Chapter 6

Healthcare and Healthcare Utilisation

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December 2020

This chapter should be cited as

Tran, M.T., L.T. Dang and N.C. Vu (2020), 'Healthcare and Healthcare Utilisation', in Vu, N.C., M.T. Tran, L.T. Dang, C.L. Chei, and Y. Saito (eds.), *Ageing and Health in Viet Nam*, Jakarta: ERIA, pp.71-85.

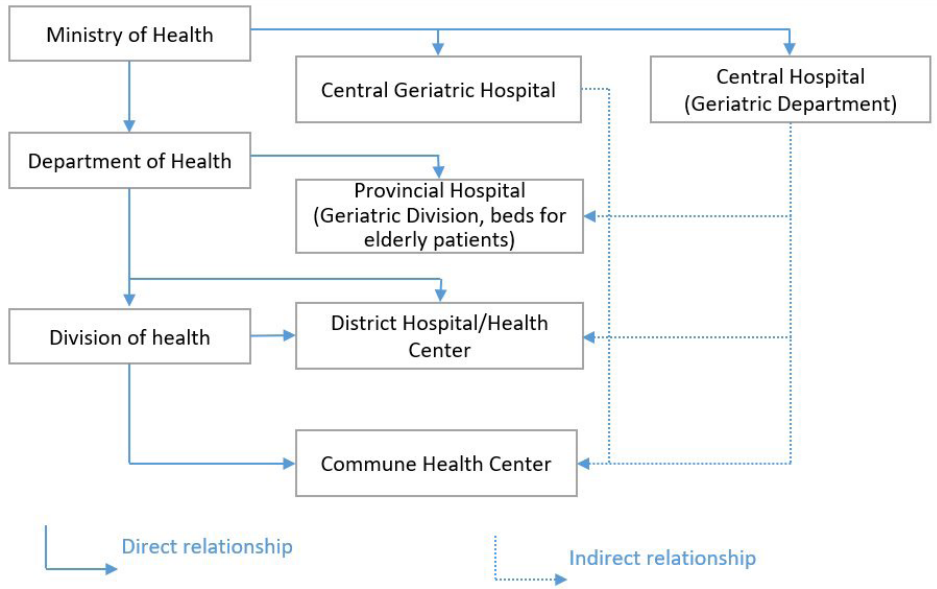
CHAPTER 6

Healthcare and Healthcare Utilisation

Mai Thi Tran, Linh Thuy Dang, and Nguyen Cong Vu

Older persons (OPs) in Viet Nam carry a heavy burden of chronic diseases such as cancer, heart disease, stroke, diabetes, joint degeneration, stress, depression, amongst others, which require long-term and expensive treatment and care. OP care is influenced by factors such as number of diseases, risk of disability, and the healthcare system. Viet Nam has three levels of formal healthcare providers (Figure 6.1): central geriatric hospital, provincial hospital geriatric division, and district hospital or health centre. OPs also receive informal and kin-based healthcare.

Figure 6.1. Public Healthcare Management for Older Persons



Source: Research Project on Care for Older Persons in ASEAN+3 (2018).

The Longitudinal Study of Ageing and Health in Viet Nam (LSAHV) includes information about OPs seeking healthcare from formal and informal sources in the recent past and about long-term care, which is a significant concern in ageing societies, including Viet Nam.

Formal Care

Formal care refers to healthcare provided by the healthcare system. The LSAHV examined two types of formal care: inpatient and outpatient care.

Inpatient Care Utilisation

Inpatient care refers to healthcare that requires the ill person to stay for an extended period in a health facility. The LSAHV defines utilisation of inpatient health services as having stayed at least overnight in a health facility in the 12 months preceding the survey (Table 6.1). A total of 21.9% of all OPs availed themselves of inpatient care within that time frame and the percentage increases with age. Amongst the oldest group (80+), about 26% stayed overnight in a health facility. The average number of times all OPs stayed in a facility was 2.27 in the previous year. The average number of hospital stays was almost the same for men and women and slightly increased with age. A small proportion stayed at private facilities (5%), with most staying at public facilities (94%).

