothing of most older persons have been met. In cases of emergencies, in disadvantaged or poor areas, clothing is often one of the first types of essential goods provided in relief efforts. In such circumstances, older persons are one of

the priority target groups. Annually, on national holidays and the Vietnamese New Year, older persons reaching 100 years of age and older persons with meritorious service to the nation are given a traditional gift of silk fabric. Nevertheless, the clothing needs of older persons are not simply having enough in quantity, warm in winter and cool in summer, but the material and designs must be appropriate for older persons, ensuring convenience for older people to perform ADLs like getting dressed and toileting.

Housing for older persons is one of the essential needs and a minimum human right, which is clearly stated in Vietnamese legal documents such as the 2013 Constitution and the Housing Law (2014). The Vietnam National Action Program for the Elderly, 2012 - 2020 has set the target for 2015 for 100% of older persons to not have to live in temporary or dilapidated dwelling. In 2014, more than 99.96% of Vietnamese households had a dwelling. Besides older persons living in households, some are being cared for in social protection centers. In general one could say that Vietnam ensures housing for older persons. Nevertheless, the design, arrangement and amenities for daily living have received little attention to ensure appropriateness for older persons. Currently there are no regulations on housing design standards appropriate for families with older persons. Almost all families lack means to prevent falls. No evaluations have been performed on ability to respond to housing needs that ensure quality and appropriateness for needs of older persons.

Meeting transport needs of older persons. Vietnam has many legal documents regulating priority to older persons with respect to public transport, including assistance with boarding and disembarking, arranging a convenient seat on public transport and reduced ticket and service prices, when using some services according to regulations. Nevertheless, only 7.3% - 30.9% of older persons have received price discounts (depending on the type of public transport; only 6.3% - 38% of older persons indicate that they were given priority for convenient seating. Most enterprises pay little attention to complying with policies on price discounts for older persons; surveillance for enforcing the laws remains weak. In addition, Vietnam still lacks detailed regulations on design standards for infrastructure, means of transport, wheelchairs or other personal transport and lighting conditions, to ensure convenience and safety for older persons.

2. Social environment to ensure spiritual well-being among older persons

Meet needs for lifelong learning. The 2013 Constitution, 2005 Education Law and 2009 Law on the Elderly institutionalized the right to lifelong learning. Currently about 2 million people aged 60 to 64 have high technical qualifications; this is relatively high compared to many countries. Nevertheless, in 2009, about one third of people aged 60 to 64 years and nearly two-thirds of people aged 65 and older had education level below primary completion. The proportion with technical qualifications in the age group 65 and older is substantially lower than in younger age groups. Low educational attainment among older persons adversely affects their quality of life and cognitive ability for analysis and decision-making, particularly in the area of health care. The government facilitates older people to participate in literacy training and improvements in their qualifications in the national education system as well as learning through activities of clubs and community learning centers.

Satisfying information needs. The 2013 Constitution states that citizens have the right to access information. The Vietnam National Action Program for the Elderly 2012

- 2020 also has a target for television broadcasts targeted to older persons. Mass media in Vietnam is quite diverse; most older persons live with their family, so information access is linked to that of the family. In 2014, 93.9% of households used a television; 85% used a telephone; 25.1% used a computer. Vietnam has a magazine entitled "Older persons" and many programs and shows for older persons in the mass media. Over 80% of older persons report regularly reading the newspaper or watching television and listening to the radio. In addition, older persons can access information through activities of mass organizations, clubs for older persons. In this way, older persons not only access information on economics, culture, society, recreation, and entertainment, but also access knowledge on disease prevention and health care. Nevertheless, policies and information dissemination have not yet paid attention to the special needs of older persons, with distinct programs for older persons different from the general population.

Access to tourism, sports and entertainment among older persons are mentioned as rights in the Law on the Elderly (2009) and various sub-legal documents guide measures to ensure this right. On tourism, older persons usually have a need to visit places they dreamed about in the past, but weren't able to visit, but also a need to visit places of historical or spiritual significance. However the proportion of older persons travelling for tourism remains quite low. In 2009, people aged 55 years of age or older only accounted for 7.4% of all domestic tourists, even though they account for 12.3% of total population. The proportion of older persons that benefit from policies on price discounts for visiting tourist sites reached only 32.4%.

