THE AGING POPULATION IN VIET NAM

Current status, prognosis, and possible policy responses




July 2011

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FOREWORD

As a result of sharp reductions in fertility and mortality as well as increased life expectancy at birth, the elderly population in Viet Nam is increasing rapidly in both absolute and relative numbers. According to United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), population starts aging when the percentage of older-age persons to the total population represents more than 10 percent. The population projections by the General Statistics Office (GSO, 2010) show that the elderly population (persons aged 60 and over) as a percent of the total population will reach 10 percent in 2017, or the Vietnamese population will enter the so-called "aging phase" from 2017 onward.

Similar to rapid population growth, rapid population aging creates various pressures on economic growth, as well as on the infrastructure and social protection services. In addition, research indicates that population aging has significant effects on family relationships, lifestyles, as well as on the social protection system, especially the national pension scheme. As such, aging issues have been considered a priority in Viet Nam's Socio Economic Development Strategy over the next decade, as well as the draft of the Socio-Economic Development Plan for the period of 2011-2015. Furthermore, the issue has been addressed in several of the national strategies such as the Population and Reproductive Health Strategy, and other sectoral policies and strategies.

The present report titled "Aging Population in Viet Nam: Current status, prognosis, and possible policy responses" has been commissioned by UNFPA within the context of the current UN One Plan. The report aims to provide a comprehensive review and analysis of related issues, and provide tentative recommendations for policy responses to issues related to aging in the years to come.

We would like to express sincere thanks to Dr. Giang Thanh Long, from the National Economics University, for the development of this report. We also wish to thank numerous colleagues at the Central Party Committee for Popularization and Education, the National Assembly Committee for Social Affairs, the Ministry of Health, the Ministry of Labour, Invalids, and Social Affairs, the General Statistics Office, the General Office of Population and Family Planning, the Viet Nam Association for the Elderly, the Viet Nam Fatherland Front, United Nations agencies and experts from international and national organizations, for their valuable comments and suggestions for the report.

We would like to recommend the report to all policymakers, managers, researchers, and other professionals, who are concerned about sustainable, pro-poor and inclusive growth. We also hope this document will provide welcome evidence for those supporting overall social development, social protection, and universal access to quality health and education.

Bruce Campbell
Representative of the United Nations Population Fund in Viet Nam

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GLOSSARY OF TERMS USED IN THE REPORT

"AGING", "AGED", "VERY AGED" AND "HYPER AGED" POPULATION

According to Cowgill and Holmes (1970) (as quoted in Andrews and Philips, 2006), a population is classified as "aging" when the elderly (65 and over) account for 7 to 9.9% of the total population. Similarly, 10-19.9% of people 65 and over identifies a population which is "aged"; a population with 20-29.9% of people of 65 and over is "very aged" and more than 30% of aged people describes a population which is "hyper aged". This categorization is used by the United Nations and other international organizations.

Some reports use 60 as a threshold for category. A population is classified as "aging" when the persons aged 60 and over account for 10% of the total population; it is classified as "aged", "very aged" and "hyper aged" with percentages of 20%, 30% and 35%, respectively.

AGING INDEX

According to UN-DESA (2005), aging index is calculated as the number of persons 60 years old or over per hundred persons under age 15 (or children). When this index is greater than 100, the elderly population is greater than the child population.

COMPULSORY/ MANDATORY SOCIAL INSURANCE

Compulsory/mandatory social insurance means that both employees and employers are obliged to join and pay contributions. Compulsory social insurance benefits comprise of compensation for: Sickness; Maternity leave; Employment injury as well as Occupational and disease; Old age; and Survivors of an employee.

DEMOGRAPHIC TRANSITION

Demographic transition refers to the changes that populations experience from high birth and death rates to low rates of births and deaths.

ECONOMICALLY ACTIVE POPULATION

The Economically Active Population of a country is also often called the Labor Force. The Labor Statistics department of the International Labor Office (ILO) defines that a Labor Force includes employed and unemployed persons. According to the GSO (2009), an Economically Active Population includes those aged 15 and over regardless of being employed or unemployed during a particular time of reference (7 days prior to a survey/census date).

ECONOMICALLY INACTIVE POPULATION

According to the Labor Statistics department of the International Labor Office (ILO), an Economically Inactive Population includes those who are not participating in the labor force due to a variety of reasons such as: the responsibility to do housework, retirement, illness, old age, loss of the ability to work, enrollment in schools, or simply the lack of desire or ability to find work. According to the GSO (2009), this group comprises of those aged 15 and over who are not employed during a time of reference (7 days prior to survey/census date).

ELDERLY/OLDER PERSONS

In this report in general, the elderly are defined as persons aged 60 and over. However, whenever Viet Nam is compared with other countries, an elderly is defined as a person aged 65 and over.

MEDIAN AGE

The age which divides a population into two numerically equal groups; that is, half the people are younger than this age and half are older.

MIDDLE INCOME COUNTRY

Annually, the World Bank classifies countries in terms of income. Based on the 2008 Gross National Income (GNI) per capita index, the current classification is as follows: Low Income Countries ($975 or less); Lower Middle Income Countries ($976-$3,855), Upper Middle Income Countries ($3,856-$11,905); and High-Income Countries ($11,906 or more).

NON-CONTRIBUTORY PENSIONS (OR SOCIAL PENSIONS)

Social pensions are benefits provided to beneficiaries without any payments/contributions in return. Certain conditions apply for eligibility. For instance, in Viet Nam, under Decree 67/2007 (currently, Decree 13/2010), social pensions at a minimum rate of VND 180,000 per person per month are provided to elderly people aged 80 and over who do not have any contributory pensions or social allowances, or to poor elderly living alone without any support from any source whatsoever.

NOTIONAL DEFINED CONTRIBUTION (NDC) PENSION SCHEME

NDC is a scheme designed to set up a worker's account is set up as a bookkeeping device, in order to keep track of and safeguard contributions plus imputed interest at a rate determined by the government. When a worker reaches retirement age, the notional accumulation in his/her account is converted into annuity (of which the quantity depends on the expected duration of retirement and the interest rate) and paid to his/her retirement out of contributions which younger workers are making at that time, as they build up their own accounts. However, funds are never accumulated in these accounts. Instead, money is used to pay current benefits and the accounts are notional or empty.

PAY-AS-YOU-GO (PAYG) PENSION SCHEME

PAYG is a method of financing whereby current outlays on pension benefits are paid out of current revenues from an earmarked tax, often a payroll tax. In the future, when current contributors will become pensioners, their benefits will be paid by contributions from the subsequent working generations.

PENSION SCHEME DEPENDENCY RATIO

The ratio between the number of pensioners and the number of active contributors.

POTENTIAL SUPPORT RATIO

The ratio between the working-age population and the elderly population.