OPs' answers to 'Who paid the most for the last hospitalisation?' reflect heavy reliance on children as informal financial support: 41.8% said their children paid the most whilst 37.0 % said they themselves or their spouse (13.9%).

About 90.2% of hospitalised OPs used national health insurance benefits thanks to the 2008 Law on Health Insurance (25/2008/QH12) and other regulations such as Government Regulation 68/2008/ND-CP, Prime Minister's Decision 485/2006/QD-TTg in 2006, the 2009 Law on the Elderly, and Decision 4858/QD-BYT 2013 of the Ministry of Health. This decision of the Ministry of Health includes 'the number of beds for elderly patients' in the criteria for assessing the quality of hospital services (Chapter 1).

Table 6.1. Inpatient Utilisation by Sex and Age

Inpatient Utilisation	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% who stayed overnight in a hospital/ other medical facility in the past year because of an illness/accident in the past 12 months	21.0	22.5	n.s.	20.4	22.6	26.0	n.s	21.9
N	2,570	3,480		2,638	2,004	1,408		*6.050*
Mean number of times stayed at least overnight in a hospital	2.10	2.40	n.s.	2.20	2.20	2.49	n.s.	2.27
N	*439*	*600*		403	367	269		*1,039*
Type of facility used the last time hospitalised								
Commune health centre	6.7	10.4		8.3	6.7	13.5		8.9
District hospital	41.0	42.9		41.8	40.1	44.4		42.1
Provincial general hospital	24.5	22.4		22.6	20.9	28.1		23.3
Provincial/speciality hospital	9.5	3.8		5.5	8.8	4.4		6.1
National general hospital	9.2	9.2	n.s.	10.2	9.9	5.7	n.s.	9.2
National specialty hospital	2.6	5.9		4.6	7.4	0.8		4.6
Private clinic	1.6	1.4		1.9	1.1	0.6		1.5
Private hospital	3.0	2.9		3.2	2.8	2.3		2.9
International hospital	0.9	0.04		0.5	0.4	0.1		0.4
Others	1.0	1.1		1.4	1.1	0.1		1.1
N	532	710		471	439	332		*1,242*
Who paid the most for the hospitalisation								
Respondent	36.9	37.0		43.4	33.2	24.3		37.0
Spouse	18.9	10.5		19.7	9.7	3.4		13.9
Children	32.9	47.8	n.s.	27.9	53.9	64.6	n.s.	41.8
Grandchildren	0.2	0.5		0.2	0.2	1.1		0.4
Other relatives	1.9	1.6		2.2	0.6	1.9		1.7
Others (e.g. pension)	9.2	2.6		6.7	2.5	4.8		5.2
N	*533*	*710*		471	437	335		*1243*
% who received benefit from health insurance								
Yes	91.5	89.3	n.s.	91.6	89.4	87.4	n.s.	90.2
No	1.6	1.3		1.7	1.3	0.7		1.4
% Who have other insurance aside from health insurance	19.3	14.8	n.s.	14.1	18.3	21.6	n.s.	16.6
N	*536*	*712*		473	440	335		1,248
Who used discounts for senior citizens (%)	42.9	38.0	n.s.	35.1	33.9	61.4	n.s.	40.1
N	*536*	*712*		473	440	335		1,248

Sig = Statistical significance, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data.

Outpatient Care Utilisation

Slightly more OPs went for outpatient than inpatient care (Table 6.2). About 30% reported receiving medical care for an illness or accident in the previous 12 months without staying overnight in a medical facility (women: 29.7%; men: 26.6%). The percentage of OPs using outpatient services increases with age.

OP outpatients prefer public facilities (87%) over private facilities (13%). This utilisation pattern of outpatient care is similar to that of inpatient care. About 70% of those who received outpatient care saw a physician for most of their health problems.