On participation in sports, annually over 900 sports competitions and prizes are organized with more than 1 million elderly athletes participating. A campaign for Vietnamese breathing and yoga exercises is being strongly developed in the grassroots and more than 55 provinces have disseminated Tai Chi exercises. It is estimated that 15% - 20% of older persons in rural areas and 60% of older persons in urban areas participate regularly in physical exercise. Nationally there are more than 58 099 clubs with many diverse types of cultural, sports, dancing, chess and other activities, which have attracted nearly 2.6 million older persons (about 30% of all older persons in Vietnam) to participate, thus contributing to improving health, reducing disease, and contributing to preserving and developing Vietnamese traditional culture. However, the proportion of people who have benefitted from discount policies for participating in sports activities has only reached 12.5%, while in rural areas that is only 10%.

Family relations of older persons. In Vietnamese traditional family, children and grandchildren are taught filial piety towards their parents, grandparents and ancestors. The right and obligation to care for older persons and parents is codified in Vietnamese laws, including the Law on the Elderly (2009) and the Law on Marriage and Family (2014).

According to the Nationwide Survey on the Family (2006), 51.4% of older persons think that they should live with their children or grandchildren. However, only 32.6% of families have older person members. Elder abuse appears to be on a downward trend, but it still exists, with 4042 incidents in 2011, 2232 in 2012, 2367 in 2013 and 1432 in 2014. A majority of elder abuse cases received timely interventions. Besides elder abuse, neglect is another problem. Children and grandchildren seldom confide in or exchange information with their grandparents or parents, adversely affecting emotions of older persons. The risk

of family conflict with older persons is rising and becoming an important concern due to the decline in family culture and social awareness.

Social relations of older persons. Traditions and laws in Vietnam both promote respect for older persons. Older persons have actively integrated and participated in community activities. By the end of 2014, nationally the Vietnam Association of the Elderly (VAE) had more than 8 469 000 members, accounting for nearly 90% of older persons. Nationally some 1.24 million older persons (13.2%) participated in the Communist Party, local authorities and mass organizations, contributing actively to community development.

In the community, from 2010 to the present, on average each year the local authorities organized a celebration of longevity for more than 1 million older persons (in ages ending in 0 or 5). Local authorities or mass organizations paid visits to more than 900 000 older persons facing illness or disease, or to give them presents on holidays. Just in 2015, there were 22 659 older persons 100 years old and older who were sent greeting cards and gifts from Vietnam's President to celebrate their longevity. When older people pass away a solemn, modest cost, culturally appropriate funeral is organized, by the family, local authorities, mass organizations and block captains, even for older persons without family members.

Ensuring freedom of religion and belief. Vietnam's Constitutions have always stipulated the right to freedom of religion and belief of citizens, including older persons. Most families in Vietnam follow the tradition of ancestor worship. Major religions like Buddhism, Catholicism, Protestantism, Cao Dai and Hoa Hao have existed in Vietnam for a long time with the participation of large extended families and many generations. In social protection establishments for care of older persons there is usually a space set aside for older persons to perform their own religious rituals. Many older persons regularly go to the pagoda or church and participate in holidays, or even go on pilgrimages to other places of worship. Religious freedom has contributed to satisfying the moral and spiritual life of older persons. Stable spiritual life contributes to improving health of older persons. As a result, local authorities, mass organizations and social organizations in the localities and families or facilities caring for older persons facilitate practice of spiritual beliefs, and punish anyone who abuses people's right to freedom of religion.

Economic activity. The Law on the Elderly (2009) and the Labor Code (2012) both stipulate and facilitate older people to work in jobs appropriate for their health and career occupation to promote their role in society. Some legal documents have stipulated concretely that prolonging the working life for some population groups in high level management or highly trained instructors is a prerequisite for developing other policies to promote work among older persons, particularly those with high technical qualifications. The proportion and number of older persons in the workforce nationally have risen over time. In 2015, more than 4.49 million older persons had employment, accounting for 8.4% of the total formal workforce. In addition, more than 95 000 older persons run farms or service or production facilities; more than 300 000 older persons have been nominated and given awards for excellence in their occupation/business. Besides activities that bring in income, 27.2% of older persons care for grandchildren; 17.4% of older persons support their children or grandchildren in a family enterprise; 27.5% of older persons do housework and 7.6% of older persons participate in charities and community service.

