General Statistics Office

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United Nations Population Fund

OLDER PERSONS IN VIET NAM:
An Analysis of The Population Change and Family Planning Survey 2021

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

ADLs	Activities of Daily Living
GSO	General Statistics Office (Viet Nam)
PCS	Population Change and Family Planning Survey
PHC	Population and Housing Census
SDGs	Sustainable Development Goals
UNFPA	United Nations Population Fund

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FOREWORD

The Viet Nam Population Change and Family Planning Survey 2021 was conducted on 1 April 2021 as specified by Decision No. 1903/QD-TCTK dated 30 December 2020 of the Director General of the General Statistics Office. This annual survey collects information about the population of Viet Nam, including basic characteristics of the population, population changes and the extent to which family planning methods are used. The survey data provides the basis for synthesizing and compiling indicators on population and family planning in six indicator frameworks: national level; planning, investment and statistics; Association of Southeast Asian Nations (ASEAN); the sustainable development of Viet Nam; and youth and gender. The data also assists those working in the field of population and family planning with assessments and planning, and is used for building a national database on population and family planning, meeting the needs of domestic and foreign private users and ensures international comparability.

For the first time, the 2021 survey included a new module on older persons and their care needs and situation. Following the General Statistics Office (GSO)'s study on population ageing and older persons in Viet Nam based on the 2019 Population and Housing Census, the health issues and care needs of older persons have continued to be analysed. The evidence gathered on the socioeconomic and health status and care needs of older persons will be used to make appropriate policy recommendations for an ageing population and to build a sustainable society.

This thematic book, **"Older persons in Viet Nam: An analysis of the Population Change and Family Planning Survey 2021",** builds on previous analyses of population ageing and older persons in Viet Nam. The results show that the population ageing trend continues its fast pace and reveals major differences in the health and care needs of older persons based on age, gender, place of residence and ethnicity. All these issues require plans, policies and programmes to adapt to an ageing population and meet the individual care needs of older persons.

This book was developed with technical and financial support from the United Nations Population Fund (UNFPA) and financial support from the Government of Japan. We would like to thank Associate Professor Giang Thanh Long of National Economics University for analysing the data and writing this book. We would like to express our sincere thanks to the experts and staff of the UNFPA Country Office in Viet Nam and the UNFPA Regional Office for Asia and the Pacific for their valuable comments.

We are pleased to introduce this book on population ageing and care for older persons in Viet Nam – a topic that has attracted a great deal of attention from researchers, administrators, policymakers and the wider society. We look forward to your comments to continue improving the quality of publications by the General Statistics Office and UNFPA.

GENERAL STATISTICS OFFICE OF VIET NAM

EXECUTIVE SUMMARY

Rapid population ageing is having socioeconomic impacts across a range of sectors in Viet Nam, and this trend is expected to continue in the coming decades. Surveys on older persons are crucial to providing updated data and evidence to formulate strategies, policies and programmes and adapt to this reality. This report used data from the 2021 Population Change and Family Planning Survey (hereafter known as PCS) to analyse the demographic, socioeconomic and health characteristics of older persons, their activities of daily living (ADLs), care needs and responses and the willingness of families to pay for care services. Policy issues are addressed and recommendations are presented. The key findings and policy discussions are outlined below.

KEY FINDINGS:

1. DEMOGRAPHIC CHARACTERISTICS OF THE OLDER POPULATION

- Between 2019 and 2021, the population of Viet Nam increased by 2.07 million (from 96.21 million to 98.28 million) while the population of older persons (those aged 60 and over) increased by 1.17 million (from 11.41 million to 12.58 million), an increase from 11.86 per cent to 12.80 per cent of the total population. This ageing trend continues to gain pace in Viet Nam.
- Of the 12.58 million older persons in Viet Nam, 4.62 million lived in urban areas (36.72 per cent) and 7.96 million in rural areas (63.28 per cent). There were 5.30 million older men (42.18 per cent) and 7.28 million older women (57.82 per cent). By ethnicity, there were 11.29 million Kinh persons (89.75 per cent) and 1.29 million persons of other ethnicities (10.25 per cent).
- Older women outnumbered older men in all age groups (60–64, 65–69, 70–74, 75–79 and 80 and over) and more older persons lived in rural areas than urban centres. About 50 per cent of the older population lived in the country's Red River Delta and Northern and Southern Central Coast regions.
- Compared with data from the 2019 Population and Housing Census (PHC), the proportion of older persons in all provinces increased slightly. However, there were significant differences between provinces and cities. The older population remained lower in many provinces in the Northern Midlands and Mountains and the Central Highlands regions, which are also the regions with the highest fertility rates and lowest life expectancies at birth. In contrast, many provinces in the Northern and Southern Central Coast region had a growing older population, higher than the country average, which could be explained in part by the large outmigration of working-age persons.
- The ageing indices (measured by the number of older persons per every 100 children aged 0–14) were significantly different between provinces and cities. Thai Binh province had the highest index (95.77) while Lai Chau province had the lowest (19.02). In 2021, no province had a higher older population than child population.

2. SOCIOECONOMIC CHARACTERISTICS OF OLDER PERSONS

- In terms of marital status, more than two thirds of older persons were married, about one quarter were widowed, while those who were separated, divorced or single accounted for a small proportion. The higher the age, the higher the rate of widowhood. Older women were widowed at a rate four times higher than older men. Of those who were widowed, older women accounted for about 85 per cent of all age groups.

- In terms of family relations, 58.64 per cent of older persons were heads of households, 28.27 per cent were the spouse of household heads, 10.63 per cent were parents of household heads, while other relations (such as children of household heads or no relation to household heads) accounted for a small proportion.

- There were 4.43 million older persons who lived alone; lived with other older persons; or lived in a household with only older persons and children under 15. Of those persons, about 74 per cent lived near their children (57.65 per cent lived in the same village and 16.36 per cent in the same ward). There was a significant difference between older persons who lived in urban and rural areas: about 78 per cent of rural older persons lived near their children compared with around 61 per cent of urban older persons. The higher the age, the higher the rate of living near children: about 87 per cent of the "oldest old" (aged 80 and over) lived near their children compared with about 76 per cent of the "middle old" (aged 70–79) and around 68 per cent of the "young old" (aged 60–69). About 73 per cent of the oldest old lived with their children in the same village.

3. HEALTH ISSUES OF OLDER PERSONS

- About 38 per cent of older persons self-assessed their health status as "very good" or "good", 46 per cent as "moderate" and 16 per cent as "bad" or "very bad". These results differed quite significantly from the Survey on Older Persons and Social Health Insurance in 2019 (OP&SHI 2019) conducted by the Ministry of Health and other organizations (2021), which showed rates of 10 per cent, 38 per cent and 52 per cent, respectively. There were also significant differences by age group (older persons in higher age groups had a lower rate of self-assessment for "very good/good" health status); gender (older women had a lower rate of self-assessed "very good/good" health status than older men); ethnicity (older Kinh persons had a higher rate of self-assessed "very good/good" health status than older persons of other ethnicities); and place of residence (rural older persons had a lower rate of self-assessed "very good/good" health status than urban older persons). In terms of marital status and gender, the results showed that older persons who were "currently married" had a higher rate of "very good/good" health status than those who were "widowed" or "other" (single, separated or divorced). The results indicated significant differences in terms of education (which was measured by ability to read and write). A higher percentage of those who could read and write assessed their health as "very good/good" and a lower percentage as "bad/very bad" compared with those who could not read and write. In both groups, older men had a higher rate of "very good/good" and a lower rate of "bad/very bad" health status than older women.

- About 11.7 per cent of the older population (or 1.47 million older persons) had at least one functional disability (vision; hearing; mobility; cognition; and communication). For each function, differences in disability prevalence by age group, gender, ethnicity and place of residence were the same as those for self-assessed health status.

- 6.32 per cent of the older population (or about 796,000 older persons) found it very difficult to perform or could not perform at least one of the following of activities of daily living (ADLs): eating, putting on or taking off clothes, bathing or washing, getting up when lying down and getting to and using the toilet. These older persons needed substantial help or assistance with ADLs. There were significant differences by age (older persons of higher ages, particularly the oldest old, had a higher rate of difficulty), gender (older women had a higher rate of difficulty than older men); ethnicity (persons of other ethnicities had a higher rate of difficulty than Kinh persons) and place of residence (rural residents had a higher rate of difficulty than urban residents).
- At the provincial level, the number of older persons who needed help or assistance with ADLs were high in provinces with a large population size or a high older population, and vice versa.

4. CARE NEEDS OF OLDER PERSONS AND RESPONSES

- About 80 per cent of older persons who needed help or assistance with ADLs received care from others. The rate of those receiving care differed significantly by age (persons of a higher age had a higher rate of receiving help or assistance with ADLs).
- For older persons who received help or assistance, caregivers were primarily family members (spouse, children and grandchildren). The percentage of those who received care in communities or institutions was quite low. If a caregiver was a spouse, there were major differences by age and gender: persons of higher ages had a lower rate of receiving care from their spouse (60.75 per cent for 60–69, 36.69 per cent for 70–79 and 11.70 per cent for 80 and over) and older men had a higher rate of receiving care from their wives than older women from their husbands (52.34 per cent versus 10.67 per cent). There were no significant differences in care provision between sons and sons-in-law, but a higher percentage of daughters and daughters-in-law provided care to aged mothers than to fathers. Gender differences in ADLs, especially for personal activities, could help explain these differences.
- There were two types of unmet care needs: type 1 – Older persons who needed help and received help or assistance with ADLs but the care was not as they expected; and type 2 – Older persons who needed help but did not receive any help or assistance with ADLs. Data showed that type 1 and type 2 each accounted for 0.15 per cent of unmet care needs. In other words, the total rate of unmet care needs for older persons needing care was 0.3 per cent or 2,400 persons. Although negligible, there were differences in terms of age (persons of higher ages had a higher rate of unmet care needs than those who were younger), gender (older women had a higher rate than older men), ethnicity (older persons of other ethnicities had a higher rate than Kinh persons) and place of residence (rural residents had a higher rate than their urban counterparts). Although a very high percentage of care needs are being met in Viet Nam, the survey could not provide data to evaluate the quality of care provided to older persons.
- About 90 per cent of older persons and 92 per cent of those needing assistance with ADLs wanted to receive care at home, and there were low rates of institutional care (both inpatient and outpatient) for both these groups.
- About 36 per cent of older persons said that they and their families would be willing to pay for care services. However, there were differences by age group (persons in higher age

groups had a higher rate of willingness); gender (older men had a higher rate of willingness than older women); ethnicity (Kinh persons had a higher rate of willingness than persons of other ethnicities); and place of residence (urban residents had a higher rate of willingness than rural residents).

5. POLICY RECOMMENDATIONS

Based on the findings of the survey and this analysis, the following policy recommendations are proposed.

- First, strengthen the health care system. This includes promoting the use of information and communications technology (ICT) in the management of health care services in rural and ethnic minority areas to improve access for older persons. The oldest old (those aged 80 and over) and older women should be given priority in access to and use of care services.

- Second, define long-term care (LTC) services for older persons, which include health care, social care and spiritual care, to ensure social inclusion, better health status and assistance with ADLs. These services should be accessible, affordable and adequate. Since most older persons still receive care at home, developing home-based care services for older persons should be promoted, including free training courses in basic aged care skills for home-based caregivers, and provision of replacement care. The family doctor system and social work services should be expanded to ensure that all older persons are able to receive health care and consultation services. At the same time, a community-based care system should be developed and integrated with the home-based care system to reduce care burdens for family members.

  Along with home-based care and community-based care, the quality and readiness of institutional care should be gradually improved to meet the future care needs of older persons. As mentioned earlier, there are differences in the care needs of older persons based on age, gender and other characteristics, which means the individual care needs of older persons should be carefully considered when designing and providing services. In other words, it is critical to develop an ecosystem of care in communities to navigate and support older persons in different stages of care.

- Third, there is a tremendous need to study, amend and formulate policies for long-term care insurance (LTCI), drawing on international experiences, to adapt to the population ageing expected to continue in Viet Nam in the coming decades and to ensure LTC is financially viable.

- Fourth, although institutional care needs were not high at the time of the survey, the living arrangements of older persons have changed (for example, a lower rate of older persons are living with children and grandchildren, and fewer children are living nearby to take care of older persons due to outmigration). This means institutional care – both inpatient and outpatient – will increase in the coming years. As such, there should be an integrated care system combining home-based, community-based and institutional care. Moreover, the private sector should be encouraged in providing care services to older persons via public-private partnerships.

I. INTRODUCTION

Having adaptive strategies and policies to meet the needs of an ageing population requires data and information that fully capture demographic trends and the unique characteristics of older persons. Evidence from large-scale and representative surveys is important for government to formulate policies that reflect older persons' characteristics and promote the ongoing contributions of older persons to their families, communities and society as a whole.

The Population Change and Family Planning Survey (hereafter known as PCS) is conducted annually on 1 April to collect basic data on population and housing in Viet Nam. This data is then used to formulate socioeconomic policies and monitor the implementation of the Sustainable Development Goals (SDGs), which the Government of Viet Nam has committed to implement. The PCS provides comprehensive data that is representative at the socio-economic region, provincial, urban and rural level for all population groups, including older persons. For the first time in 2021, a new module on older persons, their care needs and care situation was added to the survey.

The sample for PCS 2021 was selected using clusters in two stages. Stage 1 selected 7,640 enumeration areas (EAs) from the surveyed enumeration areas in PHC 2019. These enumeration areas were equally distributed with 120 EAs for each province/city, except Ha Noi and Ho Chi Minh City, which each had 160 EAs. Stage 2 selected 40 households per EA using systematic random sampling (rather than selecting all households in an EA). There were 305,600 households (representing 1.12 per cent of the country's households) selected, and 148,413 older persons (representing 1.18 per cent of the older population, which was similar to the rate of the whole sample) were selected, and were relatively equally distributed across all 63 provinces/cities, ensuring national representation of the older population of Viet Nam.

In previous Population Change and Family Planning Surveys, the older population was analysed based on various socioeconomic aspects, but none had addressed the care of older persons. Other nationally representative surveys, such as the PHC and Viet Nam Household Living Standard Survey, also did not collect data on the care of older persons. The year 2021 marked the first time the General Statistics Office of Viet Nam added a section on the care of older persons to the PCS. This allowed the GSO to gather in-depth information that would inform policy formulation and consultations related to older persons, and provide crucial pieces of information to expand the analyses of previous surveys, such as PHC 2019 and the Survey on Older Persons and Social Health Insurance in 2019 (OP&SHI) conducted by the Ministry of Health and other organizations, as well as evaluate the care needs of older persons over time.

The main aim of this thematic book is to provide an analysis of older persons (those aged 60 and over) in Viet Nam in 2021. The sampled population was nationally representative of the country's 12.58 million older persons. The book provides data on the demographic, socioeconomic, health and disability status of older persons, as well as the difficulties they experience, and then discusses policy issues and proposes recommendations with a particular focus on aged care.