REPLACEMENT LEVEL FERTILITY RATE

According to the Population Reference Bureau (PRB, 2005) and other UN organizations, the Replacement Level Fertility Rate is the average number of daughters that would be born to a woman (or a group of women) if she (they) passed through her (their) lifetime conforming to the age-specific fertility

and mortality rates for a given year. In other words, this is the level of fertility at which a couple has just enough children to replace themselves. Currently, this rate is about 2.1.

REPLACEMENT RATE

The value of pension as a proportion of a worker's wage during certain periods. For instance, in this report, the replacement rate is measured by dividing the average pension by the average insurable earning for each type of pension.

SUPPLEMENTARY INSURANCE

Supplementary insurance is an additional (often private) insurance which provides coverage in excess of primary insurance.

TOTAL FERTILITY RATE (TFR)

According to the United Nations Department for Economic and Social Affairs UN-DESA (2005), the Total Fertility Rate is the average number of children a woman would bear during the course of her lifetime if the current age-specific fertility rates remained constant throughout her childbearing years (normally between the ages of 15 and 49).

VOLUNTARY SOCIAL INSURANCE

Voluntary social insurance indicates a type of social insurance fund in which employees join voluntarily, and for which they themselves select the contribution rate and mode of paying for social insurance premiums to the fund according to their available income. Voluntary social insurance benefits comprise of: Old age benefit, health care benefit and survivors' benefit.

EXECUTIVE SUMMARY

Recent population data have indicated that Viet Nam is reaching the end of its "demographic transition" marked by three emerging characteristics, i.e., decreasing fertility rates, decreasing mortality rates, and increasing life expectancy. As a result, the child population has declined and the working-age population and elderly population have increased. The population projections by the General Statistics Office 2010 (GSO, 2010) show that the elderly population (persons aged 60 and over) as a percentage of the total population will reach 10 percent in 2017, or the Vietnamese population will enter the so-called "aging phase" from 2017 onward[1]. Furthermore, Viet Nam will enter an "aged phase" in the following two decades when the aging index will increase from 35.5 in 2009 to more than 100 in 2032. Such trends and the pace at which the population is aging has created a number of big opportunities as well as challenges for Viet Nam with regard to securing resources for the increasing elderly population. Analysis of the current situation and projections for the aging population and the elderly will provide important inputs for designing and implementing policies and programmes. Such programmes, through which a strong social protection system is put in place to secure income for the elderly via employment and retirement benefits, are essential to achieve "successful aging"; quality elderly care services are for a mentally and physically healthy elderly population; and social participation activities for an active elderly population contribute to the wellbeing and prosperity of individual families and society as a whole.

Following below are the emerging characteristics of the aging population in Viet Nam, as well as of the family of Vietnamese elderly, in terms of health, employment and work, and social protection.

1) The Vietnamese elderly population has increased in both absolute and relative numbers, and increased more rapidly than other population groups. The aging index thus increases swiftly as well. If compared regionally and globally, the time span to reach the stage of "aged population" will be much shorter for Viet Nam than elsewhere. In addition, the oldest age groups of the elderly population (80 and over) have increased.

2) The living arrangements, cultural and spiritual traditions, as well as education achievements of the elderly have changed significantly over time. The percentage of elderly living with their children has diminished, while the percentage of elderly living alone or with spouses has increased. Most of the elderly are still living in rural areas. There are also big regional and provincial differences in terms of numbers of the elderly. Rural-urban migration is one of various causes for this diversity in distribution of the elderly population, as well as the increasing number of 'skip-generation' elderly households[2].

1. The results from the Population and Housing Census 2009 show that the elderly population as a percentage of the total population was 9 percent. Some other data show that aging in Viet Nam is even faster (for instance, the Viet Nam Household Living Standards Survey (VHLSS) in 2008 shows that the elderly accounted for 10.3 percent of the total population, meaning that Viet Nam has enter the "aging phase"). However, to make analysis consistent throughout the report, this report will use the population projection results by the General Statistical Office in 2010 (GSO, 2010).
2. "Skip-generation" families are those families in which only grandparents are living with grandchildren.

3) The types and causes of diseases of the elderly have changed substantially from communicable ones to non-communicable and chronic ones. The average treatment cost for an elderly person is about 7-8 times the cost of that for a child. At the same time, there is a vast difference between elderly groups in terms of accessing healthcare services; the elderly living in rural, mountainous areas and who are ethnic minority people only have access to poor quality services. While the number of elderly people has increased significantly, insufficient investments have been made in an appropriate elderly care system. Also, the elderly themselves are not aware of health risks which concern them. While life expectancy of the elderly is increasing, healthy life conditions for the elderly have not been significantly improved.

4) Employment, work and income need to be considered as affecting the lives of the elderly. Data from the Viet Nam Household Living Standard Survey (VHLSS) in 2008 show that about 43 percent of the elderly are still working in different sectors, yet most of them are working in the agricultural sector providing them with only minimal and unstable income. The Labor Force Participation Rate is lower for people of a more advanced age. The rate of labour force participation is furthermore significantly higher for the elderly living in the rural areas versus the rate for their urban counterparts.

5) The coverage rates for the elderly in the contributory pension scheme and social allowance schemes are low. Benefit levels are low as well and account for only a small proportion of elderly household expenditure. The current social protection schemes are not pro-elderly, especially with regard to the vulnerable elderly among this age group since they cannot participate in these schemes due to strict regulations or low benefit levels. The current contributory pension scheme based on the PAYG financial mechanism will not be sustainable, which in turn create inequities between generations, gender, and economic sectors.

Taking into consideration the characteristics mentioned above, this report is concluded with several recommendations for specific policy responses in order to reach a 'successful aging' population:

Recommendation 1: To improve the attitude and awareness of policy makers and society as a whole regarding challenges associated with an aging population and with the current living standards of the elderly.

Recommendation 2: To promote economic growth and development along with social protection provision, in order to guarantee and improve income for the elderly via support for their employment and retirement.

Viet Nam can promote economic growth and development by taking advantage of the on-going "demographic bonus", in order to have an aging population with a high income in the future. The current contributory pension should be gradually adjusted from PAYG DB to a system of individual accounts with a Notional Defined Contribution (NDC) scheme as a transitional step; such a transformation will guarantee generational equity, long-term pension fund balance as well as the current development of the financial markets in Viet Nam. Types of insurance should also be diversified in order to improve accessibility to these by different population groups; voluntary insurance

should be clearly defined while mandatory and other insurance schemes should be based on the affordability of participants. Both voluntary and mandatory insurance schemes should be articulated.

The participation of the elderly in the labour force should furthermore be promoted, particularly in the manufacturing industries where "learning by doing" is currently the main mode of training. Such participation will be cost-saving.

Social allowances for the vulnerable elderly should become a universal system in which special attention should be given to rural and female elderly. Benefit levels and modes of delivery of such allowances need to be considered, in order to guarantee proper living standards and health for the elderly. Inclusion and exclusion errors in identifying beneficiaries should be mitigated.