Satisfying the desire and need for employment and participation in the socio-economy is an inevitable societal need for Vietnam's older persons. It can promote the role of older persons in society, help them to generate their own income and escape poverty, while at the same time improve health and morale of older persons.

Chapter VIII. Priority issues and recommendations towards healthy aging

1. Priority issues to be resolved

1.1. Priority issues of health among older persons and population aging

Challenges due to population aging: Aging in Vietnam is occurring very rapidly, the proportion of population in working ages is falling rapidly, and the time to prepare for an old population is very short. There is a feminization of aging, with many widowed individuals living on their own. Population projections indicate a hyperaged population in rural areas in the future, which has not yet been acknowledge in policymaking.

Priority health problems: There is not yet an appropriate orientation for health care for older persons with different health statuses. Some aspects of health care, such as mental health, prevention of disability, fall prevention, have received inadequate attention. Behavioral risk factors contribute importantly to burden of disease among older persons, but there are not yet solutions for risk factor control from young ages to ensure that the next generations experience healthier aging.

1.2. Priorities for providing medical and healthcare services for older persons

State management: The roles and accountability mechanism for units participating in the Health care for the Elderly Project are not clear, particularly the role of the General Department of Preventive Medicine. There is a lack of intersectoral cooperation in many health care activities for older persons. Devolution of responsibility to the provinces has caused difficulties in implementing national targets for health care of older persons.

Organization of health care service delivery for older persons: There is a lack of close linkages between preventive and curative care and between levels of facilities, adversely affecting the ability to provide comprehensive and continuous health care for older persons. The effectiveness of IEC on prevention and control of NCDs for older persons is not high. An appropriate health checkup package and guidelines for screening and management of disease, setting up a health management file for older persons in the commune level have not yet been put in place. There is no regulatory document specifying the function and tasks of geriatric departments in hospitals and guiding referrals and continuous monitoring of chronic disease patients. Drug procurement, ensuring availability, prescribing and providing drug information for patients have not yet paid adequate attention to the special needs of older persons. Application of family practice principles and family practice clinic models in health management and care for older persons at the grassroots level are still facing some difficulties. Rehabilitation activities in the community, palliative care and end-of-life care for older persons remain limited.

Inputs: Human resources with training in geriatrics are few in number; there is no competency standard for health workers in geriatric medicine; training in health care for older persons does not yet meet requirements. Capacity of health workers to control NCDs, provide palliative care and guide rehabilitation exercises for older persons in the community are still very limited. No sustainable financial measures are in place for periodic

health checkups or screening for older persons. A large share of older persons aged 80 and older do not yet have health insurance, even though premiums are fully subsidized. Health insurance does not reimburse services such as hearing aids or prescription glasses, so poor older persons have difficulty accessing these services to increase their ability to independently perform ADLs. The policy and financial mechanism for CHSs don't encourage health workers to manage and care for health of older persons in an effective and pro-active way.

1.3. Priority issues of LTC for older persons

State management of LTC for older persons: Some regulations on social assistance do not take into account the special needs of older persons. Intersectoral linkages in developing and implementing policies on LTC for older persons are weak. The number of older persons benefitting from social assistance, social work services remains small compared to actual needs of society. Regulations on obligations of family members to care for older persons don't adequately take into consideration the practical difficulties of families with average and lower income, or people working inflexible work hours.

Organization of LTC models

Home-based care: In many cases, the care needs of older persons exceed the ability of the family to meet them. The ISHC model is effective, but has not been scaled up due to a lack of funds and support staff. Home health care services have a narrowly defined scope of practice, and have not yet been widely provided to meet healthcare needs of older persons with disabilities or severe illness. There are no regulations on day-care models for older persons who can still partially take care of themselves. There is no standard contract or commitment document for arrangements to care for older persons, making it difficult to protect the rights of older persons receiving care.