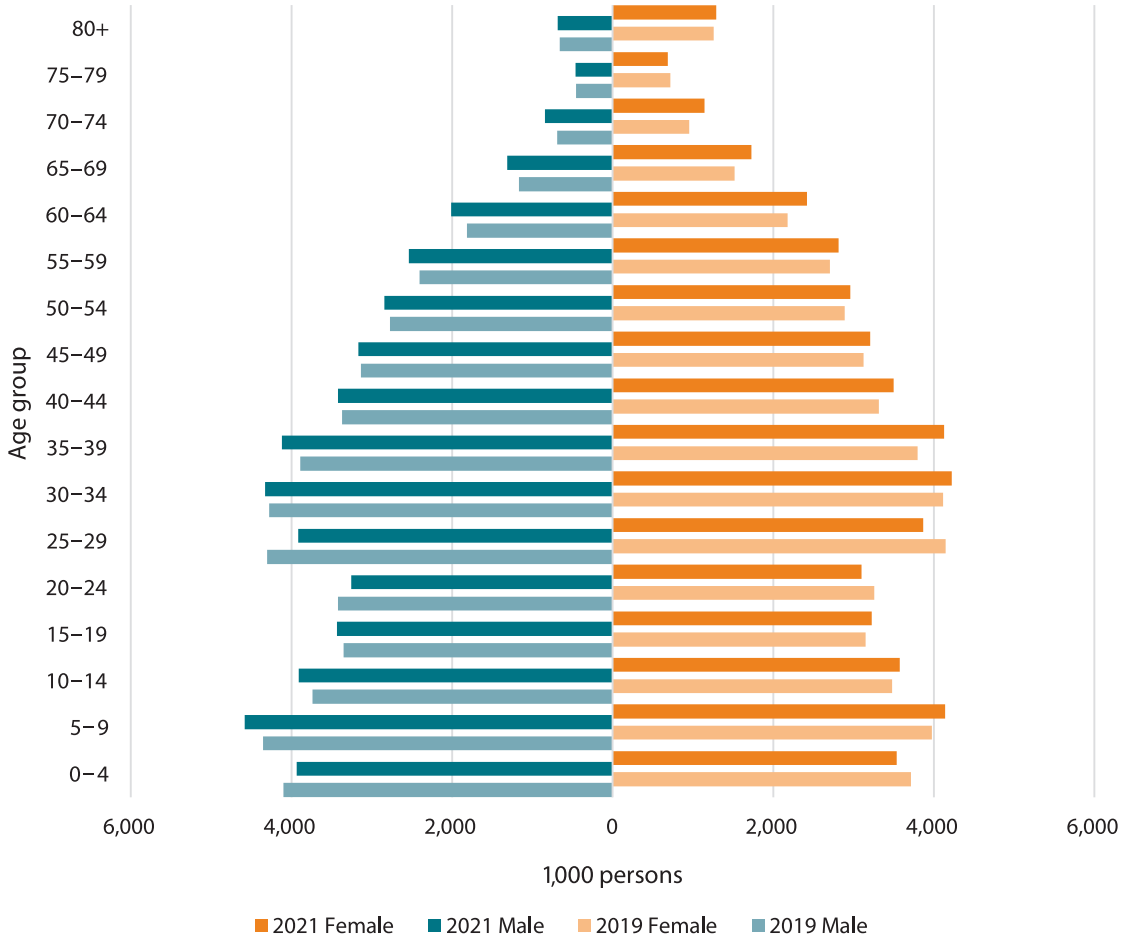
Although the data from PCS 2021 could provide comprehensive data on the demographic, socioeconomic, health and disability status of older persons, there were some unavoidable limitations. First, the living arrangements of older persons (i.e. those with whom older persons lived) could not be defined separately for each type (such as living alone, living with an aged spouse only or living with children) or were merged with different categories into one (such as living alone or living with grandchildren under 15). As a result, the care needs and unmet care needs of older persons could not be analysed in further detail in terms of living arrangements. Second, since all questions related to health status and performance of ADLs were self-assessed by older persons, there could be concerns about the quality of responses. Wrong answers may have been provided if respondents misunderstood the questions, which would mean the results for health-related indicators, especially those related to disability, might not be correct. Third, the survey did not include any questions about whether older persons were satisfied with the care they received, so this could not be evaluated.

II. KEY FINDINGS

1. DEMOGRAPHIC CHARACTERISTICS OF THE OLDER POPULATION

The total population of Viet Nam was 96.21 million on 1 April 2019, but had increased to 98.28 million on 1 April 2021. The number of older persons (those aged 60 and over) was 11.41 million (11.86 per cent of the total population) in 2019 compared with 12.58 million (12.80 per cent of the total population) in 2021. Between 2019 and 2021, therefore, the total population increased by 2.07 million while the older population increased by 1.17 million (accounting for 56.52 per cent). **Figure 1** presents the population pyramids for 2019 and 2021.

Figure 1. Population pyramids of Viet Nam, 2019 and 2021



Source: Illustration based on data from PHC 2019 and PCS 2021

1.1. OLDER POPULATION BY AGE, SEX, ETHNICITY AND PLACE OF RESIDENCE

Of the 12.58 million older persons in Viet Nam, 4.62 million lived in urban areas (36.72 per cent) and 7.96 million lived in rural areas (63.28 per cent). There were 5.30 million older men (42.18 per cent) and 7.28 million older women (57.82 per cent). In terms of ethnicity, there

were 11.29 million Kinh persons (89.75 per cent) and 1.29 million persons of other ethnicities (10.25 per cent).

Older women outnumber older men in Viet Nam, both by age group and place of residence. Also, in higher age groups, a higher percentage of older persons lived in rural areas than urban areas (**Table 1**). These trends were quite similar to those found by a GSO analysis (GSO 2021).

Table 1. Percentage of older population by place of residence and sex

Age group	Total		Urban		Rural	
	Male	Female	Male	Female	Male	Female
60–64	45.35	54.65	45.81	54.19	45.06	54.94
65–69	43.15	56.85	43.71	56.29	42.82	57.18
70–74	42.33	57.67	41.30	58.70	42.93	57.07
75–79	40.06	59.94	42.31	57.69	38.75	61.25
80+	34.65	65.35	37.07	62.93	33.48	66.52
Total	**42.18**	**57.82**	**43.05**	**56.95**	**41.67**	**58.33**

Source: Calculations based on data from PCS 2021

1.2. OLDER POPULATION BY AGE, GENDER AND SOCIOECONOMIC REGION

In terms of socioeconomic region, about 50 per cent of the older population in Viet Nam lived in the Red River Delta (28.29 per cent of the total population or about 3.56 million older persons) and Northern and Southern Central Coast (22.43 per cent of the total population or about 2.82 million older persons). The two regions with the lowest rate and number of older persons were the Northern Midlands and Mountains (11.60 per cent of the total population or about 1.46 million older persons) and the Central Highlands (4.33 per cent of the total population or about 544,000 older persons).

By socioeconomic region, **Table 2** shows that the Red River Delta had the highest older population (15.45 per cent) while the Central Highlands had the lowest (9.05 per cent). **Table 2** shows that the highest proportion of older men and older women were in the Red River Delta (13.59 per cent and 17.25 per cent, respectively) and the lowest in the Central Highlands (7.82 per cent and 10.30 per cent, respectively). In all socioeconomic regions, there were more older women than older men.

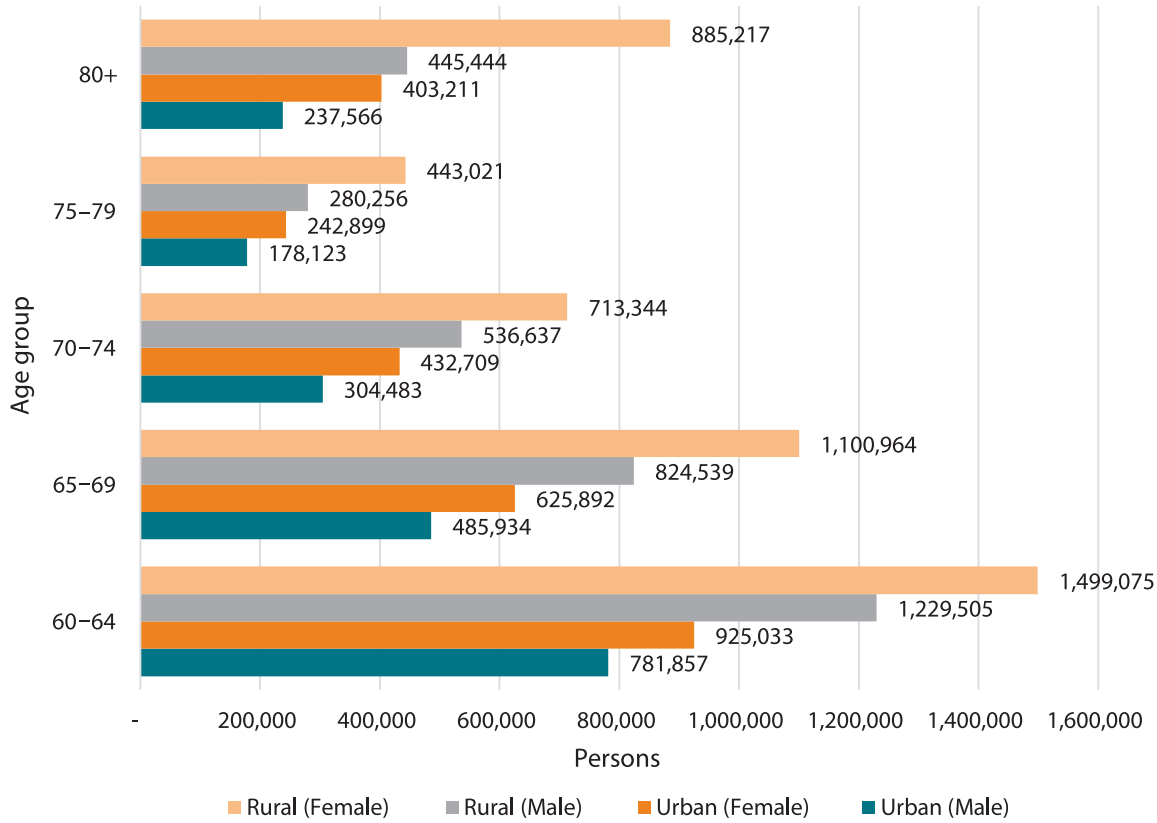
Table 2. Percentage of older population in socioeconomic regions, total and by sex

Total	Total	Male	Female
	12.80	10.88	14.68
Northern Midlands and Mountains	11.34	9.44	13.23
Red River Delta	15.45	13.59	17.25
Northern and Southern Central Coast	13.83	11.68	15.94
Central Highlands	9.05	7.82	10.30
Southeast	9.74	8.08	11.38
Mekong River Delta	13.74	11.56	15.88

Source: Calculations based on data from PCS 2021

Figure 2 shows the number of older persons by sex in six socioeconomic regions. In general, there were more older women than older men in all regions.

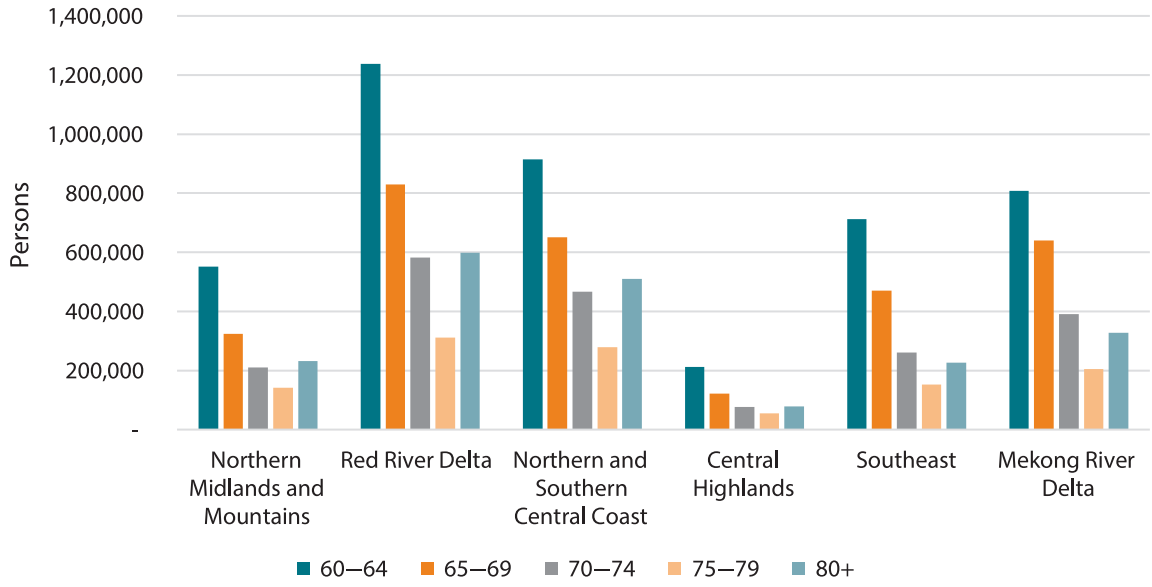
Figure 2. Distribution of older population by sex and socioeconomic region



Source: Calculations based on data from PCS 2021

Figure 3 shows the distribution of older persons by age group and socioeconomic region. In general, the youngest group (aged 60–64) had the highest numbers and rates in all regions. In the Red River Delta and Northern and Southern Central Coast, the oldest age group (aged 80 and over) had the highest numbers and rates of all regions. As will be discussed, age and gender differences in the socioeconomic and health conditions of older persons along with different distribution of older population have various implications for addressing the care needs of older persons in different regions, places of residence and provinces/cities.

Figure 3. Distribution of older population by age and socioeconomic region



Source: Calculations based on data from PCS 2021

Table 3 shows the rates of older persons in the total population at different ages (60 and over; 65 and over; and 75 and over) in six socioeconomic regions and places of residence (urban and rural areas). The Red River Delta had the highest rate of older persons across all age groups. This was followed by the Northern and Southern Central Coast where high rates of outmigration by working-age persons have led to a relatively high older population. This result was quite similar to the findings of PHC 2019. In all age groups, rural areas had higher older populations than urban areas.

Table 3: Percentage of older population by region and place of residence

	60+ (%)	65+ (%)	75+ (%)
Total	12.80	8.28	3.17
By socioeconomic region			
Northern Midlands and Mountains	11.34	7.05	2.91
Red River Delta	15.45	10.08	3.95
Northern and Southern Central Coast	13.83	9.34	3.87
Central Highlands	9.05	5.51	2.21
Southeast	9.74	5.94	2.03
Mekong River Delta	13.74	9.06	3.08
By place of residence			
Urban	12.61	7.95	2.90
Rural	12.91	8.48	3.33

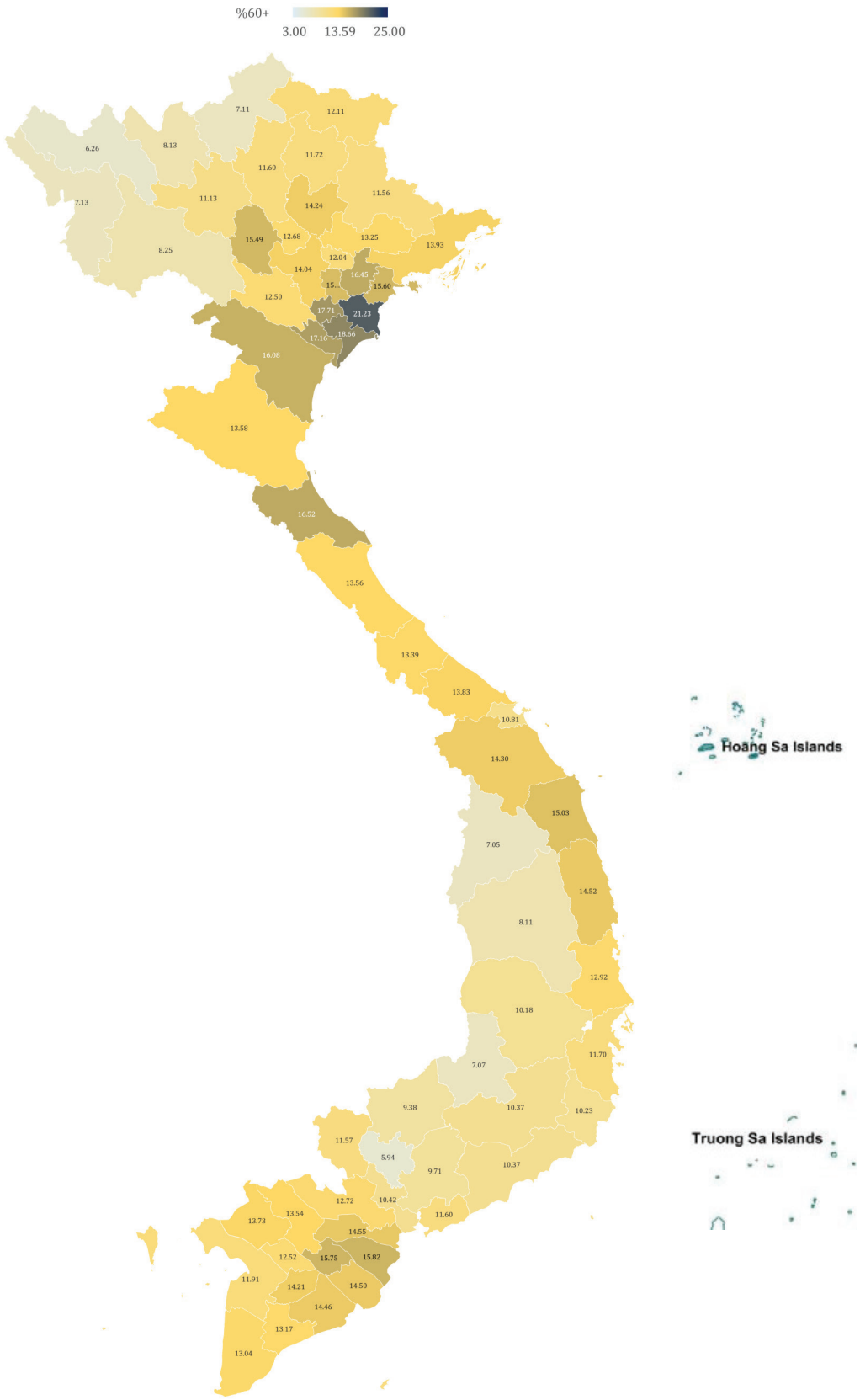
Source: Calculations based on data from PCS 2021