Recommendation 3: To strengthen healthcare services and to build and expand elderly care services with active participation from all sectors in order to improve national capacity with regard to elderly care. Among a variety of measures, it is important to emphasize health education and improvement of awareness and knowledge of healthy aging, to avoid illnesses and disabilities in later life; To increase management and control of chronic diseases, especially cardiac problems, high blood pressure, joint deterioration, diabetes, and cancer, along with the application of new consultation techniques and early treatments as well as long-term treatments of chronic diseases. An elderly-friendly living environment is very much needed. In particular, a comprehensive national strategy for elderly care should be developed with quantitative and gender-based targets, in order to reduce and prevent chronic diseases, disabilities and deaths.
Furthermore, the building and enhancing of networks for health care and elderly care are important, especially of those related to chronic diseases. Such networks need to ensure and improve accessibility for the most vulnerable elderly groups, such as for those living in rural areas, for elderly females or for elderly belonging to an ethnic minority. Additionally, the government should strongly support elderly care activities at public social assistance centres and private elderly shelters. Elderly care at the social assistance centres needs to be combined with community-based elderly care, whereas home care for the elderly should also be encouraged.

Priority should be given to investment in and development of the gerontology system nationwide. A unified network of elderly nursing centres needs to be developed and managed, based on the actual needs and conditions of each locality. Training courses for gerontology nurses need to be formulated and conducted in line with the new demand for human resources for the elderly care network and with the actual local conditions in each time period. Basic principles and approaches of healthcare for the elderly need to be incorporated into training programmes for medical students, nurses, and other medical staff. In the longer term, Viet Nam will thus be able to provide high quality human resources for elderly care in other countries as well.

Training programmes also need to be formulated and implemented for non-official caregivers; Information and training need to be provided to family members and non-official caregivers with regard to appropriate care for the elderly. These policy actions should be community-based.

Recommendation 4: To improve the roles of political, social and professional associations with regard to making and advocating policies and programmes on aging and

for the elderly. Activities promoting the responsibilities of families, communities and the society as a whole for the elderly need to be encouraged and expanded. Coordination and cooperation between professional entities in proposing various types of living arrangements for the elderly will also be needed, whether at home with children and grandchildren or in social shelters. Community-based activities for the elderly are necessary to ensure that their opinions are incorporated into policies and that they can take an active part in their communities.

Recommendation 5: To generate nationally representative data and comprehensive studies on aging and the elderly population: Such data and studies will provide essential inputs for the development of appropriate policies. The lack of coordination between researchers and policy makers need to be mitigated, as this presents one of the biggest issues when discussing aging and the elderly in Viet Nam. In a number of relevant cursory studies the elderly are considered to be burdens rather than important contributors to their country and families through their social and economic activities. Without nationally representative data, it has thus far been difficult to provide substantive policies.

"The issue of ageing must be at the centre of the global development agenda. Today, the elderly are the world's fastest-growing population group, and among the poorest. One person in ten is 60 years and older, but by 2050, the rate will be one person in five. We must meet the needs of the older persons who are alive today and plan ahead to meet the needs of the elderly tomorrow. In the developing world, there are almost 400 million people over age 60, the majority of whom are women, and this figure is expected to rise dramatically in the coming decade".

UNFPA Former Executive Director
Ms. Thoraya Obaid's address to The Second World Assembly on Ageing in Madrid in 2002.

"As the proportion of the world's population in the older ages continues to increase, the need for improved information and analysis of demographic ageing increases. Knowledge is essential to assist policy makers define, formulate and evaluate goals and programmes, and to raise public awareness and support for needed policy changes."

United Nations. 2009. World Population Ageing 2009.

I. INTRODUCTION

I. INTRODUCTION

Changes in the age structure of populations have significant impacts on the socio-economic development of nations, regions and the whole world. One of such changes in recent years is "aging", i.e., both the number of elderly and the percentage of elderly in the total population have increased. An aging population results from three demographic forces: declining fertility rates, declining mortality rates, and increasing life expectancies. Population projections by the United Nations (2008) show that the elderly population will increase from 697 million (or 10 percent of the world population) in 2010 to about 2 billion (or 23 percent of the world population) in 2050. The projections also reveal that aging populations will occur in most of the developing countries and that even the pace at which aging takes place in these countries will be higher than that in developed countries. An aging population in countries characterized by a low socio-economic development level presents a serious policy challenge since such a segment of the population will require huge expenditures on healthcare, retirement allocations and social allowances. In other words, without proper anticipation and preventive measures taken from the present onward, less healthy and low-income elderly populations will cause governments to have huge expenditures, which in turn will negatively influence long-term fiscal sustainability and economic growth.

Over time, the Vietnamese population has experienced a lot of changes in both fertility and mortality rates. With the introduction and implementation of family planning policies since 1960, the Total Fertility Rate (TFR) in Viet Nam decreased from 4.81 in 1979 to 2.33 in 1999 and 2.03 in 2009. At the same time, the general health of the population has improved due to a better healthcare system, while mortality rates have decreased and life expectancies have increased. As a result, the elderly population

has grown significantly in both numbers and as a percentage of the total population. Consequently, Viet Nam will face a status of "getting old before getting rich"; pace at which the population is growing old is rather high while the per capita income is only just reaching the level of a low middle-income country (about $US 1,170 per capita in 2010). This is an enormous challenge, which will require the government of Viet Nam to carefully plan strategies and policies from now on, in order to be adaptive to its rapidly aging population in the coming decades.

1. OBJECTIVES AND SCOPE OF THE REPORT

The main objective of this report is to provide an evidence-based analysis of aging and Viet Nam's elderly population in order to propose specific policies on population and development for the period 2011-2020 and beyond. In this context the following issues will be discussed:

1) Aging and the elderly population in Viet Nam in terms of demographic trends; living arrangements; health and healthcare services; work, employment and income; and social protection schemes for the elderly. A number of relevant issues will be analysed, including the coverage, accessibility, distribution and poverty reduction of contributory pension and social allowance schemes.

2) Several important policies and programmes for the elderly will be analysed in terms of their advantages and drawbacks. More importantly, the report will shed light on policy gaps which will hamper pro-active adaptation to the aging population in Viet Nam.

3) Based on the analyses mentioned above, some policy recommendations towards aging and the Vietnamese elderly will be made, in order to obtain a "successfully aging population".

2. METHODOLOGY AND DATA FOR THE REPORT

Besides describing and analysing statistical data of demographic changes, aging and the elderly in Viet Nam, research results from various multivariate and/or micro-simulation studies will be used as well to provide evidence for policy debates.

Analyses in this report will be based mostly on secondary datasets of different sizes and levels representation, as well as on relevant documents. In all analyses, an attempt has been made to use nationally representative data whenever available, such as those from the Viet Nam (Household) Living Standards Surveys or the Population and Housing Censuses. In addition, the report will also use data from smaller-sized surveys in order to illustrate with appropriate examples.