Table 6.2. Outpatient Utilisation by Sex and Age

Outpatient Utilisation	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% who received medical care for an illness/accident from any medical facility or practitioner without staying overnight in the past 12 months	26.6	29.7	n.s.	25.8	31.3	33.1	n.s.	28.4
N	*2,570*	*3,480*		*2,638*	*2,004*	*1,408*		*6.050*
Type of facility visited most as an out-patient								
Commune health centre	38.8	43.0		37.5	42.4	50.0		41.3
District hospital	30.9	28.6		31.3	28.3	26.2		29.5
Provincial general hospital	10.2	7.7		8.4	9.7	8.0		8.7
Provincial or specialty hospital	5.4	2.6		3.8	5.5	1.0		3.7
National general hospital	3.7	3.1	n.s.	4.1	3.5	1.1	n.s.	3.3
National specialty hospital	1.4	1.3		1.8	0.3	1.5		1.3
Private clinic	4.7	6.4		6.2	3.7	7.1		5.7
Private hospital	2.6	4.1		3.2	5.0	2.2		3.5
International hospital	0.5	0.4		0.7	0.2	0.0		0.4
Others	1.9	2.8		3.0	1.4	2.4		2.4
N	*677*	*1,043*		*699*	*598*	*423*		*1,720*
Health practitioner seen most often for health problems								
Traditional practitioner	5.9	6.3		6.1	3.8	9.6		6.2
Doctor	67.5	66.2		70.4	65.0	59.1		66.7
Nurse	0.1	0.8	n.s.	0.3	1.1	0.4	n.s.	0.5
Midwife	0.0	0.0		0.0	0.0	0.0		0.0
Commune health worker	20.8	23.3		19.2	27.1	24.0		22.3
Others	2.8	3.4		2.3	2.3	3.8		2.6
N	*662*	*1,030*		*685*	*586*	*421*		*1,692*

Sig = Statistical significance, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data..

Unmet Need for Healthcare

About 3 in 10 OPs received outpatient care in the previous year but not because they had low medical need: 13% of OPs reported that they felt ill in the previous 12 months but did not go to doctor (Table 6.3). The most common reason for not seeking medical care at that time was not having enough money (35.7%).

Table 6.3. Unmet Need for Healthcare by Sex and Age

Unmet Need for Health Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% who felt ill and thought about seeing a doctor but did not in the past 12 months	12.7	12.8	n.s.	12.2	13.7	13.2	n.s.	12.7
N	*2,570*	*3,480*		*2,638*	*2,004*	*1,408*		*6.050*
% whose most important reason for not seeing a doctor is not having enough money	33.3	37.6	n.s.	36.8	32.2	37.7	n.s.	35.7
N	*281*	*409*		*310*	*243*	*137*		*690*

Sig = Statistical significance, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data.

Health Insurance Coverage

LSAHV data indicate that 91% of OPs have health insurance coverage. The national health insurance system is free for the poor (11.3%); ethnic minorities (11.3%); and 'merit' people such as veterans, Vietnamese Heroic Mothers, spouses of martyrs, and war invalids (37.5%); of insured OPs, 32.3% are covered by voluntary health insurance (Table 6.4). There is no sex or age difference in health insurance coverage, except for merit OPs and OPs insured by voluntary health insurance. Male merit OPs with health insurance make up a significantly higher proportion (45.3%) than their female counterparts (31.6%). As for OPs with voluntary health insurance, the percentage of coverage decreases with age. Merit OPs in the oldest age group (80+) make up the highest proportion of OPs with health insurance (42%).

Table 6.4. Health Insurance Coverage by Sex and Age

Health Insurance Coverage	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% who have health insurance	91.1	90.9	n.s.	89.6	91.4	95.1	n.s.	91.0
N	*2,570*	*3,480*		*2,638*	*2,004*	*1,408*		*6,050*
Type of health insurance								
For poor people	8.4	13.4	n.s.	9.3	14.8	12.8	n.s.	11.3
For ethnic minority	10.0	12.3	n.s.	11.7	9.8	11.9	n.s.	11.3
For merit people	45.3	31.6	*	34.3	41.5	42.0	n.s.	37.5
Compulsory	3.6	4.0	n.s.	4.2	3.0	3.5	n.s.	3.8
Voluntary	29.9	34.1	n.s.	38.1	29.6	17.1	*	32.3
Private	1.4	1.4	n.s.	1.5	1.3	1.2	n.s.	1.4
N	*2,303*	*3,110*		*2,305*	*1,793*	*1,315*		*5,413*

Sig = Statistical significance, * $p < 0.05$, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data.