1.3. RATE OF THE OLDER POPULATION BY PROVINCE

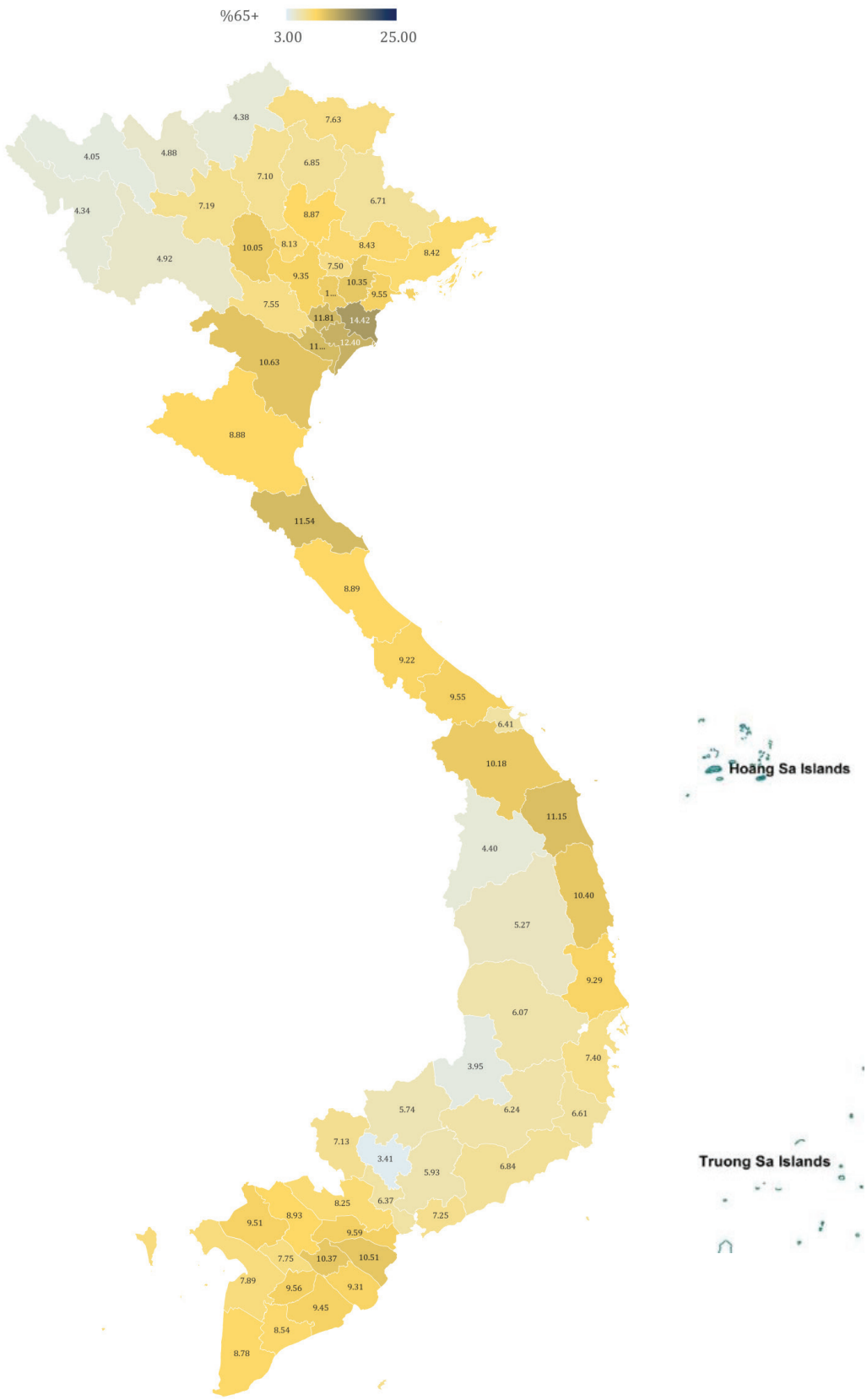
Figure 4 shows the rate of the older population by province in 2021. In this figure, older persons are defined as those aged 60 and over (as in the Law on the Elderly in Viet Nam) or those aged 65 and over (for international comparison). Compared with the results of PHC 2019, the rate of older persons aged 60 and over in all provinces increased slightly. Many provinces in the Northern Midlands and Mountains and the Central Highlands regions still had quite a low older population due to having the highest fertility rates and lowest life expectancies at birth of all provinces. In contrast, many provinces in the Northern and Southern Central Coast region had higher older populations than the national average, which could be explained in part by high rates of outmigration of the working-age population. Thai Binh had the highest rates of older persons aged 60 and over (21.23 per cent) and 65 and over (14.42 per cent), while Lai Chau had the lowest rates (6.26 per cent and 4.05 per cent, respectively).

Figure 5 shows the provincial ageing index (the number of older persons aged 60 and over for every 100 children aged 0–14). When a province has an index of more than 100, the number of older persons is higher than the number of children. The survey results showed that provinces with a high rate of older persons also had a high ageing index, and vice versa. For instance, Thai Binh, Ben Tre and Hai Duong had the highest older populations, and provinces in the Northern Midlands and Mountains and the Central Highlands regions (such as Ha Giang, Dien Bien, Lai Chau, Đak Nong, and Kon Tum) had the lowest older populations. These provinces also had the highest and lowest ageing indices, respectively (Thai Binh had the highest ageing index at 95.77 while Lai Chau had the lowest ageing index at 19.02).

Figure 4. Percentage of older population (60+ and 65+) by province

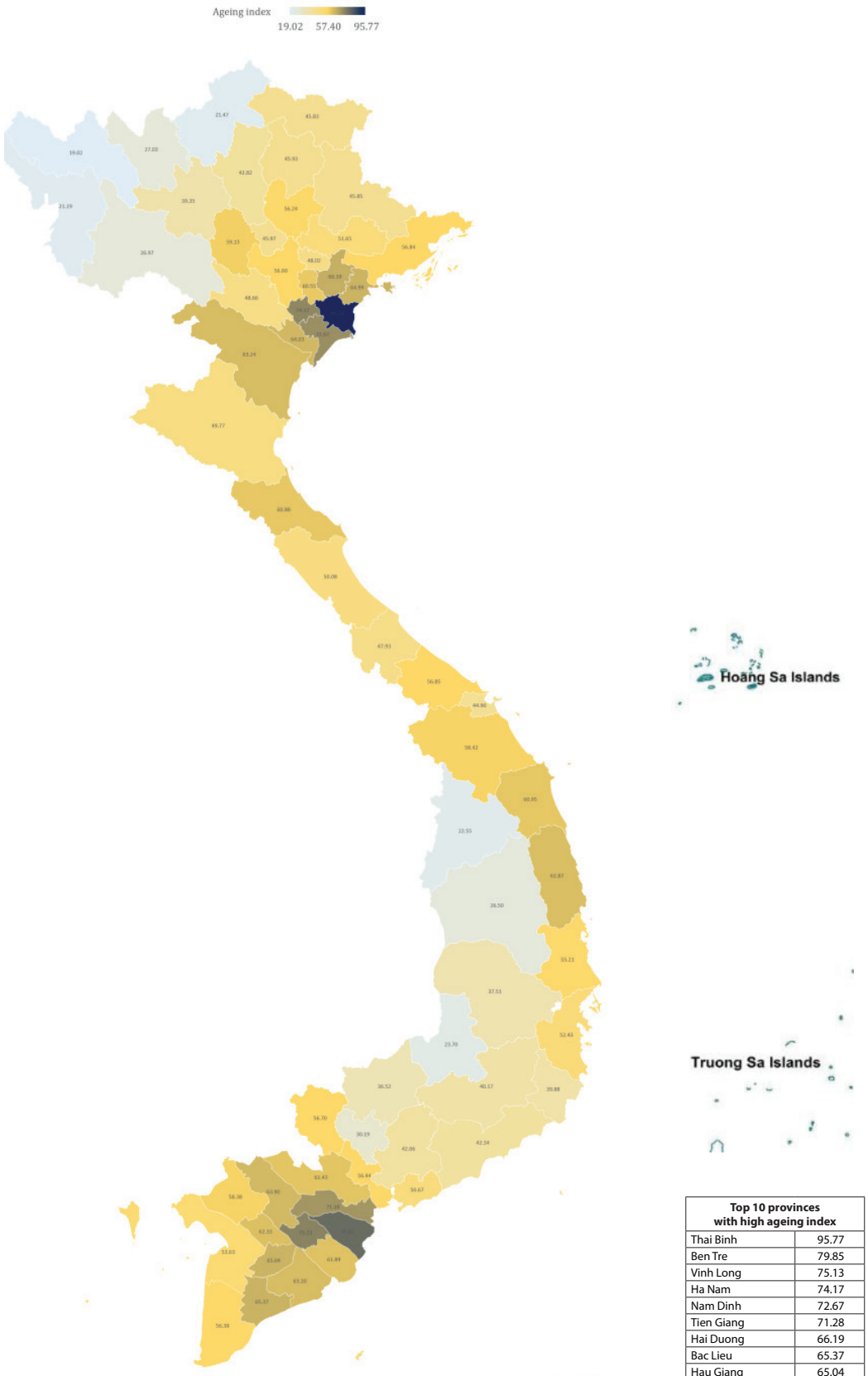


Source: Calculations based on data from PCS 2021



Source: Calculations based on data from PCS 2021

Figure 5. Ageing index by province



Top 10 provinces with high ageing index	
Thai Binh	95.77
Ben Tre	79.85
Vinh Long	75.13
Ha Nam	74.17
Nam Dinh	72.67
Tien Giang	71.28
Hai Duong	66.19
Bac Lieu	65.37
Hau Giang	65.04
Hai Phong	64.99

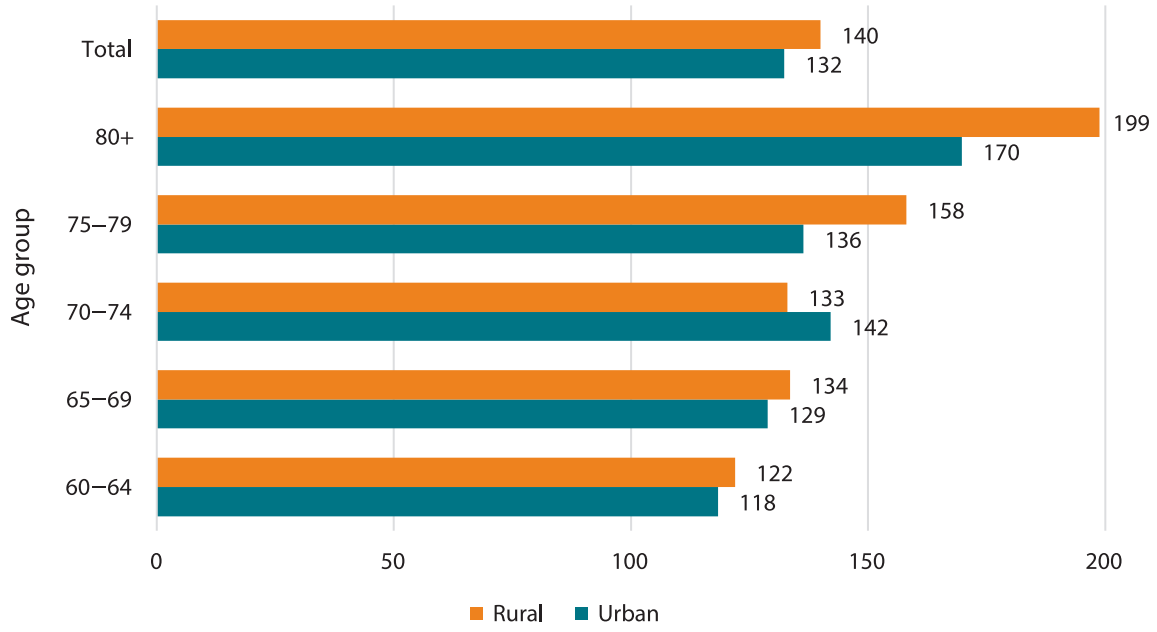
Source: Calculations based on data from PCS 2021

1.4. SEX RATIO OF THE OLDER POPULATION

The sex ratio of the same age group (the number of older women for every 100 older men) is an important demographic indicator because it is related to various characteristics of older persons such as widowhood by age and sex. As the following sections explain, this indicator affects the care of older persons.

Figure 6 shows the sex ratio of the older population by age and place of residence (urban or rural). In higher age groups, the sex ratio was higher, meaning there were more older women than older men. The sex ratio in rural areas was higher than in urban areas, which could be due to the differences in mortality rates between older men and women in different age groups (the difference was greater in higher age groups). The difference was smaller than in 2019, which could be because the health status of older persons has improved due to better overall health and a more accessible health care system that has enabled older persons to receive adequate health care services. The feminization of the older population, particularly in the highest age groups, implies there are various issues with the care of older persons.

Figure 6. Sex ratio of the older population by age and place of residence



Source: Calculations based on data from PCS 2021

In terms of socioeconomic region, the average sex ratio of the older population for all of Viet Nam was 137, while the Southeast region was highest (144) and the Central Highlands region was lowest (129).

2. SOCIOECONOMIC CHARACTERISTICS OF OLDER PERSONS[1]

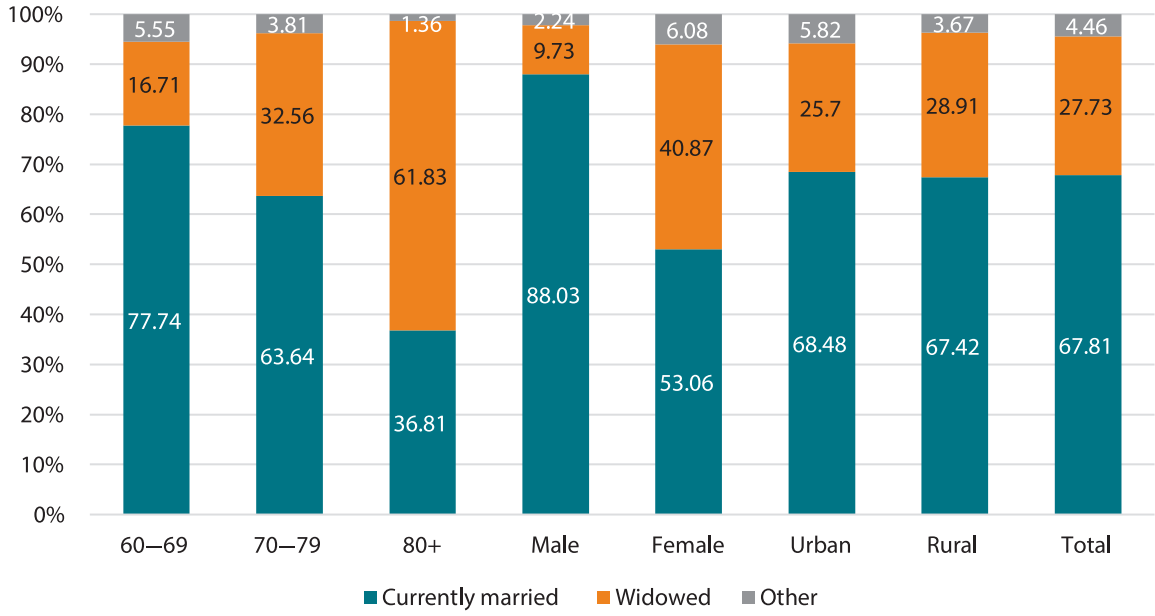
2.1. MARITAL STATUS

Figure 7 shows the marital status of older persons by age group. According to the survey, most older persons were married or widowed while those who were single, separated or

1. To compare the results with previous national and international studies, the older population was categorized into three groups: 60-69 (the young old); 70-79 (the middle old) and 80 and over (the oldest old).

divorced accounted for a very small proportion. Compared with the results of PHC 2019, the proportion of married older persons increased slightly (from 67.65 per cent in 2019 to 67.81 per cent in 2021) and the proportion of widowed older persons declined (from 28.19 per cent in 2019 to 27.73 per cent in 2021). When combined with the results of previous surveys, the data shows a large and persistent difference over time: the oldest old (80 and over) had a widowhood rate about four times higher than that of the young old (60–69), and older women had a widowhood rate more than four times higher than that of older men.

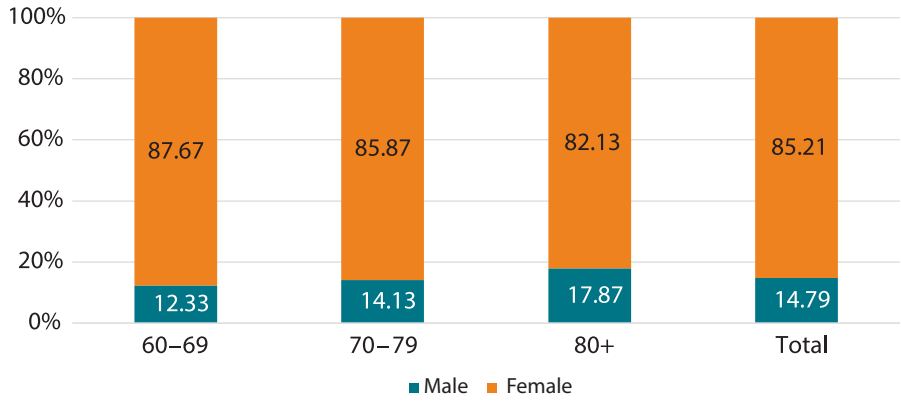
Figure 7. Marital status of older persons by age, sex and place of residence



Source: Calculations based on data from PCS 2021

Figure 8 shows that older women accounted for 85.21 per cent of widowed older persons in all age groups. This has significance for the care of older persons since living alone due to widowhood – most of whom are older women – may lead to various physical and mental health issues for older persons in general and older women in particular.