Since aging and the elderly are comprehensive issues related to different sectors, data must be collected from different sources. However, because data from different sources may be inconsistent in terms of definitions and measurements, this may be considered a limitation of the current report.

3. CONTENTS OF THE REPORT

This report includes four parts. Following the Introductory part, Part II will present characteristics of aging and the elderly in Viet Nam, such as aging trends and pace; elderly living arrangements; healthcare

for the elderly; work, employment and income; and social protection schemes for the elderly. The report will especially focus on the contributory pension scheme, social allowance scheme, and healthcare system, in order to point out various challenges for Viet Nam when seeking solutions for the vicious circle of aging - illness - poverty. Part III will provide an analysis of the current policies and programmes for the elderly as well as the national strategies towards an aging population. Finally, Part IV provides policy recommendations for an aging population, especially for reaching a population stage of 'successful aging', in which the Vietnamese elderly will be healthy and able to be active in all social and economic activities.

II. CHARACTERISTICS OF AGING AND THE VIETNAMESE ELDERLY

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1. DEMOGRAPHIC CHARACTERISTICS

Over the past three decades, the Vietnamese population has changed significantly in terms of size and age structure. The elderly as a percentage of the total population has increased due to three important factors: declining fertility rates, decreasing mortality rates, and increasing life expectancies. The Total Fertility Rate (TFR) decreased from 5.25 in 1975 to 3.8 in 1989 and to 2.03 in 2009. The Infant Mortality Rate in 2009 was 16‰, which is 20 ‰ - point decrease in comparison with 1999. Life expectancy at birth was 72.8 in 2009 - an increase of 4.6 years and 8 years in comparison with 1999 and 1989, respectively. The rate of population growth decreased from an annual average of 2.4 percent during 1975-1989 to 1.7 percent during 1989-1999, and to 1.2 percent during 1999-2009. As such, the Vietnamese population has experienced three trends: the percentage of child population (aged 0-14) has decreased; the percentage of working-age population (aged 15-59) has increased; and the percentage of elderly population (aged 60 and over) has also increased. Table 1 shows that, if the year 1979 is considered as the base year, during the period 1979-2009 the total population increased by 1.6 times; the child population decreased by half; the working-age population increased by 2.08 times, while the elderly population increased by 2.12 times. In other words, the fastest growth was experienced in the elderly population in comparison with other population groups over the past three decades. This is the first and clearest characteristic of population aging in Viet Nam.

Table 1. Age structure of the Vietnamese population, 1979-2009

Year	Number of persons (millions)				Percentage of the total population		
	Total	0-14	15-59	60+	0-14	15-59	60+
1979	53.74	23.40	26.63	3.71	41.80	51.30	6.90
1989	64.38	24.98	34.76	4.64	39.20	53.60	7.20
1999	76.33	25.56	44.58	6.19	33.00	58.90	8.10
2009	85.79	21.45	56.62	7.72	25.00	66.00	9.00

Source: Population and Housing Census 1979, 1989, 1999 and 2009

The population projections by the GSO (2010) for the period 2009-2049 show that such an aging population will be presented by an increasing aging index and a lowering Potential Support Ratio (Table 2).

Table 2. Aging index and Potential Support Ratio in Viet Nam, 1979-2049

Year	1979	1989	1999	2009	2019	2024	2029	2034	2039	2044	2049
Aging index	16	17	24	36	50	65	85	107	124	141	158
Potential support ratio	7.44	7.43	7.33	7.27	5.29	4.60	3.83	3.27	2.88	2.51	2.20

Source: Population and Housing Census 1979, 1989, 1999 and 2009 and GSO (2010)

The aging index will surpass 100 in 2032, and this is the time when the elderly population will outnumber the child population. The population projections also outline that the Potential Support Ratio will decrease significantly along with the appearance of the aging population. The ratio was 7 in 2009 but will decrease to only 2 in 2049, about a three-fold decrease.

Population projections for Viet Nam by the United Nations (2008) show that, as a result of the expected aging population, the median age will increase from 28.5 in 2010 to 36.7 in 2030 and 42.4 in 2050. Life Expectancy at Birth will increase from 75.4 in 2010 to 78 and 80.4 in 2030 and 2050, respectively. The current life expectancies at age 60 for Vietnamese females and males are 20 and 18 years, respectively. These life expectancies are the same as or higher than those of the elderly in the countries with higher per capita income levels, such as Thailand, Malaysia, or Indonesia (Table 3).

Table 3. Life expectancies at 60 for Viet Nam and other regional countries

Country	Life expectancy at 60	
	Female	Male
China	20	17
Indonesia	18	16
Republic of Korea	23	18
Malaysia	19	17
Philippines	19	17
Singapore	23	20
Thailand	20	17
Viet Nam	20	18

Source: United Nations (2008)

The second characteristic of the aging population in Viet Nam is that Viet Nam will be "*aging at the oldest old*", i.e., the number of oldest old and its growth will be higher in the time to come (Table 4).

Table 4. The Vietnamese population: Rapid growth of "oldest old"

Age group (% total population)	1979	1989	1999	2009	2019	2029	2039	2049
60-64	2.28	2.40	2.31	2.26	4.29	5.28	5.80	7.04
65-69	1.90	1.90	2.20	1.81	2.78	4.56	5.21	6.14
70-74	1.34	1.40	1.58	1.65	1.67	3.36	4.30	4.89
75-79	0.90	0.80	1.09	1.40	1.16	1.91	3.28	3.87
80+	0.54	0.70	0.93	1.47	1.48	1.55	2.78	4.16
Total	6.96	7.20	8.11	8.69	11.78	16.66	21.37	26.10

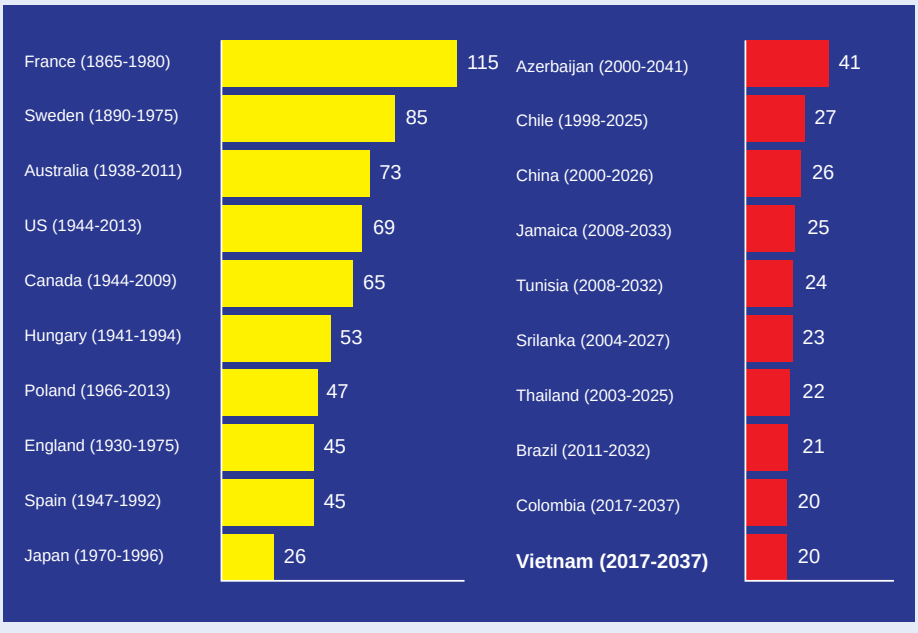
Source: Population and Housing Census 1979, 1989, 1999 and 2009; GSO (2010)