Institutional (residential) care: The new policy permitting private social protection establishments to register as a social enterprise to benefit from preferential access to land, taxes, and capital has not yet been widely disseminated or applied. Care standards at social protection establishments at present are mainly focused on infrastructure, and do not yet pay adequate attention to care processes to ensure safety, respect, and effective satisfaction of the needs of older persons. There is no legal definition of *centers for long-term health care services* for older persons stipulated in the Health care for the Elderly Project.

Human resources for LTC: Family members have an obligation to care for older persons, but often are not trained, so they lack necessary knowledge and skills. Standard competencies for care of older persons have not yet been clearly stipulated in policy as needed to develop a training curriculum. There are not yet ethical standards for personal caregivers for older persons. There is no legal basis for volunteers or paid caregivers to stipulate the scope of work and form of contract/commitment, nor assignment of responsibility and a mechanism for supervision of quality of care.

LTC financing: Policies designating certain groups of older persons as social protection beneficiaries are not based on actual need. Families with older members facing severe or very severe disabilities, or disease requiring continuous care, often cannot meet the care needs, and are at risk of falling into poverty. There is not yet a LTC insurance scheme. Health insurance still does not cover many services needed by older persons

such as health care or rehabilitation in the home or in a social protection establishment. The social insurance scheme does not yet include payments for leave to take care of sick older persons in the sick leave benefits. Remuneration policy for elementary-level elder care providers is too low compared to job requirements. Insufficient funds are available to expand the ISHC model nationally, even though this model meets many needs for LTC of older persons and the costs are low.

1.4. Priority issues for building a social environment amenable to healthy aging

Older persons have limited knowledge and weak practice related to nutrition, rest and relaxation, and physical exercise needed to prevent and control disease and improve health. Contents and method of communication are not yet appropriate for all age groups and health statuses of older persons. Physical conditions and design, arrangements and amenities in dwellings, design of infrastructure, means of transport, and other personal transport devices are not entirely appropriate with needs of older persons, particularly for convenience and safety. Income and income security are deficient for many older persons, leading to low living standards and risk of facing catastrophic spending and impoverishment due to health spending. Isolated living arrangements and intergenerational conflicts adversely affect the morale of older persons, while the model of institutional residential care is not yet widely accepted in society nor widely available. There is no mechanism or concrete measure to facilitate older persons to participate in employment or social integration activities appropriate with the abilities and situation of older persons.

2. Recommendations

2.1. General orientation for solutions

Policy measures to respond to rapid population aging

- Implement IEC to raise awareness of society on needs and rights of older persons and their caregivers. Take into account population aging when formulating national and local economic strategies, plans and policies.
- Find an appropriate solution so older persons who are still able can continue to participate in the workforce with employment appropriate for their health and capacity, in order to generate income and to avoid loneliness.
- Older persons, with a need for health care and LTC that exceeds the family's ability to provide it and older persons who don't have family support, require special attention, not simply monthly social assistance payments, but also social work services, etc.

Recommendations for health care and ensuring a healthy lifestyle

- Strengthen IEC to improve knowledge and awareness of older persons and family members about methods to maintain and improve health of older persons through physical exercise, appropriate diet, smoking cessation and other public health interventions.
- Develop models for chronic disease management for older persons in the community; ensure continuity of care appropriate with various conditions and contexts.
- Promote physical therapy, occupation therapy or other interventions to strengthen physical functioning and maintain independence of older persons when they face health problems.

- Ensure that caregivers and social workers and health care workers have adequate training, collaboration and supervision to resolve the specific needs of older persons.

2.2. Health care solutions

State management

- The MOH should provide instruction on implementing priority for medical care for older persons in public medical facilities; implement the Health care for the Elderly Project for the period 2017 - 2025 and the Project to Build and Develop the Grassroots Health Network.
- Consider establishment of a steering committee to manage health care activities for older persons, with supportive supervision from the MOH, VAE and geriatric care units.
- Set up a system for checking, monitoring, evaluation, registering, reporting and implementing health care for older persons.

Organization of service delivery

Health IEC

- Strengthen the role of the General Administration of Preventive Medicine in coordinating IEC activities and developing integrated guidelines for cost-effective NCD screening.
- Strengthen inter-sectoral collaboration in IEC activities about health care for older persons through various media with contents appropriate for older persons.