Figure 8. Percentage of widowed older persons by age group and sex



Source: Calculations based on data from PCS 2021

2.2. FAMILY RELATIONS AND LIVING ARRANGEMENTS OF OLDER PERSONS

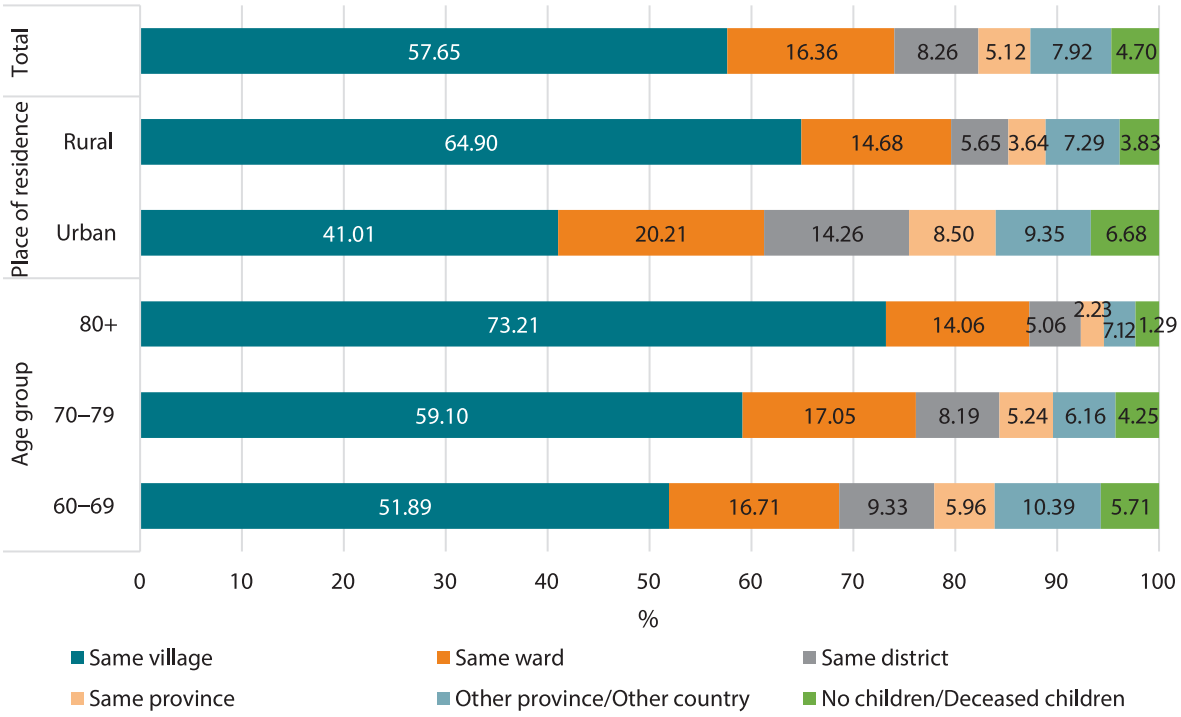
In terms of head of household and relationship to head of household, the results show that 58.64 per cent of older persons were the heads of household; 28.27 per cent were the spouse of the heads of household; 10.63 per cent were parents of the heads of household; and other relations (such as children of the heads of household or no family relation) accounted for a small proportion.

One of the many important ways in which older persons could receive help or assistance from children or other family members (such as siblings, grandchildren or other persons) is living nearby. **Figure 9** shows the living arrangements of older persons relative to their children of those who lived alone, those who lived with only other older persons and those who lived in households with only other older persons and/or children under 15 years of age. Of the 12.58 million older persons in Viet Nam, 4.43 million lived in such households, among which about 74 per cent lived near their children (57.65 per cent of which lived in the same village and 16.36 per cent lived in the same ward/commune).

There were significant differences in the living arrangements of urban and rural older persons. About 78 per cent of rural residents lived near their children compared with 61 per cent of urban residents. In contrast, urban older persons had a higher percentage of children living in the same province or other province/foreign country than rural residents (17.85 per cent and 13.04 per cent, respectively). The results also indicate that older persons in higher age groups tended to live near their children: around 87 per cent of the oldest old, about 76 per cent of the middle old and around 68 per cent of the young old. About 73 per cent of the oldest old had children living in the same village. The 2019 Survey on Older Persons and Social Health Insurance (OP&SHI) conducted by the Ministry of Health and other organizations (2021) also showed quite similar trends by age. Older persons in higher age groups tended to live alone but near their children (2.5 per cent of those aged 60–69); 4.1 per cent of those aged 70–79 and 6.2 per cent of those 80 and over), and a higher percentage of rural older persons lived alone but near their children than urban residents at 4.4 per cent and 1.4 per cent, respectively. These consistent findings imply that such living arrangements are crucial to the care of older

persons since most older persons in Viet Nam live in rural areas and care is provided primarily by family members.

Figure 9. Living arrangements of older persons relative to their children

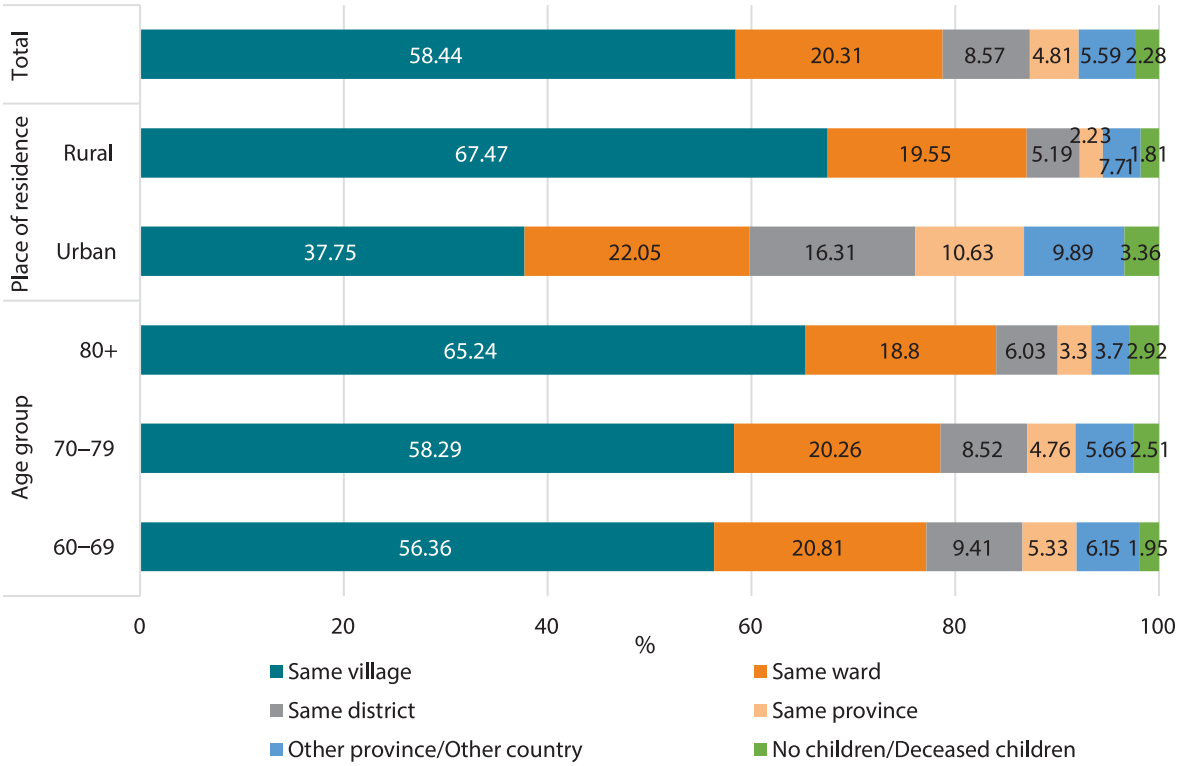


Note: This figure shows the living arrangements of older persons who lived alone, with only other older persons or in a household with only older persons and/or children under 15.

Source: Calculations based on data from PCS 2021

Similarly, **Figure 10** shows the living arrangements of older persons relative to other family members (siblings, grandchildren or others) for those who lived alone; lived with other older persons; or lived in a household with only older persons and children under 15. Of the 4.43 million older persons, about 79 per cent lived near their family members (58.44 per cent of which lived in the same village and 20.31 per cent in the same ward/commune). There were significant differences in terms of place of residence and age. More rural residents lived near their family members than urban residents, and more older persons in higher age groups lived near their family members than those who were younger. This is a good sign for the care of older persons, as family members are still the primary caregivers.

Figure 10. Living arrangements of older persons with family members



Note: This figure shows the living arrangements of older persons who lived alone, with other older persons or in a household with only older persons and/or children under 15.

Source: Calculations based on data from PCS 2021

Of the 4.43 million older persons who lived alone; lived with other older persons; or lived in a household with only older persons and children under 15, some 4.7 per cent did not have children or their children were deceased, and 2.28 per cent did not have family members or their family members had passed away. Since these persons might be vulnerable to economic or health shocks, they will need to be cared for in communities and supported with relevant social protection policies.

3. THE HEALTH OF OLDER PERSONS

3.1. SELF-RATED HEALTH (SRH)

The self-assessed health status of older persons in **Figure 11** is based on a scale of "very good", "good", "moderate", "bad" and "very bad". To compare the results of previous surveys, health status was divided into three categories: "very good/good", "moderate" and "bad/very bad". About 38 per cent of older persons self-assessed their health as "very good" or "good"; around 16 per cent rated their health as "bad" or "very bad", while 46 per cent assessed their health as "moderate". These results were quite different from the 2019 OP&SHI survey, which were 10 per cent, 52 per cent and 38 per cent, respectively (Ministry of Health and other organizations 2021).

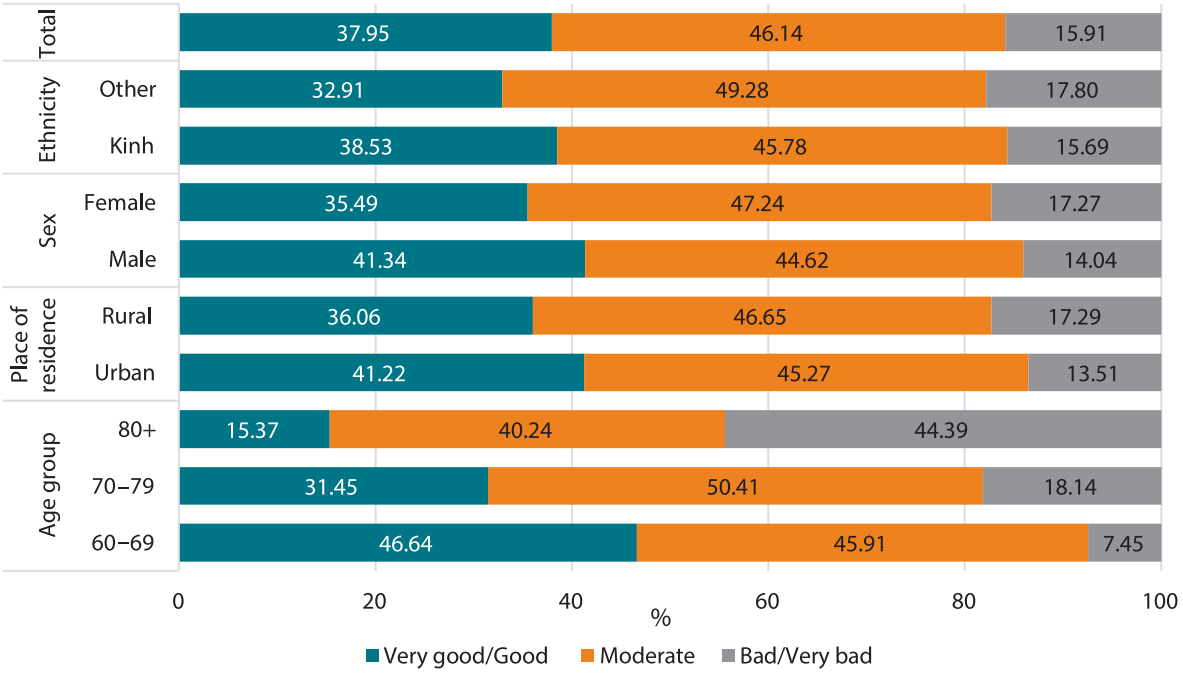
In terms of age group, a lower percentage of the oldest old (15.37 per cent) rated their health as "very good/good" compared with the middle old (31.45 per cent) and the young old (46.64 per cent). The percentage of the oldest old who rated their health status as "bad/very bad" was also much higher than other groups (44.39 per cent compared with 18.14 per cent and

7.45 per cent, respectively). In terms of place of residence, a higher percentage of urban older persons rated their health status as "very good/good" than their rural counterparts (41.22 per cent versus 36.06 per cent) and a lower percentage rated their health as "bad/very bad" (13.51 per cent versus 17.29 per cent).

There could be various reasons for these differences, including that urban older persons had better living conditions and better access to and use of health care services than their rural counterparts. The sex disaggregated findings were the same: a higher percentage of older men rated their health status as "very good/good" than older women (41.34 per cent versus 35.39 per cent) and a lower percentage as "bad/very bad" (14.04 per cent versus 17.27 per cent). In terms of ethnicity, a higher percentage of Kinh older persons rated their health status as "very good/good" than older persons of other ethnicities (38.53 per cent versus 32.91 per cent) and a lower percentage as "bad/very bad" (15.69 per cent versus 17.80 per cent).

All of these trends were quite similar to those found in surveys by the Viet Nam Women's Union (VWU, 2012) and the Ministry of Health and other organizations (2021). In general, however, there has been a sharp increase in the percentage of older persons rating their health as "very good/good" and a significant reduction in those rating it as "bad/very bad". For instance, Ministry of Health and other organizations (2021) found that only 12.5 per cent of the oldest old rated their health status as "very good/good" while in PCS 2021 it was 15.37 per cent. Similarly, those rating their health as "bad/very bad" were 62.6 per cent and 44.39 per cent in the two surveys, respectively.

Figure 11. Self-rated health status by age, place of residence, sex and ethnicity



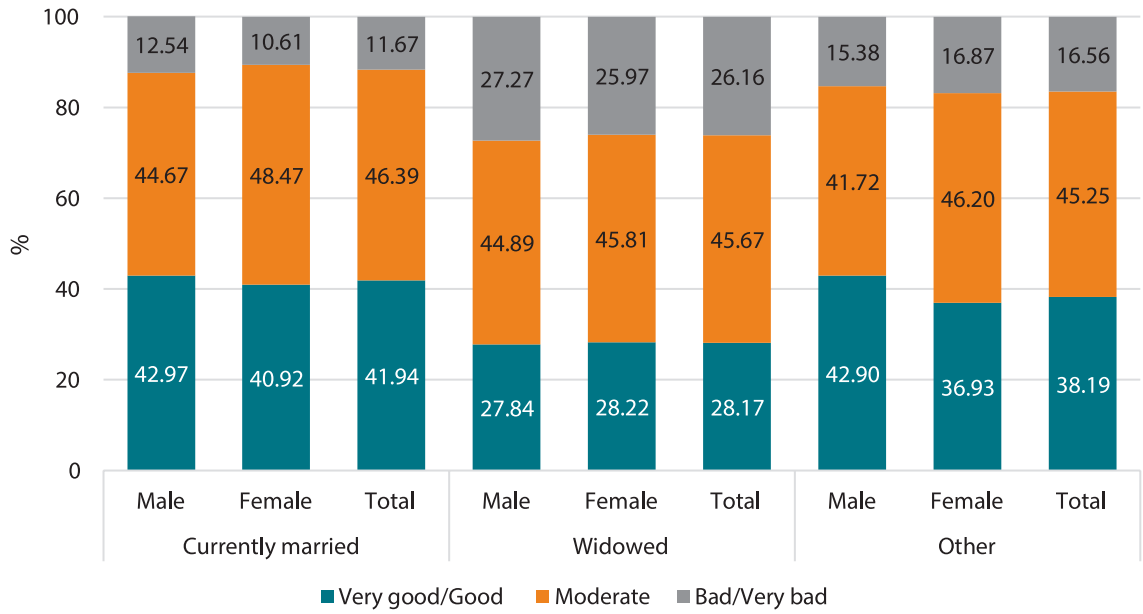
Source: Calculations based on data from PCS 2021

Various studies have also shown that the health status of older persons is closely related to their marital status and living arrangements.[2] **Figure 12** shows the self-rated health status of older persons by sex and marital status. Of the three categories of marital status ("currently

2. See, for instance, Terrawichichainan et al. (2015) for Myanmar, Thailand and Viet Nam; Giang et al. (2019) and Giang et al. (2020) for Viet Nam; Loichinger & Pothisiri (2018) for Thailand; and Boro et al. (2021) for India.

married", "widowed" and "other" (single, separated or divorced), both men and women who were currently married had higher rates of "very good/good" health status than older persons who were widowed or other. There were differences between older men and women within each category: among those who were currently married, a higher percentage of older men rated their health as "very good/good" than older women (42.97 per cent versus 40.92 per cent). In contrast, among those who were widowed, older men had a slightly lower rate of "very good/good" health than older women (27.84 per cent versus 28.22 per cent). In both categories of "currently married" and "widowed", a higher percentage of older men rated their health as "bad/very bad" than older women (12.54 per cent versus 10.61 per cent for those currently married and 27.27 per cent versus 25.97 per cent for those who were widowed). For the category of "other", the situation was different. A higher percentage of older men rated their health as "very good/good" than older women (42.90 per cent versus 36.93 per cent) and a lower percentage as "bad/very bad" (15.38 per cent versus 16.87 per cent).