Public Health Services for Older Persons

The law on the elderly (39/2009/QH12), adopted on 1 July 2010, defines the rights and obligations of OPs:

(1) OPs who are 80+ are served first in hospitals and clinics, except children's hospitals.
(2) Geriatric departments must provide beds for OPs.
(3) Healthcare centres and communities are responsible for OPs' primary healthcare.
(4) OPs who are 80+ and do not have a pension receive a monthly allowance and free health insurance.
(5) Poor OPs who do not have relatives and are not in good health can stay in nursing homes and are provided with free food, free care, medicines, and rehabilitation, and with funeral service when they die.

Level of Use and Source of Medicines for Hypertension and Diabetes

Because of ageing and lifestyle changes, more OPs are being diagnosed with hypertension (HTN) and/or diabetes. Of OPs diagnosed with HTN, 85.9% are taking medications and about 70% obtain them from health centres (Table 6.5). Of OPs diagnosed with diabetes, 86.5% take medications and 80.8% receive them from health centres all the time.

Table 6.5. Level of Use and Source of Medicines and Supplements by Sex and Age

Level of Use and Source of Medicines and Supplements	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% who take any medicine for:								
High blood pressure	83.0	87.8	n.s.	83.9	88.0	87.7	n.s.	85.9
N	*1,006*	*1,500*		*875*	*942*	*689*		*2,506*
Diabetes	80.3	90.3	n.s.	90.1	77.5	88.9	n.s.	86.5
N	*210*	*350*		*243*	*230*	*87*		*560*
% who get medicine from health center(s) all the time								
High blood pressure	66.7	71.9	n.s.	69.7	71.9	66.8	n.s.	69.8
N	*1,006*	*1,500*		*875*	*942*	*689*		*2,506*
Diabetes	78.1	82.5	n.s.	86.8	68.4	82.5	n.s.	80.8
N	*210*	*350*		*243*	*230*	*87*		*560*
% taking any supplement	10.3	11.3	n.s.	9.8	11.2	13.9	n.s.	10.9
N	*2,570*	*3,480*		*2,638*	*2,004*	*1,408*		*6,050*

Sig = Statistical significance, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data.

We asked OPs whether they were taking supplements such as multivitamins, antioxidants, and food supplements. Only 10.9% said they were. Women (11.3%) were more likely to report taking supplements than men (10.3%). Although the proportion of OPs taking a supplement increased with age, the difference was not significant (60–69 years: 9.8%; 70–79: 11.2%; and 80+: 13.9%).

Informal Care

Informal healthcare refers to care received from kin and others when one is ill. We asked the OPs to identify who usually took care of them when they were sick from when they turned 60 to the time of the survey.

The most commonly cited person is the spouse (40.8%) but there is a clear disparity between men and women: more men (61.1%) than women (25.5%) are more likely to name their spouse. More women (36.1%) than men (23.7%) report a son as their principal caregiver.

Table 6.6. Person Who Usually Takes Care of Older Person When He/She is Sick Since Age 60 by Sex and Age

Person Who Usually Takes Care of Older Person	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
Spouse	61.1	25.5		49.3	36.3	17.1		40.8
Son	23.7	36.1		27.0	32.4	41.5		30.7
Daughter	8.0	16.9		9.4	16.6	20.7		13.1
Daughter-in-law	1.6	8.3		3.8	6.0	10.2		5.4
Son-in-law	0.2	0.0	***	0.0	0.2	0.1	n.s.	0.1
Grandchild	0.5	1.7		0.7	1.2	2.9		1.2
Other relatives	0.8	2.8		2.3	1.7	1.0		1.9
None/Self	2.0	4.3		4.1	2.5	1.8		3.3
Helper	0.0	0.3		0.0	0.2	0.7		0.2
Others	0.5	1.2		0.8	1.0	1.1		0.9
N	*2,570*	*3,480*		*2,638*	*2,004*	*1,408*		*6,050*

Sig = Statistical significance, *** $p < 0.001$, n.s. = not significant.
Source: Calculated by PHAD using original LSAHV data.

The percentage of OPs cared for by a spouse decreases with age and the percentage of sons as caregivers increases with age (Table 6.6). The reasons are age-related changes in marital composition (increasing widowhood), differential mortality patterns of men and women (women live longer), and parents living with a son's rather than a daughter's family. Caregiving for OPs is mostly a male role.