Periodic health checkups, health management for older persons

- Develop an essential health checkup service package for older persons that is appropriate with their needs and based on evidence of cost-effectiveness. Ensure consistency in guidelines on periodic checkups, screening, establishing a patient health management record and grassroots level health management for older persons. Develop a health management booklet for older persons appropriate with the case mix of older persons.
- District level health workers should collaborate with the commune level to participate in periodic health checkups and follow up for older patient cases where diseases were detected, to ensure confirmation of diagnosis and an appropriate disease management plan.

Medical services for older persons

- Strengthen training and technology transfer assistance to boost capacity of CHS to provide medical services and detect, diagnose, manage and treat chronic diseases in older persons.
- Develop the National Geriatrics Hospital according to the project approved by the MOH. Develop legal documents on the function and tasks of geriatric departments and requirements and competency standards for geriatric specialists.
- Develop regulations and guidelines about patient information and referrals for older patients with chronic disease who have been stabilized at higher level facilities to return to the CHS for continued disease management.

Other health care services for older persons

- MOH develop legislation/regulations to support and facilitate development of home health care services for older persons.
- Supplement existing rehabilitation guidelines in the community and create conditions (e.g. equipment) appropriate with the rehabilitation needs of older persons at the commune level and at home.
- Develop palliative care treatment guidelines appropriate with older persons in the community, with contents to serve older patients, as well as caregivers and family members.
- Ensure that older persons suffering pain can access pain relief medication as needed, including during palliative care provided at home.

Inputs to health care for older persons

Health financing

- Overcome impediments to insurance coverage for people aged 80 and older who don't yet have health insurance. Consider a policy to support health insurance enrollment for people aged 60 to 79 who don't yet have health insurance.
- Develop financial solutions using funds from health insurance, state budget or other sources to implement periodic health checkups and screening for older persons.
- Consider options for financial support for interventions that cure or mitigate disabilities in poor older persons, such as cataract surgery, prescription glasses and hearing aids.
- Create an appropriate financial mechanism to incentivize and motivate commune health workers to more pro-actively provide health care services to older persons.

Health human resources

- Develop standard geriatric care competencies to serve as a basis for adjusting the training curriculum for doctors and nurses who care for older patients.
- Review, update, adjust and supplement health worker training curricula according to standard competencies to better meet the needs of older persons both in terms of medical technical knowledge and psychosocial interactions.
- The MOET the should issue a training code for geriatric specialization in the national post-graduated education system. Strengthen training of geriatric specialists in the provinces.
- Continue to expand CME on geriatric knowledge and competencies for health workers administrative who participate in providing health care for older persons.
- Undertake the procedures to establish the Vietnam Geriatrics Society and the Northern branch of this association. Strengthen the role of the Society in developing professional guidelines in geriatric medicine. Consider issuing certification to the HCMC Geriatrics Association for providing CME training in geriatrics.
- Develop geriatric health worker teams to provide health care for older persons in hospitals, consisting of doctors, nurses, rehabilitation technicians, social workers and caregivers.

Pharmaceutical management

- Review the insurance drug formulary for suitability with the needs of older persons; supplement special indications for use to fit with specific pharmaceutical needs of older persons.
- Consider revisions to regulations on health insurance claims processing for drugs used to treat chronic disease that continue over several years. Balance between the interests of monitoring the disease, costs and mobility difficulties of older people to access drugs needed to manage their diseases.

2.3 Long-term care solutions

State management

- Strengthen the role of the Vietnam National Committee on Aging, the VAE at all levels and the Department of Social Protection (labor sector) in developing, evaluating and revising policies for older persons.
- Implement research (needs assessment, response capacity,…) to provide evidence for developing policies appropriate for LTC of older persons at home and in institutional settings.
- Based on research findings on needs assessment, review the groups of older persons designated as social protection beneficiaries with an orientation towards expanding the scope of older persons to receive social assistance funds based on need.
- Develop an inter-sectoral collaboration mechanism between the labor and health sectors for formulating and implementing policies on LTC for older persons.
- Revise regulations on conditional business registration, ensure that they are consistent with stipulations in the Law on the Elderly and sub-legal documents, particularly in relation to issuing permits for operating in the field of care for older persons.