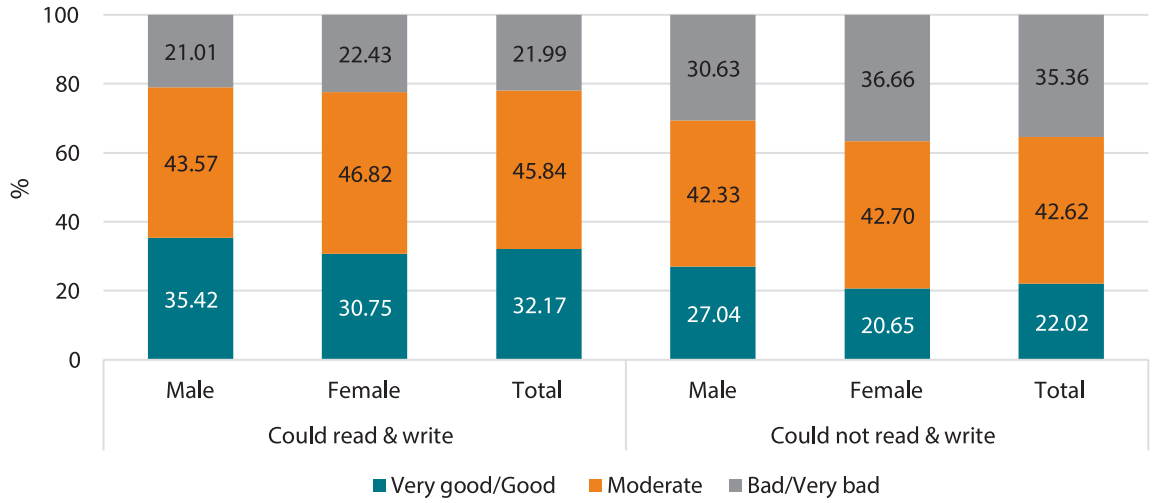
Figure 12. Self-rated health status by marital status and sex



Source: Calculations based on data from PCS 2021

Figure 13 shows the results of self-rated health by education. In this analysis, education was defined as the ability to read and write. The persons represented in this figure were those who did not go to school or were not able to complete primary level. PCS 2021 found there were 3.72 million persons in this category. In general, those who could read and write had a significantly higher rate of "very good/good" health (32.17 per cent versus 22.02 per cent) and a substantially lower rate of "bad/very bad" health than those who could not read and write (21.99 per cent versus 35.36 per cent). There were gender differences in both groups of older persons: older men had a higher rate of "very good/good" health and a lower rate of "bad/very bad" health than older women.

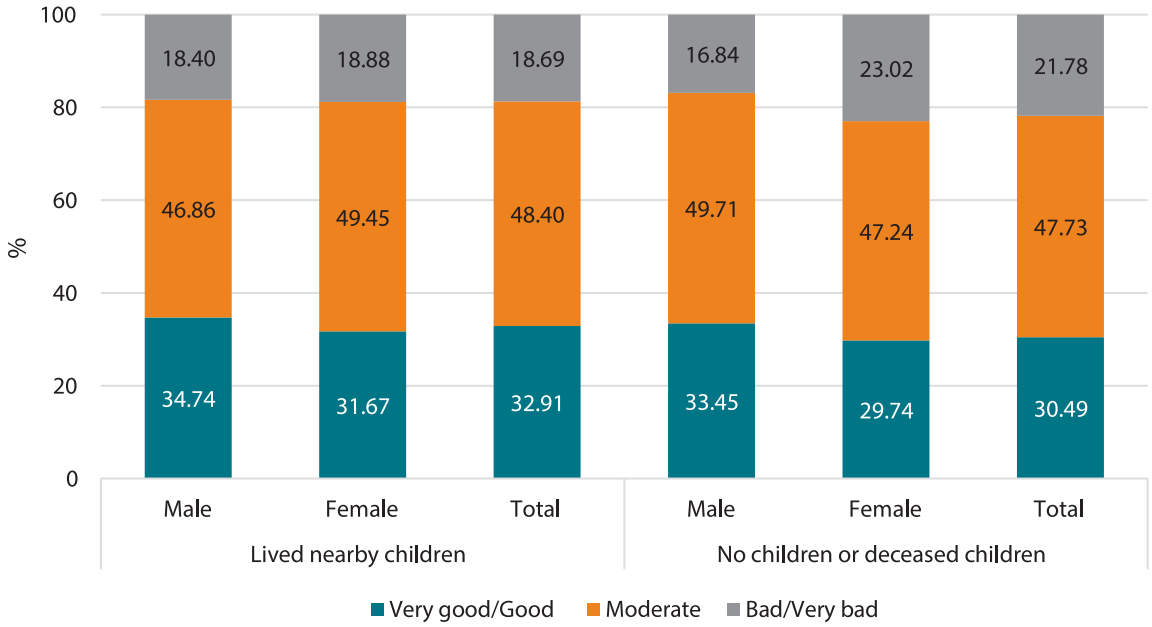
Figure 13. Self-rated health status by education and sex



Source: Calculations based on data from PCS 2021

To illustrate the self-rated health status of older persons by living arrangements, **Figure 14** presents the results for older persons with children living nearby (in the same village or ward/commune) as well as older persons who did not have children or their children had passed away. These persons either lived in a household with other older persons or in a household with at least one child under 15. In both cases, a higher percentage of older men rated their health as "very good/good" and a lower percentage as "bad/very bad" than older women. For those with children living nearby, 34.74 per cent of men rated their health as "very good/good" compared with 31.67 per cent of women, and 18.40 per cent of men rated their health as "bad/very bad" compared with 18.88 per cent of women. For those who did not have children or their children had passed away, 33.45 per cent of men rated their health as "very good/good" compared with 29.74 per cent of women, and 16.84 per cent of men rated their health as "bad/very bad" compared with 23.02 per cent of women.

Figure 14. Self-rated health status by living arrangements and sex



Source: Calculations based on data from PCS 2021

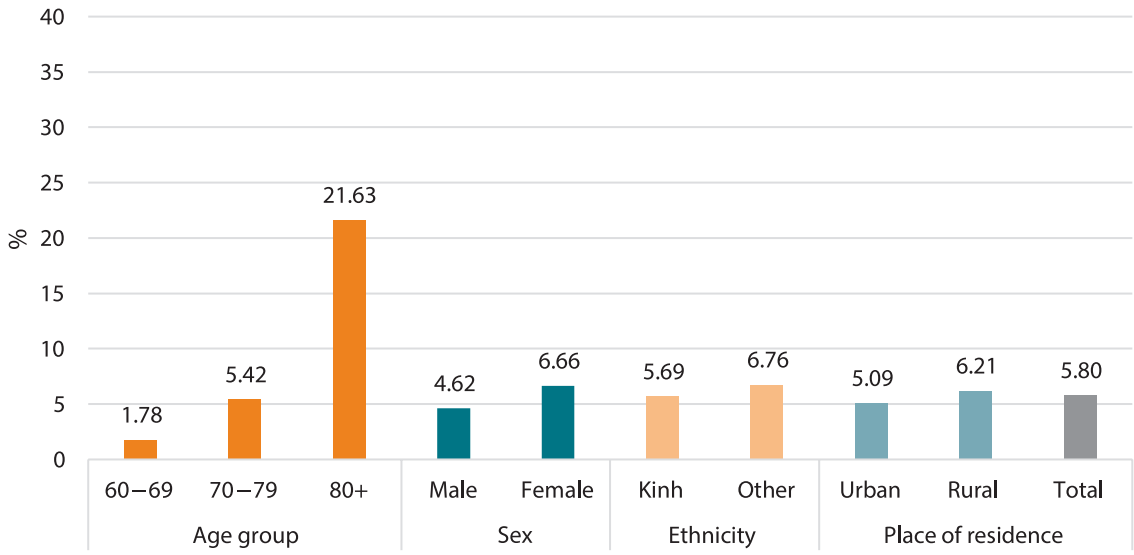
3.2. DISABILITY, PHYSICAL AND COGNITIVE HEALTH

To assess functional disability, PCS 2021 asked older persons about: i) vision (even with glasses); ii) hearing (even with a hearing aid); iii) mobility (walking or climbing steps); iv) cognition (remembering or concentrating); and v) communicating in a common language (understanding or being understood). Older respondents were asked to self-assess the difficulty of performing these functions by choosing one of the following: i) not difficult at all; ii) a bit difficult; iii) very difficult; and iv) could not perform.

In this report, an older person is considered to have a functional disability if they chose "very difficult" or "could not perform" for that function. An older person is considered to have at least one functional disability if they had either of these responses for at least one of the functions listed above.

Figure 15 shows that about 5.8 per cent of the older population had a vision disability (even with glasses). There were significant differences by age group. The disability rate increased as people aged, with the oldest old having a much higher rate than other groups: 21.63 per cent versus 5.42 per cent of the middle old and 1.78 per cent of the young old. Similarly, older men, Kinh persons and urban residents had lower rates of vision disability than older women, persons of other ethnicities and rural residents.

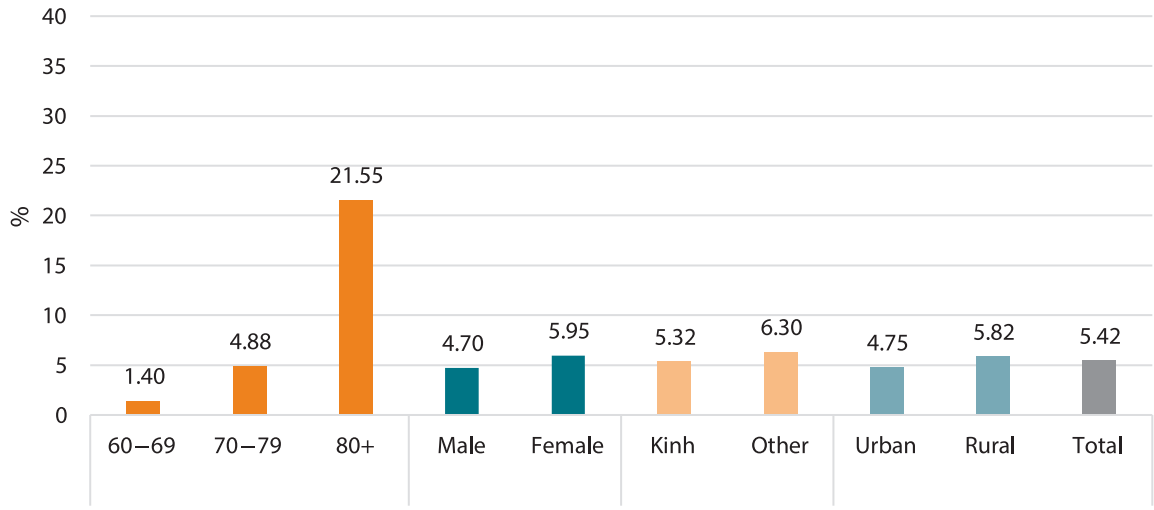
Figure 15. Percentage of older persons with a vision disability



Source: Calculations based on data from PCS 2021

Figure 16 shows rates of hearing disability for various groups of older persons. Overall, 5.42 per cent of the older population had a hearing disability and there were large differences by age group. The oldest old had a much higher rate than the other two groups: 21.55 per cent versus 4.88 per cent for the middle old and 1.48 per cent for the young old. Older men, Kinh persons and urban residents had lower rates of hearing disability than older women, persons of other ethnicities and rural residents (4.7 per cent versus 5.95 per cent by gender; 5.32 per cent versus 6.3 per cent by ethnicity; and 4.75 per cent versus 5.82 per cent by place of residence). These results were quite similar to those found by the Japan Fund for Poverty Reduction, the GSO and UNFPA (2021) based on data from PHC 2019.

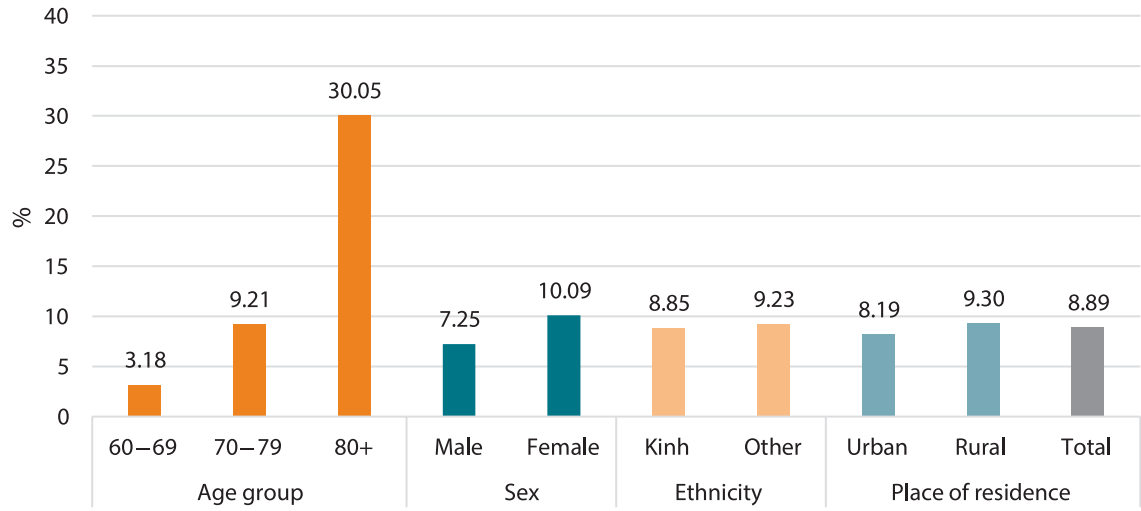
Figure 16. Percentage of older persons with a hearing disability



Source: Calculations based on data from PCS 2021

The physical health of older persons was self-assessed based on their mobility ability, i.e. their ability to walk or to climb steps (see **Figure 17**). About nine per cent of the older population had mobility disability, including around 30 per cent of the oldest old, 9.21 per cent of the middle old and 3.18 per cent of the young old. There were also significant differences in terms of gender (7.25 per cent of older men versus 10.09 per cent of older women), ethnicity (8.85 per cent of Kinh persons versus 9.23 per cent of other ethnicities) and place of residence (8.19 per cent of urban residents versus 9.30 per cent of rural residents). These results were quite similar to those found by the Japan Fund for Poverty Reduction, the GSO and UNFPA (2021) based on data from PHC 2019.