Long-term Care

The LSAHV is the first ageing survey in Viet Nam to explore the issue of long-term care (LTC), which 'covers those activities undertaken by others to ensure that people with, or at risk of, a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity' (World Health Organization,2017: 2). LTC is nonmedical care provided to those who need continuous assistance in performing the basic activities of daily living.

Long-term Care: Current Practice

Of the 5,354 OPs in the LSAHV sample, 1,118 or 20.4% are receiving care because of a continuing health condition. Slightly more male than female OPs receive LTC (21.3% vs. 19.8%). The number of OPs receiving LTC increases with age (60–69: 16.1%; 70–79: 24.1%; and 80+: 34.3%). 86% of them require daily care (Table 6.7).

Table 6.7. Long-term Care by Sex and Age

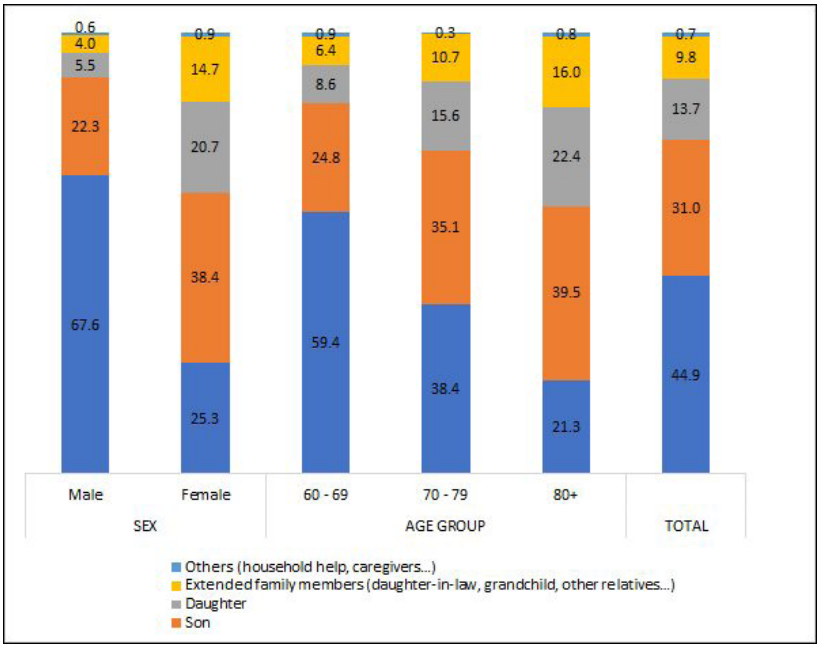
Long-term Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
% currently receiving care because of continuing condition of ill health or disability	21.3	19.8	n.s.	16.1	24.1	34.3	*	20.4
N	*2,361*	*2,993*		*2,530*	*1,833*	*991*		*5354*
Person mainly taking care of older person								
Spouse	67.6	25.3		59.4	38.4	21.3		44.9
Son	22.3	38.4		24.8	35.1	39.5		31.0
Daughter	5.5	20.7		8.6	15.6	22.4		13.7
Daughter-in-law	2.5	10.1	**	3.7	8.4	10.5	n.s.	6.6
Son-in-law	0.0	0.3		0.1	0.0	0.5		0.2
Grandchild	0.3	2.1		0.7	1.8	1.8		1.3
Other relatives	1.2	2.2		1.9	0.4	3.1		1.7
House help	0.2	0.3		0.1	0.2	0.5		0.2
Others	0.1	0.6		0.5	0.1	0.4		0.4
N	*490*	*628*		*375*	*413*	*330*		*1,118*
Frequency of care given	490	628		375	413	330		1,118
Every day	91.3	82.1		86.3	87.6	84.6		86.3
Every few days	3.9	9.0	n.s.	6.9	6.0	7.0	n.s.	6.7
Every week	1.8	2.5		1.9	2.2	2.9		2.2
Every month	1.2	2.5		1.4	1.7	3.4		1.9
Every few months	1.7	3.4		3.3	2.4	1.4		2.6
N	*490*	*628*		*375*	*413*	*330*		*1,118*
Kind of care provided								
Preparation of food	86.9	73.9		73.8	84.3	87.6		79.9
Give medicine	47.4	44.8		43.4	50.3	46.2		46.0
Self-care (e.g., bathing, washing)	28.2	23.6	n.s.	25.6	24.7	27.5	n.s.	25.7
Getting up from bed/chair	15.0	13.3		15.2	12.0	14.3		14.1
Assist in moving around	20.5	21.9		20.9	18.6	25.7		21.3
Others	5.7	8.3		8.6	6.8	4.4		7.1
N	*490*	*628*		*375*	*413*	*330*		*1,118*
Person older persons would like to receive care from in case older person will have dementia								
Spouse	51.2	19.5		40.0	27.2	14.4		33.5
Son	31.9	42.8		34.2	43.3	46.0		38.0
Daughter	10.9	22.5		15.1	19.6	23.7		17.3
Daughter-in-law	1.2	7.3	***	4.0	4.6	7.7	n.s.	4.6
Son-in-law	0.0	0.0		0.0	0.0	0.1		0.0
House helper	0.0	0.0		0.0	0.1	0.1		0.0
Health staffs	0.2	0.5		0.4	0.4	0.6		0.4
Nursing home staff	0.1	0.5		0.4	0.1	0.4		0.3
Others	1.0	2.6		1.8	1.7	2.7		1.9
Not sure	3.0	3.8		3.5	3.1	3.9		3.5
N	*2,361*	*2,993*		*2,530*	*1,933*	*999*		*5,354*