Organization of service delivery

LTC in the community

- Consider expanding the scope of groups of older persons entitled to state-funded social work services.
- Develop national regulations on care standards and enhance surveillance of quality of care, quality of life and entitlements of older persons receiving care in the community, appropriate for Vietnam.
- Mobilize funds from society to rapidly expand the ISHC model to other localities that do not yet have activities to support LTC for older persons.
- Study international experience to revise policies, improve the ability to meet needs for health care of older persons with disability or severe illness who face difficulties in getting to a health facility. Revise current policy on licensing home health care providers to expand the scope of services they are allowed to provide at home, health insurance reimbursement for services provided at home and quality management for health care services provided in homes.
- Study international and domestic experience on day care services for older persons in order to develop an appropriate model for Vietnam.

- Research policies to support poor and near poor families with elderly members whose care adversely affects their ability to work and earn income.

Institutionalized residential LTC

- Disseminate policies and facilitate registration of social enterprises to ensure that investors who want to invest in private social protection establishments benefit from preferential treatment.
- Clarify the concept "Center for long term health care" in the Health Care for the Elderly Project.
- Revise care standards at social protection establishments to add in standards related to care processes, safety, respect for client dignity and health care services for elderly residents of social protection establishments.

Human resources for LTC

- Develop competency standards for people providing personal care to older persons (relatives, volunteers, professional caregivers), including both social care and health care.
- Gather existing materials and videos and develop new ones to guide layperson caregivers to implement standard care procedures and improve skills to care for older persons as needed.
- Develop a training curriculum for professional caregivers to older persons with appropriate levels of training to meet needs for different forms of LTC for older persons.
- Promote participation and intersectoral collaboration in strengthening competencies for care of older persons for family members and volunteers. Link activities of clubs with the family practice model in relevant localities.
- Add community-based care of older persons into the functions and tasks of VHWs. Train VHWs in knowledge and skills for care of older persons.

LTC financing

- Study options to revise policy on social assistance payments based on level of disability. Propose adding severely disabled older persons into the group entitled to receive social assistance.
- Study options to implement LTC insurance in Vietnam's context based on experience of other countries.
- Research to revise the health care service package covered by health insurance for older persons facing mobility difficulties hindering their ability to get to a health care facility for medical or rehabilitation services in order to expand the scope of services health insurance reimburses at home or at social protection establishments.
- Consider revising the sick leave policy of the social insurance scheme to cover time taken off from work to care for older persons if the total days required exceeds annual paid leave.
- Develop a financing mechanism for LTC: Integrate this into the universal health care program; create conditions for the CHS to not only provide services at the health station, but to permit health workers to visit homes of older persons to provide care as needed.

2.4. Solutions for the social environment promoting healthy aging

- In addition to education and training to improve general knowledge, there is a need for strengthened counselling, health education for older persons with messages designed with special needs of older persons in mind, focused on healthy diet, appropriate rest and physical activity appropriate with different ages, health statuses and diseases of older persons.
- Create concrete measure to facilitate older persons, who are still able and desire to continue working, to participate in social activities, particularly people with high education levels. For other older persons, there is a need to expand the entitlement to social assistance payments and health insurance to more older persons, such as people aged 75 and older who lack stable income.
- Issue guidelines for design standards, arrange amenities in dwellings for older people to ensure they are kept warm and safe, particularly paying attention to measures to reduce the risk of falls. Take into account the needs of older persons in the design and construction of infrastructure, public works, development and operation of high rise apartment buildings and public transport.
- Combine IEC and advocacy with administrative measures to ensure development and maintenance of a harmonious environment in the family and residential community. Provide counselling to family members about how to maintain good relations with older persons, guide relatives in basic knowledge and skills for health care of older persons and encourage and support them to participate in health care for older persons in the family and community.

MEDICAL PUBLISHING HOUSE
Address: 352 Doi Can - Ba Dinh - Ha Noi
Website: www.xuatbanyhoc.vn * Email: xuatbanyhoc@fpt.vn
Tel: 024.37625934 * Fax: 024.37625923

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