Data from the past four censuses during the period 1979-2009 show that, in percentage terms, the elderly aged 60-69 increased slowly, while the older old (aged 70-79) and the oldest old (80+) increased faster. Results from the population projections by GSO (2010) for the period 2009-2049 in Table 4 indicate that Viet Nam will enter its "aging phase" at the same time as growth of the oldest old group will reach its fastest pace.

In comparison with other countries, even with developed countries or those with a higher per capita income, Viet Nam will have an even higher rate of aging. In particular, the number of years needed to increase the elderly population aged 65 and over as a percentage of the total population from 7 percent to 14 percent (or time needed to move from an "aging phase" to an "aged phase") will thus be lower than those for

other countries (Figure 1): France needed 115 years; the US needed 69 years; Japan and China needed 26 years, while Viet Nam will need only 20 years. Given the current socio-economic development levels, such a trend will be a great challenge for Viet Nam with regard to properly adapting to its aging population.

Figure 1. Time needed to move from "aging" to "aged" in some countries



Source: Kinsella and Gist (1995); U.S. Census Bureau (2005); Viet Nam: GSO (2010)

The third characteristic is that the ratio between elderly females and their male counterparts increases as age is higher (Table 5). Because the number of female elderly as a percentage of the total elderly population increases (or "feminization" of aging) and females are usually more critically vulnerable to socio-economic and health shocks, it is highly essential that elderly care policies take such a specific need into account (Pham and Do, 2009). The increasing ratio between elderly females and males as presented in Table 5 is a common observation elsewhere in the world as well. One of various reasons for such a situation is that the mortality rate for elderly males usually is higher than that for elderly females at the same ages.

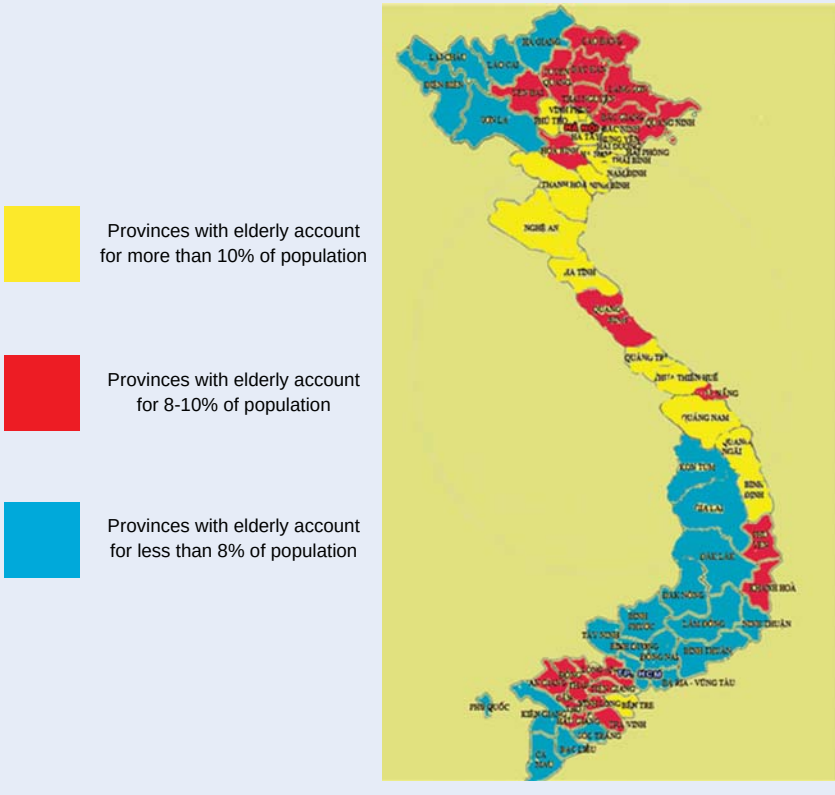
Table 5. Sex ratio between elderly females and elderly males, 2009

Age group	**60-69**	**70-79**	**80+**
Number of elderly females to 100 elderly males	131	149	200

Source: Population and Housing Census 2009

The fourth characteristic is that the aging rates are noticeably different in different regions and provinces with different socio-economic development levels (Figure 2). Figure 2 presents the distribution of the elderly population between provinces. For the provinces where the elderly account for more than 10 percent of the total population, one important factor is out-migration of the working-age population. In contrast, for provinces where the elderly account for less than 8 percent of the total population, one important factor is the simultaneous occurrence of a high fertility rate in those areas (Nguyen Dinh Cu, 2009). With the notion that aging paces differ between regions and provinces it becomes clear that thorough examinations of the socio-economic causes of demographic status for each specific region or province are needed, in order to build area sensitive development policies.

Figure 2. Distribution of the elderly population by province, 2009



Source: Population and Housing Census 2009

When comparing areas, data from the Viet Nam (Household) Living Standards Surveys collected over the past decade show that most of the elderly are still living in rural areas, even though urbanization has been progressive in Viet Nam. The percentage of elderly living in rural areas only slowly decreased from 78 percent in 1993 to 73 percent in 2008. It can furthermore be observed that about half of the elderly population are living in the Red River Delta and the Mekong River Delta - the two main agricultural production regions of the country (Table 6).