Figure 17. Percentage of older persons with a mobility disability

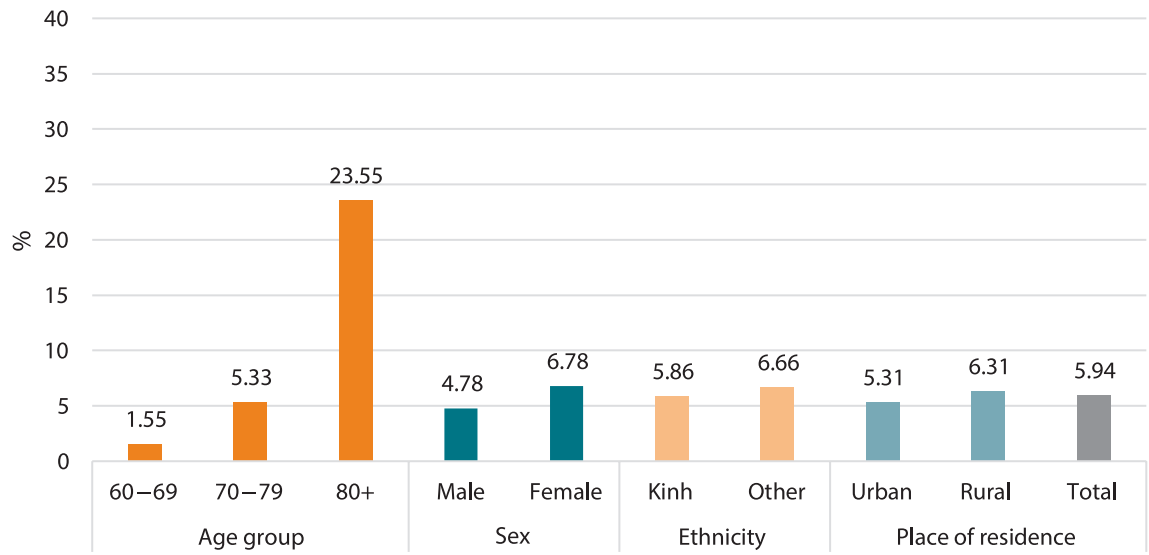


Source: Calculations based on data from PCS 2021

Around six per cent of the older population had a functional disability in cognition (remembering and concentrating) (see **Figure 18**). There were significant differences by age: 23.55 per cent of the oldest old, 5.33 per cent of the middle old and 1.55 per cent of the young old. There were also slight differences in other groups of older persons, with older women,

persons of other ethnicities and rural residents having higher rates of disability than older men, Kinh persons and urban residents.

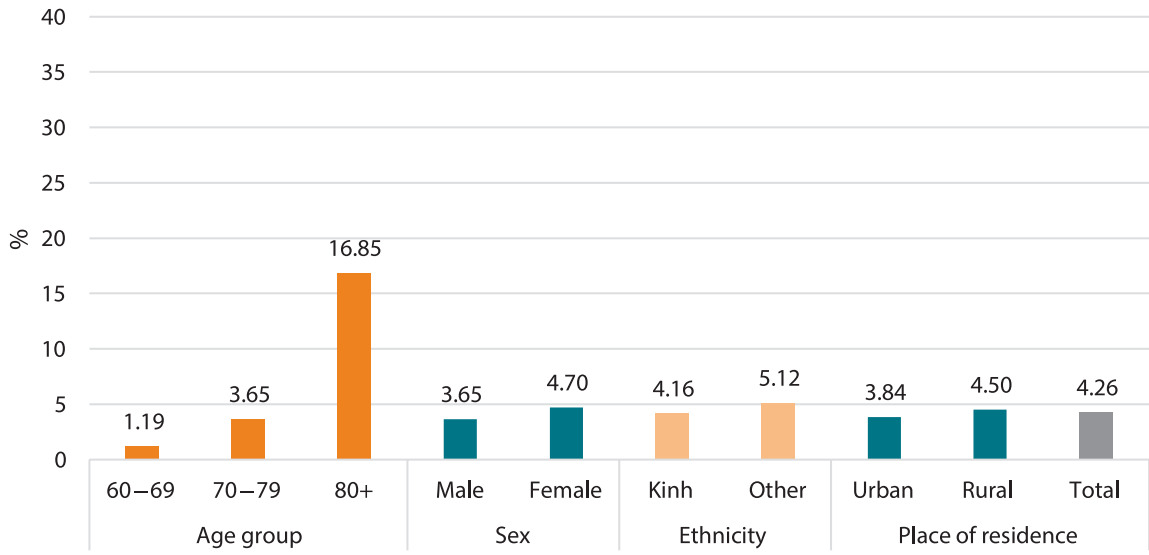
Figure 18. Percentage of older persons with a cognition disability



Source: Calculations based on data from PCS 2021

In terms of communicating in a common language, Figure 19 shows that 4.26 per cent of older persons had this functional disability. There were significant differences by age group (at higher ages, the disability rate was higher), gender (older women had a higher rate of disability than older men), ethnicity (persons of other ethnicities had a higher rate of disability than Kinh persons) and place of residence (rural residents had higher rate of disability than their urban counterparts). These results were quite similar to those found by the Japan Fund for Poverty Reduction, the GSO and UNFPA (2021).

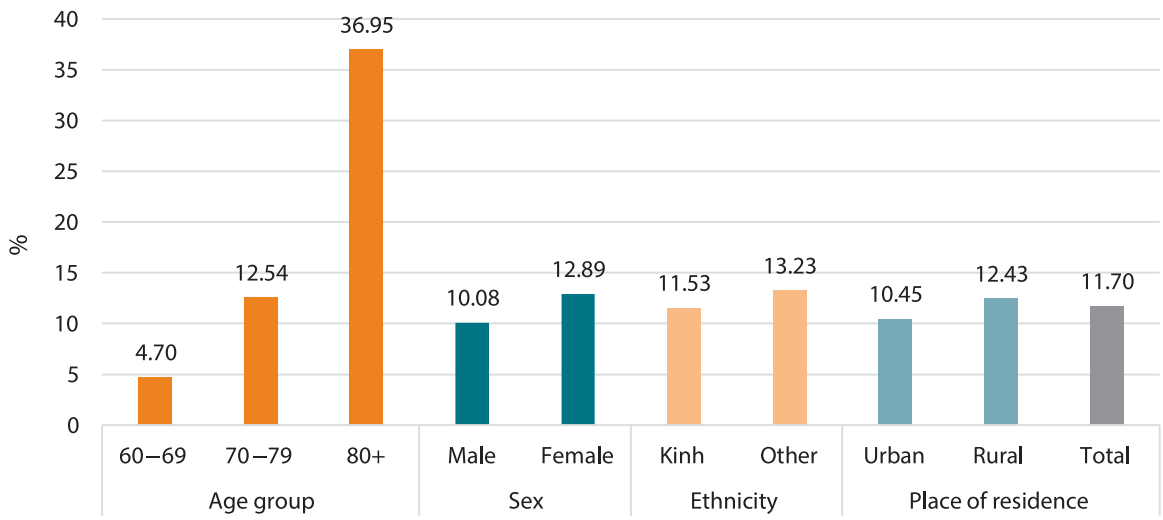
Figure 19. Percentage of older persons with a communication disability



Source: Calculations based on data from PCS 2021

Figure 20 shows the percentage of older persons who had a functional disability with at least one of the following: vision, hearing, mobility, cognition, or communication. About 11.7 per cent of older persons had at least one functional disability. The differences were clear by age, with around 37 per cent of the oldest old having at least one functional disability. Older men, Kinh persons and urban residents had lower rates of functional disability (with at least one function) than older women, persons of other ethnicities and rural residents. These results were quite similar to those found by the Japan Fund for Poverty Reduction, the GSO and UNFPA (2021) based on data from PHC 2019.

Figure 20. Percentage of older persons with at least one functional disability



Source: Calculations based on data from PCS 2021

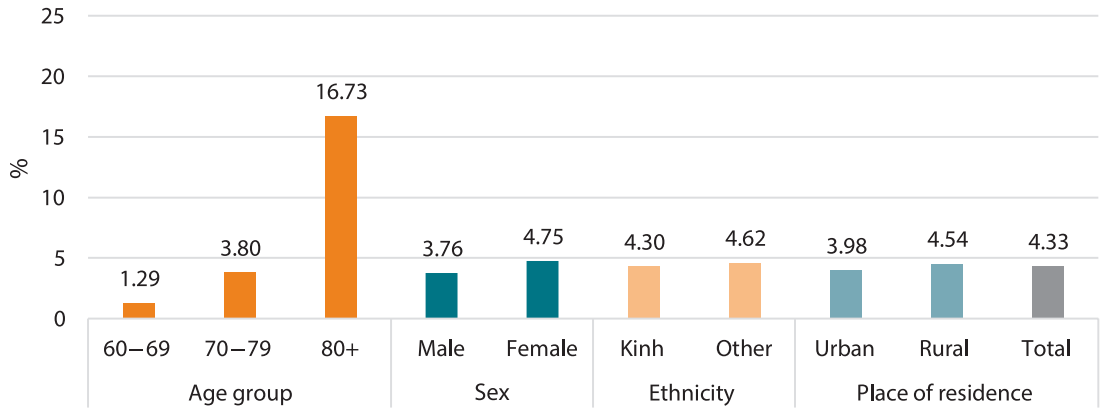
3.3. PERFORMANCE OF ACTIVITIES OF DAILY LIVING

One important factor affecting the care needs of older persons is how well they can perform activities of daily living (ADLs), which include: i) eating; ii) putting on and taking off clothes; iii) bathing and washing; iv) getting up when lying down; and v) getting to and using the toilet. To calculate the rate of older persons needing care (help or assistance) for ADL, an older person is defined as one who needs care for one ADL if they self-assessed that the ADLs is very difficult to perform or they could not perform it. An older person is generally considered to need care if they found it very difficult to perform or could not perform at least one of the ADL listed above.

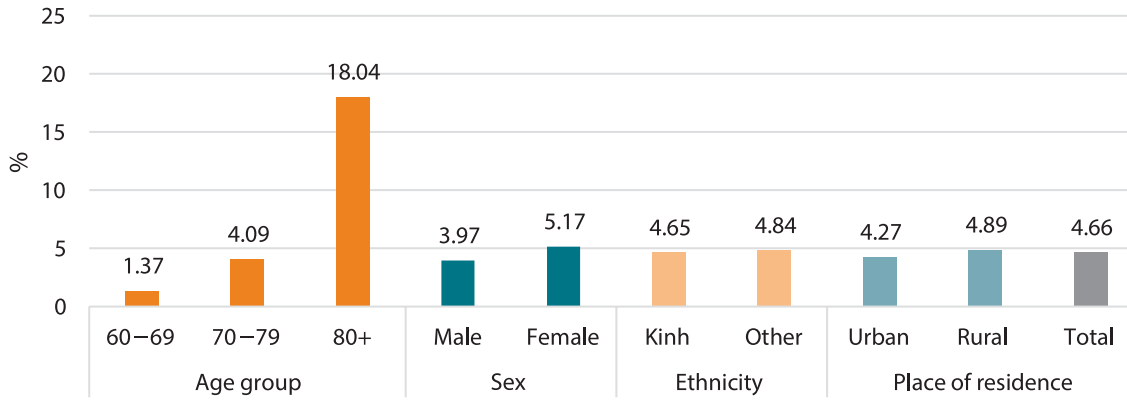
Figure 21 shows the rates of older persons in different groups needing care for each ADL. In general, for all types of ADLs, the oldest old had much higher needs than older persons in other age groups. There were differences in terms of gender (older women had higher needs than older men), ethnicity (persons of other ethnicities had higher needs than Kinh persons) and place of residence (rural residents had higher needs than their urban counterparts).

Figure 21. Percentage of older persons who needed care, by type of ADL

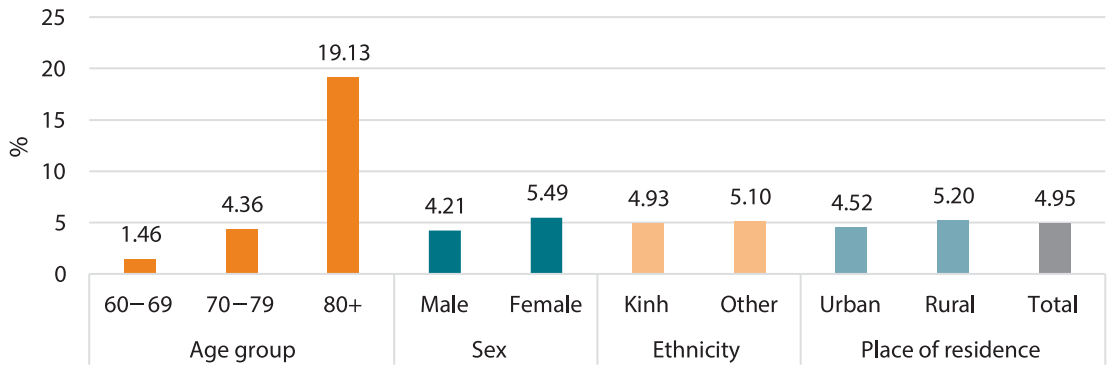
Eating



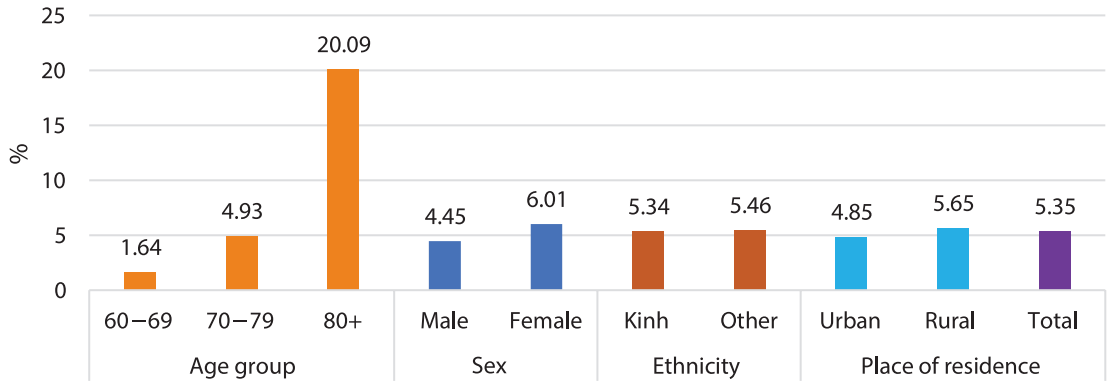
Putting on and taking off clothes



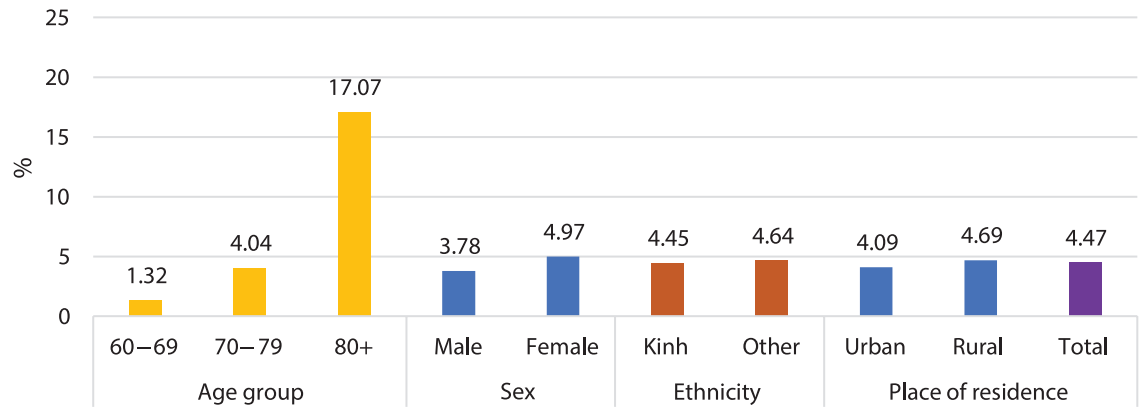
Bathing and washing



Getting up when lying down



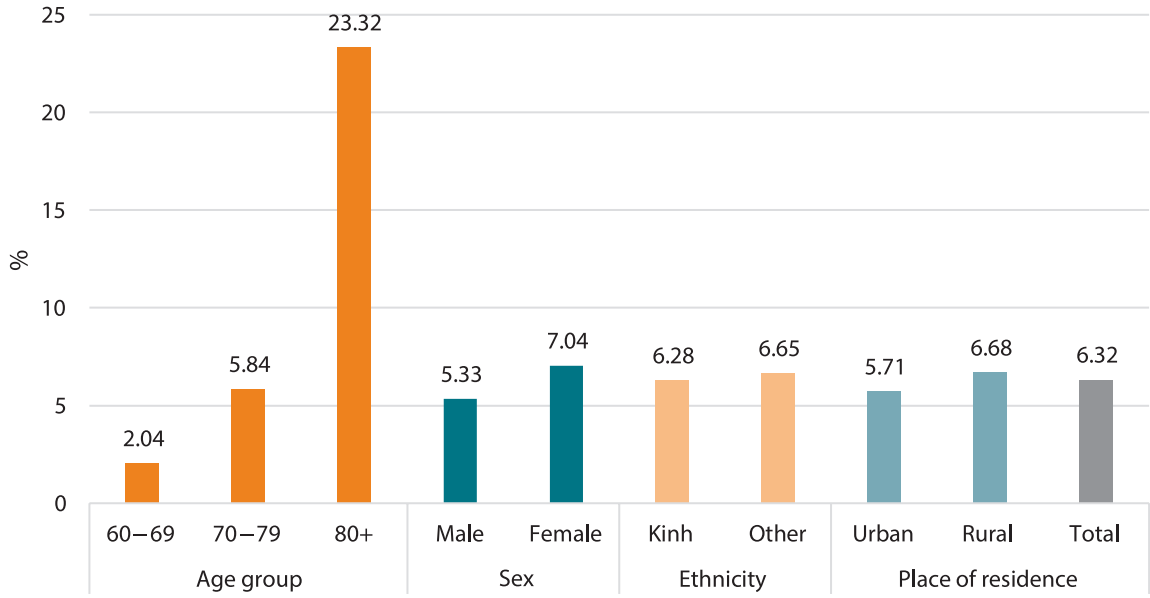
Getting to and using the toilet



Source: Calculations based on data from PCS 2021

Figure 22 shows the percentage of older persons who found it very difficult to perform or could not perform at least one of the ADLs, in other words, the percentage of older persons who needed care for ADLs by age, sex, ethnicity and place of residence. Overall, 6.32 per cent of the older population (or 796,000 persons) needed care for ADLs. There were significant differences between age groups, with 23.32 per cent of the oldest old (or 459,000 persons) needing care for ADLs. Older men, Kinh persons and urban residents all had a lower rate of care needs than older women, persons of other ethnicities and rural residents.