Long-term Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	60-69	70-79	80+	Sig	
Person who will most likely take care of older person in case older persons will have dementia								
Spouse	47.9	17.8		37.7	24.0	13.3		31.2
Son	34.1	42.9		35.5	43.5	47.1		39.0
Daughter	11.3	23.3		15.7	20.9	22.9		18.0
Daughter-in-law	1.9	8.2	**	4.4	5.8	9.4	n.s.	5.4
Son-in-law	0.0	0.2		0.1	0.0	0.1		0.1
House helper	0.4	0.2		0.3	0.3	0.2		0.3
Health staffs	0.3	0.4		0.4	0.2	0.3		0.4
Nursing home staff	0.3	0.6		0.6	0.2	0.6		0.5
Others	0.5	2.5		1.3	2.0	2.5		1.6
Not sure	3.0	3.6		3.4	2.9	3.3		3.3
N	*2,361*	*2,993*		*2,530*	*1,933*	*999*		*5,354*
Person older person would like to receive care from in case older person becomes invalid or bedridden								
Spouse	49.5	17.5		38.8	23.8	12.7		31.6
Son	32.8	40.6		32.8	43.1	46.4		37.1
Daughter	11.5	25.9		17.6	22.0	24.5		19.6
Daughter-in-law	1.5	8.4	**	4.4	5.8	8.7	n.s.	5.3
Son-in-law	0.1	0.0		0.1	0.0	0.1		0.1
House helper	0.3	0.1		0.1	0.2	0.7		0.2
Health staffs	0.2	0.5		0.3	0.3	0.4		0.3
Nursing home staff	0.5	0.7		0.7	0.2	0.5		0.6
Others	0.4	2.6		1.4	1.8	2.6		1.6
Not sure	3.0	3.5		3.5	2.8	3.1		3.3
N	*2,361*	*2,993*		*2,530*	*1,933*	*999*		*5,354*
Person who will most likely take care of older person in case older person becomes invalid or bedridden								
Spouse	45.7	16.3		35.6	22.6	12.2		29.3
Son	35.3	42.7		36.3	43.2	47.0		39.4
Daughter	12.4	24.2		16.7	22.2	23.8		19.0
Daughter-in-law	2.0	8.6		4.5	6.5	9.6		5.7
Son-in-law	0.0	0.2	**	0.1	0.0	0.1	n.s.	0.1
House helper	0.2	0.2		0.1	0.2	0.3		0.2
Health staffs	0.2	0.6		0.5	0.3	0.3		0.4
Nursing home staff	0.3	0.6		0.6	0.1	0.5		0.5
Others	0.8	2.6		1.6	1.8	2.7		1.8
Not sure	2.9	3.6		3.4	3.0	3.3		3.3
N	*2,361*	*2,993*		*2,530*	*1,933*	*999*		*5,354*

Sig = Statistical significance,* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, n.s. = not significant.
Source: Calculated by PHAD using original LSAV data.