Table 6. Distribution of the elderly population by area and region

Year	1992/93	1997/98	2002	2004	2006	2008
Regions						
Red River Delta	23.95	23.78	25.35	25.78	25.64	25.41
Northeast	13.11	13.73	10.89	10.46	10.03	10.39
Northwest	1.83	1.73	2.13	1.93	1.71	1.43
North Central Coast	13.00	14.48	13.87	12.59	12.92	15.20
South Central Coast	10.89	8.68	9.79	9.93	9.62	8.64
Central Highlands	2.03	1.85	4.01	3.40	3.82	3.07
Southeast	13.61	15.56	14.00	15.37	15.63	14.92
Mekong River Delta	21.52	20.20	19.94	20.55	20.63	20.95
Areas						
Rural	77.73	76.06	76.83	73.33	72.30	72.49
Urban	22.27	23.94	23.17	26.67	27.70	27.51

2. LIVING ARRANGEMENTS, CULTURAL AND SPIRITUAL LIFE OF THE ELDERLY

Well-being for the elderly in Viet Nam is directly influenced by their marital status; by living with or without children and grandchildren; by particular housing and other living conditions; and by their cultural and spiritual activities. Among these factors, marital status is the most important one since elderly spouses provide support for each other and share the challenges and vulnerabilities of both the material and spiritual realms of their lives. In other words, for the elderly living with a spouse brings positive impacts (Knodel and Chayovan, 2008). Data show that most of the elderly in Viet Nam are married, followed by a smaller amount of widowed elderly, while other marital statuses (such as divorce, separated, and unmarried) account for only a small proportion of the elderly population (Table 7).

Table 7. Marital status of the elderly in Viet Nam, 1993-2008

Year	1992/93	1997/98	2002	2004	2006	2008
Married	64.04	61.63	61.69	60.51	60.85	59.10
Widowed	33.91	35.81	36.44	36.99	36.87	38.65
Other	2.05	2.56	1.87	2.50	2.28	2.25

Source: VHLSS 1992/93-2008

A study by Giang and Pfau (2007) reveals that there is no significant difference between rural and urban elderly in terms of marital status. However, there is a difference for the group of widowed elderly in terms of gender and age: there is substantially higher number of widowed females than there are widowed males, and this discrepancy becomes more obvious with increasing age (Table 8). One reason for the fact that the mortality rates of elderly males are higher than those of females is, among many others, that men usually marry younger women: this consequently often results in their comparatively earlier state of widowhood.

Table 8. Percentage of widowed males and females by gender and age, 2009

Age group	60-69	70-79	80+	All
Male	5.88	15.73	36.02	13.85
Female	36.97	57.94	81.93	53.69
All	23.04	40.56	66.25	37.12

Source: Population and Housing Census 2009

In terms of living arrangements, an important question is with whom the elderly share a household. Data from the V(H)LSS for the period 1993-2008 indicate clear trends: (i) the percentage of the elderly living with children remains dominant but is decreasing (from about 80 percent in 1992/93 to 62 percent in 2008); (ii) the percentage of the elderly living alone, and with spouses is gradually increasing; (iii) the percentage of "skip-generation" families is small, but has increased more than two fold (Table 9).

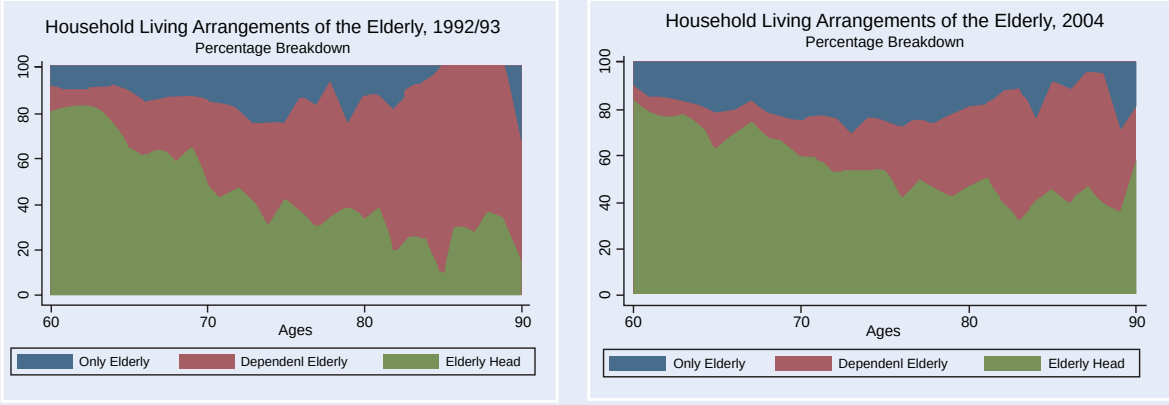
Table 9. Living arrangements of the elderly in Viet Nam, 1992/93-2008

Year	1992/93	1997/98	2002	2004	2006	2008
With children	79.73	74.48	74.27	70.65	63.74	62.61
Living alone	3.47	4.93	5.29	5.62	5.91	6.14
Only elderly couple	9.48	12.73	12.48	14.41	20.88	21.47
With grandchildren	0.68	0.74	0.82	1.09	1.16	1.41
Other	6.64	7.12	7.14	8.23	8.31	8.37
Total	100	100	100	100	100	100

Source: VHLSS 1992/93-2008

A noticeable issue is that, over time and at all ages, the percentage of the elderly living with children as dependents tends to decrease (Giang and Pfau, 2007) (Figure 3). Such a situation can be elucidated by the fact that either the economic position of the elderly has improved, or family living arrangements have changed towards more independence between elderly parents and children.

Figure 3. Swift changes in the elderly living arrangements



Source: Giang and Pfau (2007)

The percentage of the elderly living alone increased from 3.47 percent in 1992/93 to 6.14 percent in 2008. According to Giang (2011, forthcoming), most of the category of elderly living by themselves comprise of people from rural areas (about 80 percent) and females (also about 80 percent). The percentage of elderly households with only elderly couples increased more than two fold, from 9.48 percent in 1992/93 to 21.47 percent in 2008. Given the mere minimal coverage provided by the current social protection system as well as a variety of circumstances which may cause possible socio-economic shocks, such changes in living arrangements of the elderly over time will bring big challenges with regard to securing their living conditions.

The percentage of "skip-generation" elderly households is small but increasing, from 0.68 percent in 1992/93 to 1.14 percent in 2008. Data from the V(H)LSS for the period 1993-2008 show that most of such households are in rural areas. This phenomenon may result from rural-urban migration of the working-age population. Although remittances play an important role in reducing vulnerability to poverty for the elderly (Giang and Pfau, 2009a), these elderly with "skip-generation" living arrangements are especially vulnerable when remittances are their main source of income and while their out-migrated family members are forced to struggle for a living under conditions of slow economic growth as has occurred in recent years.

In terms of education and training, Giang and Pfau (2007) show that the percentage of the elderly who can read and write has increased over time, especially the number of those who completed a secondary education or have vocational training certificates. A study by UNFPA (2010a), however, emphasizes at the same time that the percentage of the elderly with certificates of university/college and higher is still small. Also, the percentages of those who have never gone to school, as well as of elderly females and elderly living in rural areas or regions with a lower socio-economic status have always been higher than the percentages of educated elderly. Reasons for the differences between elderly in terms of knowledge and education are many folds and can be attributed to underlying differences in gender, locations and regions, as well as in access to education and health services and opportunities for economic gain.