Figure 22. Percentage of older persons who needed care for ADLs

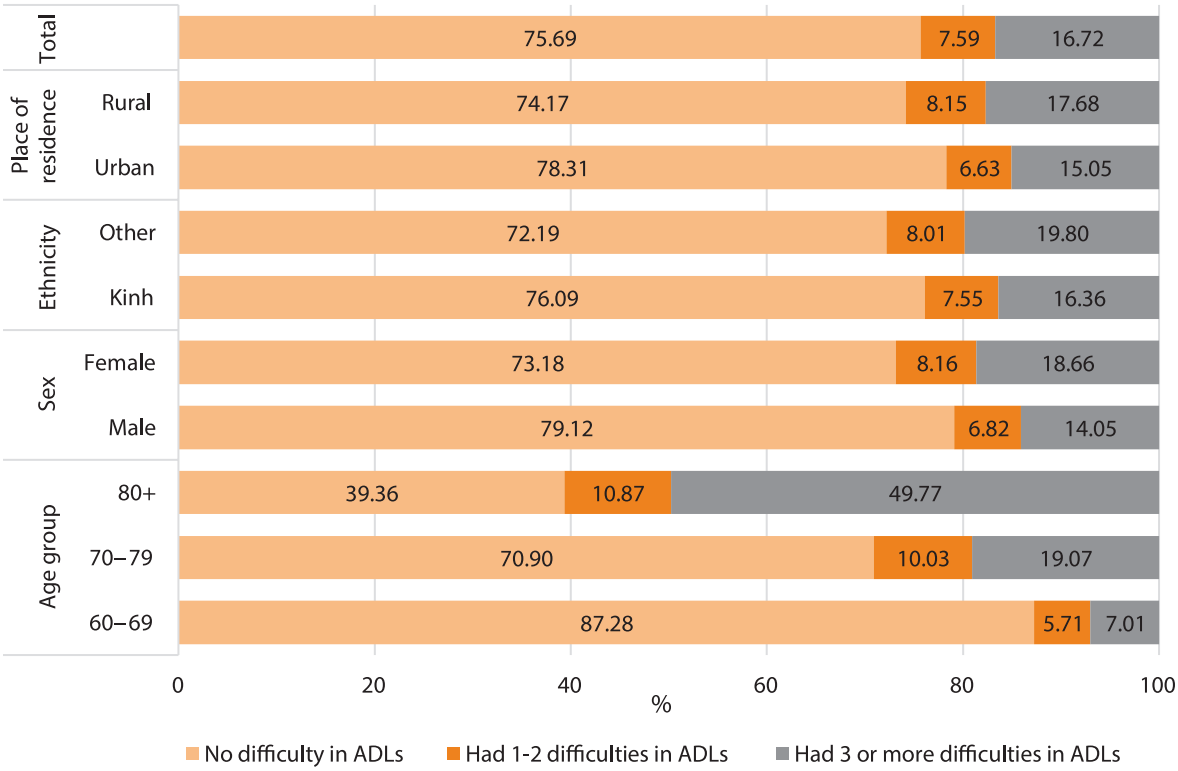


Source: Own calculations based on data from PCS 2021

To provide a more complete picture of the care needs of older persons, **Figure 23** shows the percentage of older persons who performed ADLs at different levels of difficulty (no difficulty; 1–2 difficulties; and three or more difficulties). The figure shows that about 50 per cent of the oldest old had three or more difficulties performing ADLs – much higher than the middle old (19.07 per cent) and the young old (7.01 per cent). There were also differences in terms of sex, ethnicity and place of residence, with a lower percentage of older men, Kinh persons and urban residents having three or more difficulties performing ADLs than older women,

persons of other ethnicities and rural residents. These results were quite similar to those found in the 2019 OP&SHI survey by the Ministry of Health and other organizations (2021).

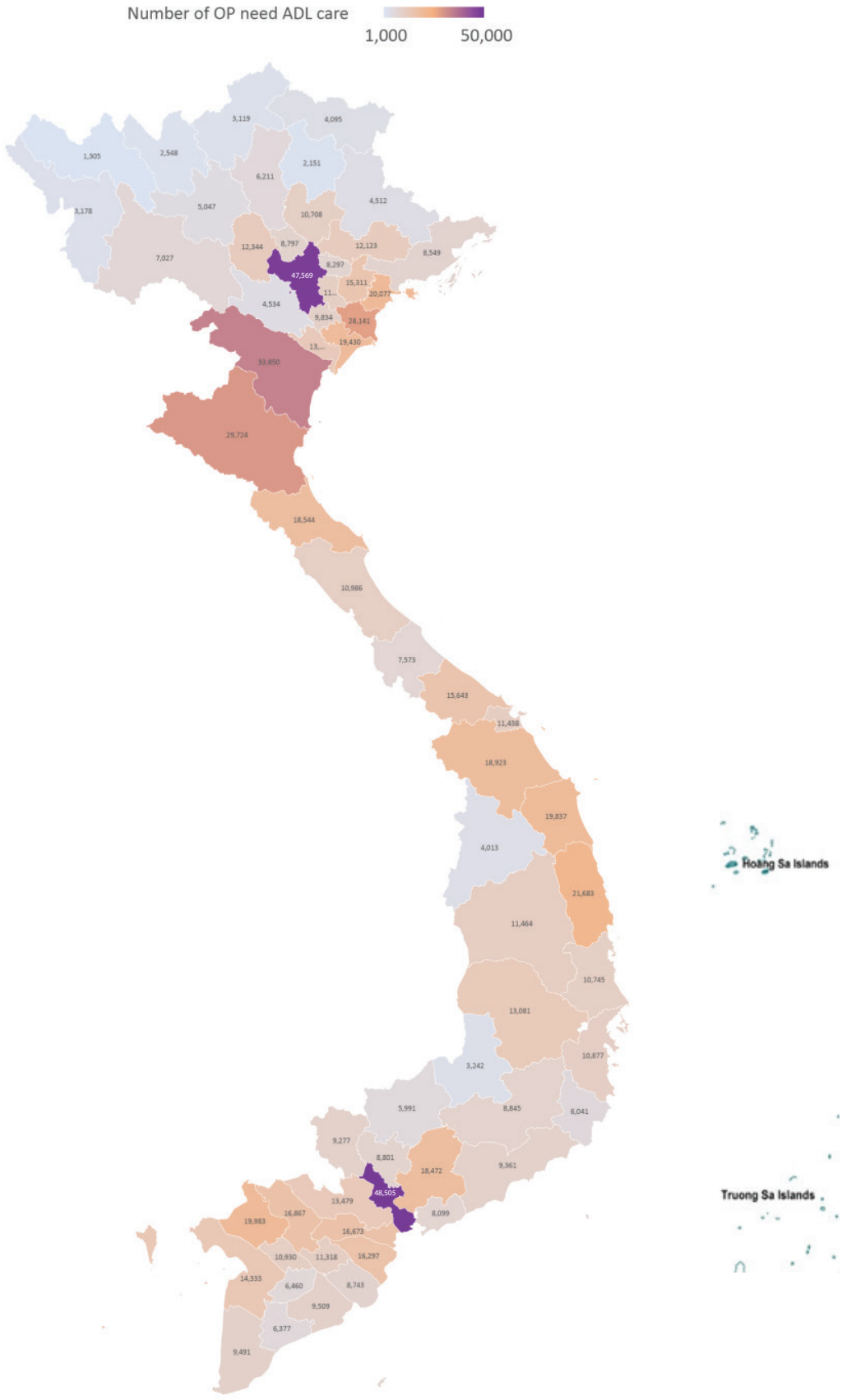
Figure 23. Percentage of older persons who had difficulties with ADLs



Source: Calculations based on data from PCS 2021

The number of older persons needing care for ADLs by province is shown in **Figure 24**. The map shows the number of older persons in each province who found it very difficult to perform or could not perform at least one ADLs. For each province, this number was calculated by the percentage of older persons who needed care for ADLs multiplied by the number of older persons in that province. In general, provinces with a high number of older persons or a higher rate of older persons needing care for ADLs had higher numbers of older persons with care needs. Five cities had the highest number of older persons needing care for ADLs: Ho Chi Minh City (48,505 persons), Ha Noi (47,569 persons), Thanh Hoa (33,850 persons), Nghe An (29,724 persons) and Thai Binh (28,141 persons). Five provinces had the lowest number of older persons needing care for ADLs: Dien Bien (3,178 persons), Ha Giang (3,119 persons), Lao Cai (2,548 persons), Bac Kan (2,151 persons) and Lai Chau (1,305 persons).

Figure 24. Number of older persons who needed care for ADLs, by province



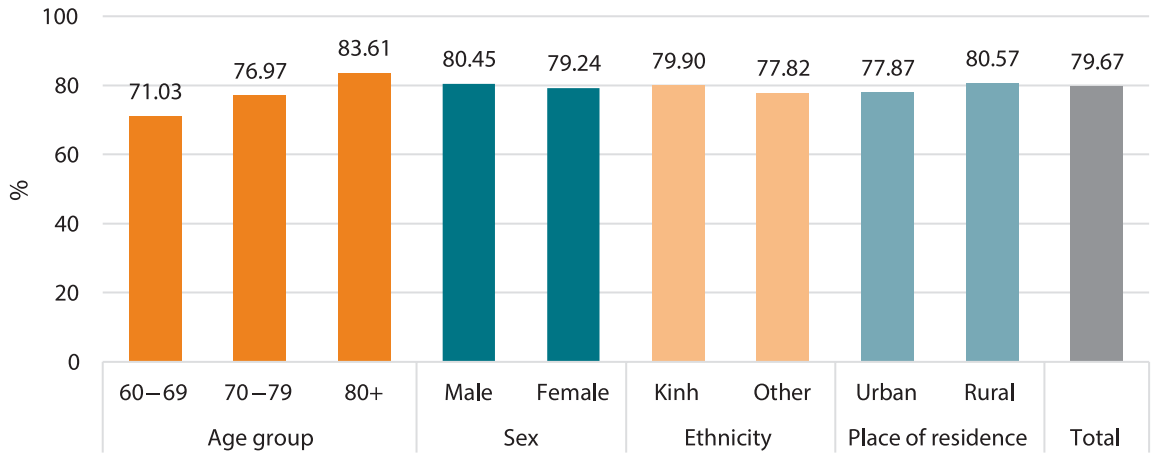
Source: Calculations based on data from PCS 2021

4. CARE NEEDS AND RESPONSIVENESS

The analyses of the disabilities and care needs of different groups of older persons could have implications for identifying which older groups should get care, to some extent the types of care that should be provided and prioritizing those who find it very difficult to perform or cannot perform ADLs. This section analyses the care provided to older persons in Viet Nam, who provided this care, whether the care older persons received was what they expected and where older persons want to receive care. All calculations and analyses assumed that older persons who found it very difficult to perform or could not perform ADLs were those who needed care (or help/assistance).

Figure 25 shows the percentage of older persons who needed care for ADLs from others. About 80 per cent of older persons who needed care received it. Older persons in higher age groups had a higher rate of receiving care (83.61 per cent for the oldest old, 76.97 per cent for the middle old and 71.03 per cent for the young old). More older men and Kinh persons received care than older women and persons of other ethnicities. More older persons living in rural areas received care than their urban counterparts since more rural older persons have children living nearby or still live as a couple than their urban counterparts.

Figure 25. Percentage of older persons needing care for ADLs who received it



Source: Calculations based on data from PCS 2021

Table 4 shows the percentage of older persons who needed care for ADLs and who provided it. In general, care for older persons was provided primarily by family members (spouse, children and grandchildren) while community-based or institution-based care was limited. More importantly, if the caregiver was a spouse, there were significant age and gender differences. A lower percentage of those in higher age groups received care from a spouse (11.70 per cent for 80 and over, 36.69 per cent for 70–79 and 60.75 per cent for 60–69). A much higher percentage of older men received care from their wives than older women from their husbands (52.34 per cent versus 10.67 per cent). Those differences were due to significant differences in widowhood between older men and women in higher age groups.

Among children, there was a higher percentage of sons provided care than daughters, but the percentage of sons-in-law provided care was much lower than daughters-in-law. In terms of the gender of older persons, there were no significant differences in care provision between sons and sons-in-law, but daughters and daughters-in-law cared for their mothers at a higher

rate than for their fathers. Gender differences in ADLs, especially for personal activities such as putting on or taking off clothes and using the toilet, could help to explain this finding.

In terms of place of residence, the rates of rural older persons receiving care from sons and daughters-in-law were higher than their urban counterparts, while the rate of rural older persons receiving care from daughters was lower than their urban counterparts. Such differences could be explained by the different living arrangements of older persons in urban and rural areas.

At the same time, the rates of older persons receiving care from hired caregivers, medical staff or staff of elder care centres were extremely low. Such findings imply that hiring home-based caregivers or caring for older persons in elder care centres have not been popular in Viet Nam. Care for older persons is still provided primarily by family members, such as a spouse, children or grandchildren. More importantly, data from PCS 2021 could not be used to evaluate the quality of home-based care provided by family members, most of whom are not professionally trained or experienced in providing care to older persons (Ministry of Health & Health Partnership Group 2018; Giang & Bui 2021). Since families are becoming smaller due to a lower fertility rate, care by family members will gradually be replaced by other types of care, including home-based care provided by professional caregivers, community-based care and institutional care.

These findings were quite similar to those found in previous surveys and reports by the Viet Nam Women's Union (2012), GSO (2021), the Ministry of Health and other organizations (2021).

Table 4. Percentage of older persons needing care for ADLs who received care from others

Caregiver	Age group			Sex		Ethnicity		Place of residence		Total
	60–69	70–79	80+	Male	Female	Kinh	Other	Urban	Rural	
Spouse	60.75	36.69	11.70	52.34	10.67	25.33	28.21	25.38	25.76	25.64
Son	32.19	43.16	52.09	46.73	46.69	46.78	46.04	44.74	47.65	46.70
Daughter	22.37	30.67	36.97	24.96	37.62	33.67	27.97	36.38	31.49	33.07
Son-in-law	4.15	4.28	5.85	6.04	4.75	5.32	4.28	5.68	4.98	5.21
Daughter-in-law	18.38	28.82	42.74	24.08	41.87	35.25	37.50	29.75	38.23	35.49
Grandson	6.55	9.88	13.15	9.90	12.07	10.96	14.16	11.81	11.04	11.29
Granddaughter	6.32	9.24	12.00	7.02	12.32	10.37	10.85	11.99	9.67	10.42
Hired caregiver	1.52	3.40	2.75	1.54	3.33	2.97	0.20	5.14	1.51	2.68
Medical staff	1.06	1.60	0.64	1.02	0.82	0.95	0.69	1.60	0.60	0.93
Staff of elderly care centre	0.00	0.00	0.06	0.04	0.03	0.04	0.00	0.00	0.05	0.04
Other	7.01	2.54	1.16	1.43	3.05	2.45	2.59	2.40	2.50	2.47

Note: The survey question was multiple choice, so the total does not necessarily equal 100 per cent.