The percentage distribution of the LTC giver is much like that of the usual caregiver of the OP during illness since age 60 (Figure 6.2). The three most common LTC givers are spouse (44.9%), son (31.0%), and daughter (13.7%); the proportions are similar to those of short-term caregivers. Males receiving LTC mostly have their spouse as caregivers (67.6%) whilst women have a son caring for them (38.4%). Members of the nuclear family (spouse and children) provide about 90% of LTC, whilst the extended family – grandchildren, daughter-in-law, and sibling – provides 9.8%. People who are not family, such as household help, caregivers, and friends, make up 1% of primary caregivers.

Figure 6.2. Distribution of Main Caregivers of Older Persons Currently Under Long-term Care by Sex and Age (%)



Source: Calculated by PHAD using original LSAHV data.

Future Long-term Care

As OPs age, the probability of their requiring care by others increases. The common reasons for needing LTC are dementia and being bedridden, which is commonly a consequence of a stroke, a fall, or both.

We asked OPs not under LTC from whom they would prefer to receive care if they developed dementia or became bedridden or invalids. The profile of the preferred caregivers is the same as that of the caregivers of OPs who were under LTC at the time of the survey. The three most preferred caregivers are son, spouse, and daughter, in that order, which reveals traditional culture, where OPs heavily rely on sons for financial, mental, and daily care.

We asked OPs who would most likely care for them if they developed dementia or became bedridden or an invalid. The preferred and most likely caregivers are similar in both situations, except for a slightly higher percentage of 'Not sure' responses to the second question. Not many OPs mentioned LTC givers or facilities that are prevalent in more advanced ageing societies, such as house helpers, health staff, and nursing homes. Few OPs (0.1%) prefer to receive LTC from a son-in-law. Evidently, provision of future LTC remains a family responsibility dominated by males, which is based in traditional culture and family structure.

Summary, Conclusions, and Recommendations

Most OPs seek healthcare from public facilities, with only a small percentage going to private facilities for inpatient and outpatient care. Almost all OPs who were hospitalised in the 12 months before the survey availed themselves of health insurance benefits either as members or dependents. Health insurance is free only for the poor, ethnic minorities, and merit people. Of OPs who were hospitalised, one-third said most of the hospitalisation expenses were paid by themselves or their children. Because the lack financial resources, two in five OPs are constrained from consulting a physician when they need outpatient services.

Because OPs are highly aware of HTN and diabetes, 85.9% of diagnosed hypertensives and 86.5% of diagnosed diabetics take medication for their conditions. Of these, 69.8% of OPs with HTN and 80.8% with diabetes receive their medication from public health facilities all the time.

Amongst all OPs, 20.4% are under LTC, with mostly a spouse, son, or daughter as the main caregiver, in that order. Men are commonly cared for by their spouse, whilst women are mostly cared for by their son. LTC is provided for the most part by close family members. The profiles of preferred and current caregivers are the same, mostly sons, spouses, and daughters, in that order. In a culture that prefers sons, such as Viet Nam, OPs rely on sons rather than people who are not members of the family or on institutional facilities such as nursing homes.

The following recommendations may be considered:

(1) Provide education and training programmes on geriatric care for caregivers who are family members of OPs and living in the household or who are volunteers to ensure that OPs receive the best in- and outpatient care.
(2) Improve treatments for chronic diseases, especially HTN and diabetes. Make sure all chronically ill OP patients have sufficient, good, and affordable health service.
(3) Develop policies that can be adapted to the ageing population to ensure that OPs have easy access to healthcare facilities and receive free medications and hospitalisation. The policies' implementation must be monitored and evaluated and its progress reported.
(4) Develop an LTC policy and integrate it with other policies. Encourage the private sector to invest in LTC facilities by offering low rent for government land and tax exemption.
(5) Extend health insurance to all OPs. They can pay different premiums depending on their income. This policy will help the near-poor.

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