Material life for the elderly, as presented through their housing conditions has improved over time. The percentage of elderly households (i.e., households with at least one elderly) with permanent houses with clean water and electricity has increased over time (Table 10). However, a number of elderly living in rural areas and regions with overall, lower socio-economic status are still experiencing poor living conditions, especially in terms of access to clean water and standard sanitation and hygiene (Giang and Pfau, 2007).

Table 10. Housing conditions of the elderly (Percent of the elderly household)

Year	1992/93	1997/98	2002	2004	2006	2008
Housing structure						
Villas	--	--	--	0.18	0.34	0.37
House with private bathroom, kitchen & toilet	4.11	6.33	7.54	6.85	11.07	14.31
House with shared bathroom, kitchen & toilet	1.91	1.93	8.66	10.51	11.36	12.62
Semi-permanent house	52.57	62.57	64.47	63.63	63.66	61.10
Permanent house	12.16	8.19	--	--	--	--
Temporary	29.25	20.98	19.33	18.83	13.58	11.60
Sources of drinking & cooking water						
Private water tap	10.24	11.17	12.03	14.72	19.60	21.17
Public water tap	2.87	3.08	4.05	3.31	2.19	3.56
Deep drill well	3.36	18.51	27.22	22.29	23.23	21.71
Hand-dug constructed well (various types)	51.00	33.22	31.95	32.38	21.97	21.95
Bought water	--	--	0.59	0.45	2.55	2.35
Filtered spring water	--	0.28	0.85	0.55	3.13	2.47
River, lake, and pond	18.50	9.91	9.66	7.49	1.24	1.36
Rain water	13.20	10.62	9.13	9.95	16.97	18.91
Other	1.09	13.21	4.52	8.86	9.12	6.52
Toilet						
Flush toilet with septic tank	12.81	15.50	18.68	25.44	34.34	40.19
Double vault compost latrine	10.98	12.79	22.75	21.24	21.53	21.33
Toilet directly over water	--	9.13	12.83	11.56	11.18	10.55
Other (Simple toilet)	55.78	45.69	29.28	27.31	23.27	14.44
No toilet	20.43	16.89	16.46	14.45	9.68	8.32
Sources of Lighting						
Electricity	52.13	80.67	86.73	93.80	96.98	98.33
Battery lamps	0.49	1.16	1.62	0.60	0.38	0.12
Gas, oil, and kerosene lamps	46.49	17.33	9.77	4.23	2.05	1.02
Other	0.59	0.84	1.88	1.37	0.59	0.53

Note: -- not available
Source: V(H)LSS 1992/93 -2008

In terms of spiritual life, a study by VNCA[3] (2007) shows that the percentage of the elderly participating in clubs for the elderly is still low (about 16 percent), reasons for which are mostly due to health problems. The percentage of the elderly having access to mass media and to good information about socio-economic issues is rather high (70 percent), but there are clear differences between various categories within the total group of elderly, e.g. with regard to age: younger elderly enjoy better access and information than older groups of elderly; with regard to areas: elderly living in urban areas have much better access and information than their rural counterparts; with regard to ethnicity: elderly among the Kinh seem to be much more aware of socio-economic issues than the ethnic minority elderly; and with regard to educational levels: elderly with higher educational levels have much better access and information than those with lower educational levels.

3. HEALTH STATUS AND HEALTH CARE SERVICES FOR THE ELDERLY

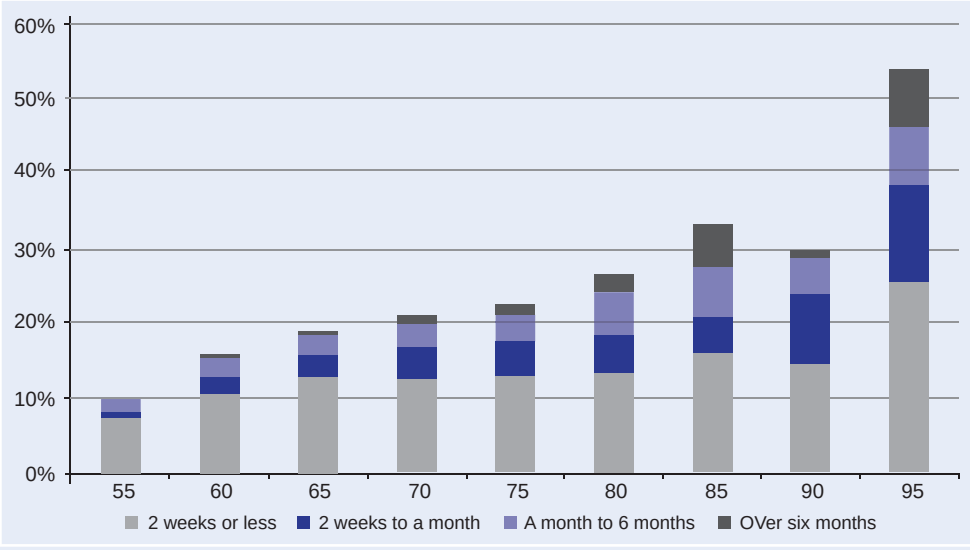
Health status is an extremely important indicator for well-being of the elderly. In practice, aging not only causes mortality risks due to physical changes, but also conditions of general malfunction and chronic diseases. Health has a direct impact on the daily life of elderly. Sidell (1995) (as quoted in Sim, 2001) shows that ill health can bring many losses, including the loss of independence and autonomy, loss of mobility, loss of dignity and privacy, and loss of confidence and self-esteem. In fact, for the elderly mental losses due to ill health are often much more problematic than material losses. Analysis of the health status and healthcare services for the elderly will provide more detailed information about the overall quality of life for the elderly, their demand for healthcare and related services within the healthcare system as a whole, as well as the health status of the elderly at home and in the community.

Over time, thanks to improved living standards and a better healthcare system, the health status of the Vietnamese elderly has improved, and thus the percentage of the elderly with fair/good health has increased, while the percentage of those with ill health has subsequently diminished (Dam et al., 2010)[4]. However, there continue to be a number of serious health challenges for the elderly in Vietnam.

3. The report of VNCA (2007) was based on surveys completed in 2007 with 2,878 elderly persons living in 72 communes in 8 provinces/cities belonging to 8 socio-economic regions: Yen Bai, Bac Giang, Ha Tay, Ha Tinh, Quang Ngai, Đak Nong, Ba Ria - Vung Tau and HCMC.

4. The results of this report are based on the surveys held in 2009 among 4,454 elderly and 483 leaders and staff working in different institutions such as social insurance, health insurance, and elderly associations in 10 provinces/cities , in 40 districts/towns; 188 communes; and 12 elderly care centres; including the provinces/cities Phu Tho, Vinh Phuc, Ha Noi, Hung Yen, Thanh Hoa, Da Nang, Khanh Hoa, Gia Lai, HCMC and Ba Ria - Vung Tau.