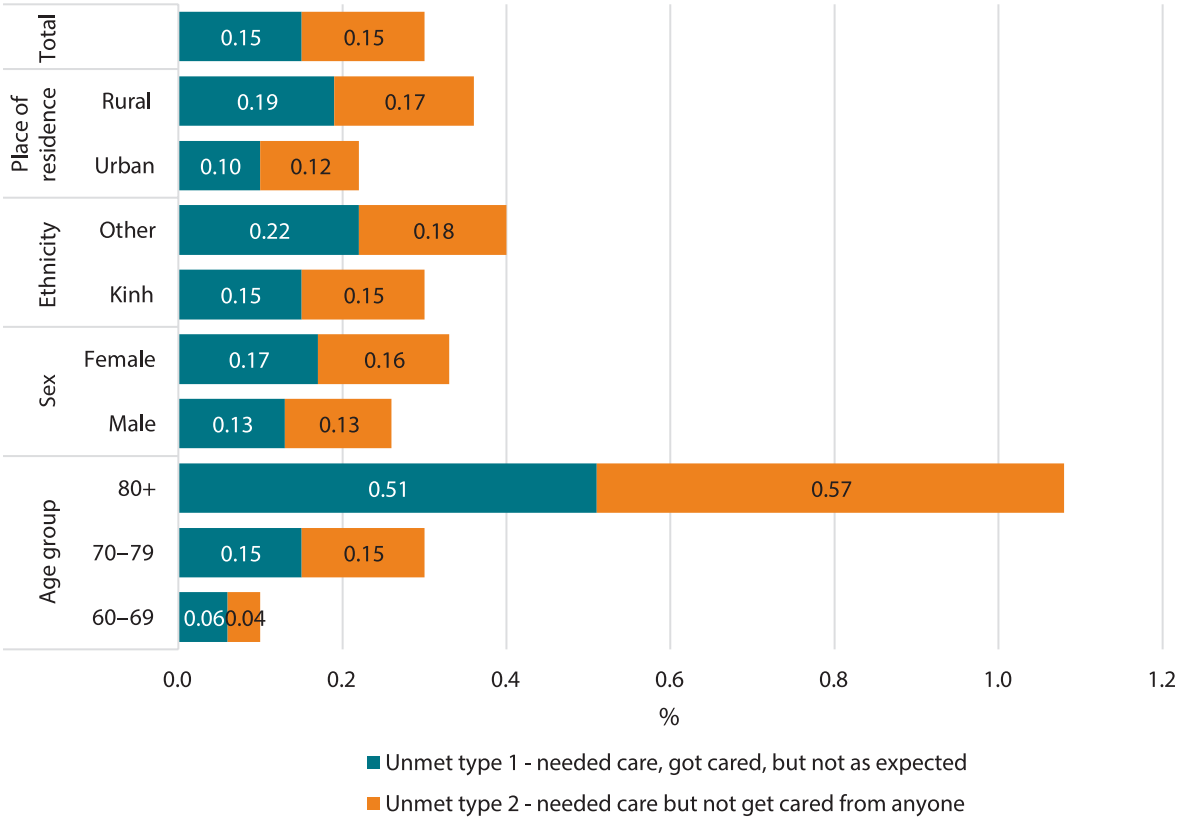
Source: Calculations based on data from PCS 2021

There are two types of unmet care needs (see, for instance, Schure et al. 2015; Teerawichitchainan & Knodel 2018). Based on questions from PCS 2021, the unmet care needs of older persons in Viet Nam have been categorized as type 1 – older persons who needed care (those who found it very difficult to perform or could not perform ADLs) and received care but it was not what they expected; and type 2 – older persons who needed care and wanted care, but did not receive it from anyone.

Figure 26 shows the results for these two types of unmet care needs by age group, gender, ethnicity and place of residence. The proportion of older persons with unmet care needs was very low (0.15 per cent for both type 1 and type 2), which means 0.3 per cent of older persons needed care but their wishes were not met or they did not receive care at all (about 2,385 older persons out of a total of 794,915 older persons who found it very difficult or impossible to perform at least one ADL).

Despite this small number, there were differences in both categories: older persons of a higher age had a greater proportion of unmet care needs than younger persons; older women had higher rates of unmet care needs than older men; persons of other ethnic minorities had a much higher rate of unmet care needs than Kinh persons; and rural older persons had a higher rate of unmet care needs than their urban counterparts. In addition, despite a very high rate of care needs being met, the survey could not provide data to evaluate the quality of care provided to older persons..

Figure 26. Percentage of older persons with unmet care needs



Note: The results were only for older persons who found it very difficult or impossible to perform at least one ADL (i.e. those who were considered to need care).
Source: Calculations based on data from PCS 2021

Figure 27 shows the survey results for where older persons wanted to be taken care of when in need. The results capture two groups: i) all older persons in Viet Nam; and ii) older persons in need of care (those who found it very difficult or impossible to perform at least one ADL).

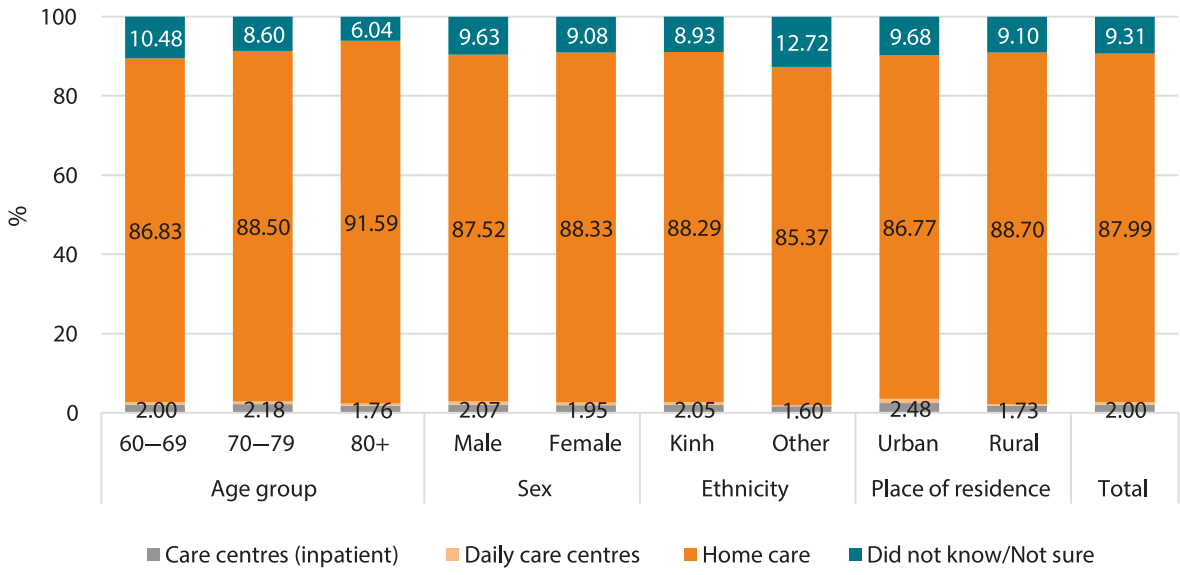
The proportion of the two groups who chose where they would like to receive care were not significantly different when classified by specific group. Most older persons still wanted to be cared for at home (86.83 per cent) and a high percentage of older persons with care needs wanted to be cared for at home (89.69 per cent). Older persons of a higher age preferred to receive care at home. Similarly, fewer older men, Kinh persons and urban residents wanted to receive care at home than older women, persons of other ethnic groups and rural residents.

Older persons who wanted to receive care in a care centre (both inpatient and outpatient) accounted for a very small proportion. However, when the entire older population or only older persons with care needs were considered, differences emerged. A higher percentage of older men, Kinh persons and urban residents wanted to receive care at care centres than older women, persons of other ethnic groups and rural residents.

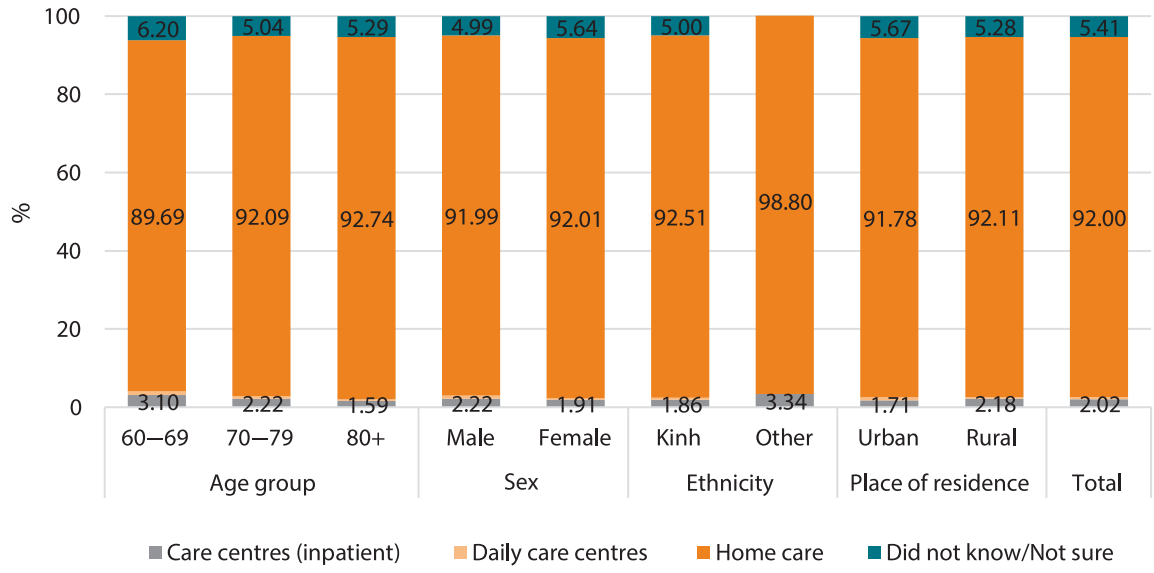
In general, home-based care was the primary form of care that older persons expected, which means that improving the quality of home-based care would be the key to improving care for older persons.

Figure 27. Where older persons want to receive care when in need

Entire older population



Only older persons with care needs

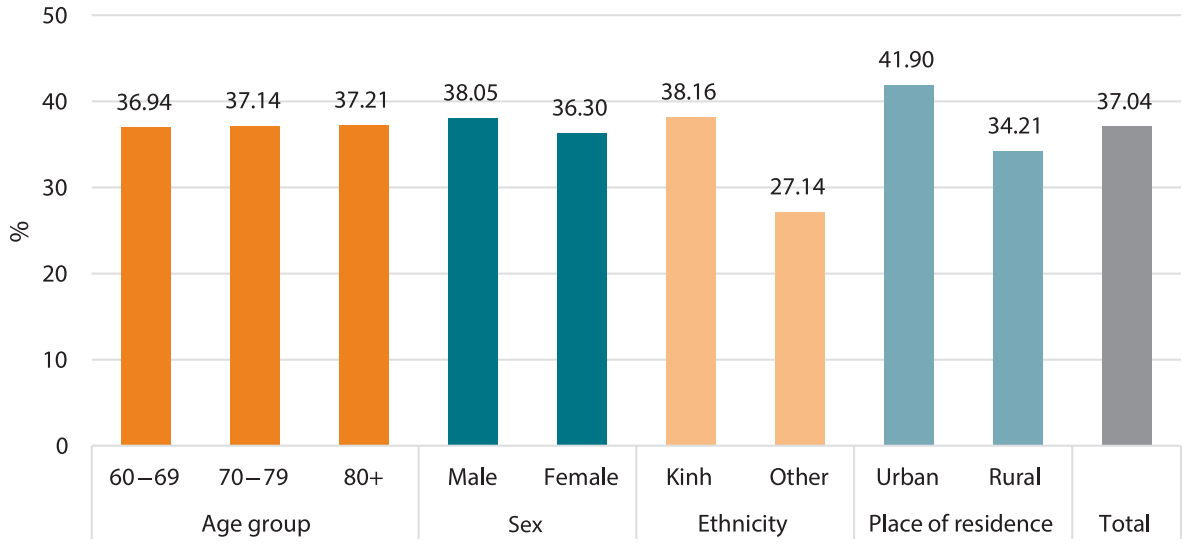


Source: Calculations based on data from PCS 2021

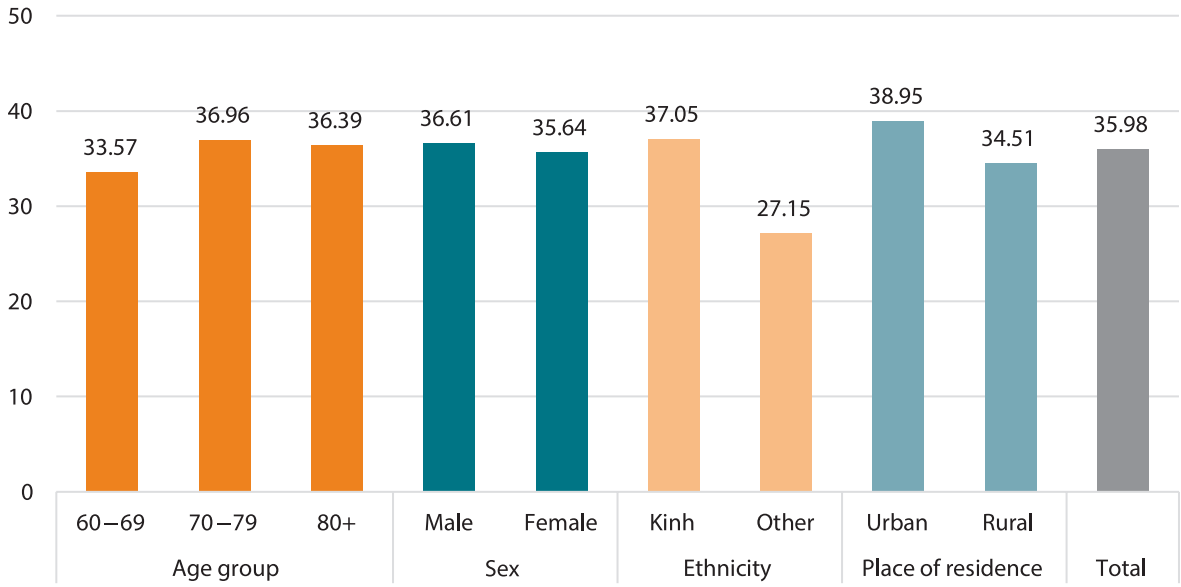
Figure 28 shows the percentage of older persons (the entire older population and only older persons with ADLs care needs) and their families willing to pay for care services. Overall, 37.04 per cent of the older population is willing to pay for care services while 35.98 per cent of older persons with ADLs care needs are willing to pay. There were not significant differences by age group in either sample. However, in both older groups, a higher percentage of older men, Kinh persons and urban residents were willing to pay for care services than older women, persons of other ethnicities and rural residents.

Figure 28. Percentage of older persons and their families willing to pay for care services

Entire older population



Only older persons with care needs



Source: Calculations based on data from PCS 2021

III. POLICY RECOMMENDATIONS

This analysis has shown that Viet Nam has a rapidly ageing population that requires relevant policies and programmes to be developed, especially for the care of older persons. Demographic and social characteristics showed that, in the highest age groups, there are significant differences between older women and men, including the differences in the rate of widowhood and in place of residence in rural and urban areas. These differences should be seen as important indicators when planning policies and programmes related to older persons.

The analysis also revealed that older persons face difficulties with ADLs and have functional disabilities in vision, hearing, mobility, cognition and communication. Older persons in higher age groups, older women, rural residents and persons of other ethnicities had higher rates of difficulty with all ADLs than younger persons, older men, urban residents and Kinh persons. The analyses also indicated that a low proportion of older people who need care are not having their care needs met, but there were differences: persons in higher age groups, older women, rural residents and persons of other ethnicities had a higher rate of unmet care needs than other groups. Despite a high rate of care needs being met, there was no data from this survey to indicate the quality of care and there is little evidence on whether family members have received training, guidance, support or the knowledge and skills to care for older persons.

Most older persons wanted to be cared for at home when they need care, and about one-third thought that they and their families would be willing to pay for care services.

Based on the results of this analysis, the following policy recommendations are offered for the care of older persons.

First, strengthen the health care system, especially the introduction of information technology into the management of medical examination and treatment and disease management, and especially in rural areas and ethnic minority areas to increase access to health care services for older persons. Priority should be given to the oldest old (aged 80 and over) and older women to access and use care services.

Second, develop service packages for the long-term care of older persons, including health care, social care and spiritual care, to ensure social inclusion, better health and support for daily personal care (such as eating, bathing and exercising). These service packages must ensure that every older person in need of care receives accessible, affordable and appropriate services. Given that families are still the primary caregivers of older persons in Viet Nam, it is necessary to develop care services and activities to support them, the first of which should be organizing free training classes in basic caregiving skills for family caregivers. Continue to expand and develop the system of family doctors and social workers so that all older people and their families can also receive medical examinations, treatment or consulting services in health care and social care. At the same time, continue to build

and develop a community-based care system that can reduce the care burden or provide replacement care for family members.

Along with home-based care and community-based care, the quality and readiness of institutional care should be gradually improved to meet the growing care needs of older persons in the future. Since there are differences in care needs based on age, gender and other characteristics, the individual care needs of older persons should be given significant attention when designing and providing services. In other words, it is critical to develop an ecosystem of care in communities to navigate and support older persons in different stages of care.

Third, research, adjust and supplement policies related to long-term care insurance (LTCI), drawing on the practical experiences of other countries, as well as conditions in Viet Nam, to adapt to the rapidly ageing population and secure financing for long-term care.

Fourth, although care needs in elder care facilities are not significant yet, changes in the living arrangements of older persons (such as fewer older persons living with children and grandchildren and children and grandchildren living farther away from older persons) indicate that the choice of care in care facilities – both inpatient and outpatient – will increase in the near future. Therefore, the first step is to build integrated models of care services at home, in the community and in care facilities. The next step is to promote the participation of the private sector in the care of older persons through public-private partnerships.

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