Figure 4. Days incapacitated in bed caused by illness and disability, by age



Source: Evans et al., (2007a)

Table 11. Health status of the elderly, by age

Age group	60-69	70-79	80+	All
Health status (%)				
Good	8.37	3.34	2.23	5.32
Normal	64.82	52.86	29.46	52.71
Ill	26.82	43.80	68.30	41.97
Illness status (%)				
No disease	12.43	8.85	3.42	9.17
Having 1 disease	72.32	75.08	82.44	75.57
Having 2 diseases	14.15	15.10	12.80	14.14
Having 3 diseases	1.02	0.97	1.34	1.08
Having 4 diseases	0.08	0.00	0.00	0.03

Source: VNCA (2007)

1) Studies by Evans et al., (2007a) (Figure 4)[5] and VNCA (2007) (Table 11) indicate that the health status of the elderly to a large extent depends on the advancement of their ages: i.e., as they become more aged, the percentage of the elderly who experience ill health is higher, and the percentage of the more advanced age elderly having the same number of diseases is higher.

2) A most urgent challenge for elderly care in Viet Nam is dealing with the various types and causes of diseases of the elderly, the pattern of which is commonly referred to as the "twin morbidity burden". On the one hand, the elderly have to live with the burden of disease due to the natural occurrence of such at an advanced age; on the other hand, they also are exposed to new diseases resulting

5. Evans et al., (2007) use VHLSS 2004.

from socio-economic changes due to the overall economic transformation and growth of their country. A study by Dam et al., (2010), for instance, reveals that 95 percent of the elderly has at least one disease, and most of them have to cope with non-contagious and chronic diseases such as joint degradation (40.62 percent); cardiac problems and blood pressure (45.6 percent); prostate (63.8 percent); and urination disorders (35.7 percent). At the same time, diseases resulting from lifestyle changes have become more common, e.g. stress and mental depression (Pham and Do, 2009) (Table 12).

Table 12. Percentage of common mental problems

		Age group	
		60-74	**>=75**
Stress	n	24/617	12/123
	%	3.90%	9.80%
Mental depression	n	7/846	7/309
	%	0.80%	2.30%

Note: All estimates are statistically significant at 5-percent significance level
Source: Pham and Do (2009)

The types of diseases experienced have shifted from contagious to non-contagious and chronic ones. This obviously presents a critical challenge for Viet Nam since non-contagious diseases often develop over a potentially prolonged period of time, for example the growing incidence of obesity marked by symptoms such as rapid weight gain and overweight. Also, since regular check-up visits to determine one's health status is not a custom among most people in Viet Nam, and at the same time many health-risk behaviors are common (e.g. smoking and drinking, particularly among men), diseases are usually only discovered at critical and late stages, when the need for then many and costly resources for treatments are unavoidable.

3) As a result, non-contagious diseases have become the primary causes of illness for the elderly in Viet Nam, and this trend will continue in the coming decades (Pham and Do, 2009). Risks of becoming disabled are also high for the Vietnamese elderly, particularly in terms of vision and hearing. Disabilities make the elderly uncomfortable, unconfident, and less socially interactive. Data from the Population and Housing Census 2009 indicate that the percentage of elderly suffering from disabilities increases with age (Table 13).

Table 13. Percentage of disability for the elderly

Type of disability	Not difficult	Difficult	Very difficult	Impossible
Vision (% by age)				
60-69	80.50	17.90	1.30	0.30
70-79	65.20	30.50	3.70	0.70
80+	45.30	41.60	10.90	2.30
Hearing (% by age)				
60-69	89.60	9.10	1.10	0.20
70-79	74.40	21.80	3.40	0.50
80+	49.60	37.10	11.50	1.80
Walking (% by age)				
60-69	87.30	10.50	1.70	0.50
70-79	71.00	23.40	4.40	1.30
80+	45.50	37.70	12.40	4.30
Memory (% by age)				
60-69	89.00	9.70	1.10	0.30
70-79	74.70	21.50	3.10	0.70
80+	51.20	35.40	10.80	2.50

Source: Population and Housing Census 2009

In terms of costs for healthcare, Pham and Do (2009) point out that, on average, the expenses for healthcare for an elderly is about 7-8 times of the costs spent for a child. It thus becomes apparent that if the diseases and disabilities of the elderly will not be controlled and mitigated, health care for the elderly will become a large and unavoidable financial burden.

4) Although the elderly usually face many health risks, it appears that most of them do not realize how to obtain good healthcare and how to take care of oneself. Results from a recent study by Tran (2010)[6] brings to light the fact that most of the elderly do not know signs of high blood pressure (66.5 percent) and causes of high blood pressure (84.1 percent) or how to prevent joint degradation (74.6 percent).

5) The accessibility to healthcare services are different for different groups of elderly, to the extent that a certain number of elderly are not even able to reach healthcare services at the time they need them most, for full treatments. In particular, the elderly living in rural, remote, border and island areas – who account for a large proportion of the elderly population – have difficulties accessing any type of healthcare services (Nguyen Quoc Anh et al., 2007). The main causes for this situation, among many others, are: weakness of the healthcare system at the grassroots level; lack of medical and facility sources for elderly care; and improper distribution of healthcare stations and centres, especially in the rural and mountainous areas. A study by Nguyen Viet Cuong (2010), explains that, for example, in rural areas where there are no communal healthcare centres, to reach

6. This study was conducted with 818 elderly living in 4 communes of Chi Linh district, Hai Duong province, which is a rural and mountainous district in the Northeast of Viet Nam.

the nearest district hospitals people have to travel an average of 13.3 kilometres in the Northeast; 22.5 kilometres in the Northwest; and 15.6 kilometres in the Central Highlands.

Another critical cause for poor accessibility is that the burden of healthcare expenses seems to be to heavier for the more vulnerable elderly groups (Table 14). Healthcare expenses for an elderly household are mostly paid out-of-pocket (OOP), while social health insurance plays a minor role (Giang, 2010a). Table 14 presents the average expenditure for healthcare of an elderly household in 2004 and 2008 in both absolute terms (actual amount of money paid) and relative terms (as a percentage of the total expenditure of an elderly household). The results indicate that the average spending on healthcare increased across all elderly groups. Although the average expenditure of a rural household is much less than that of an urban household, the higher rate of healthcare expenditure in the rural areas as compared with urban areas points to the fact that healthcare burden is weighing more heavily on the shoulders of rural elderly. Giang (2010a) also explains that, as a percentage of total household expenditure, the poorest elderly households spend similar amounts on healthcare as the richest elderly households, but their visits to hospitals and healthcare centres are only half those of their counterparts.

Table 14. Healthcare expenditure for the elderly in Viet Nam

Elderly group	2004		2008	
	Expenditure on health (VND 1,000)	Share of health expenditure in living expenditure (%)	Expenditure on health (VND 1,000)	Share of health expenditure in living expenditure (%)
Residential areas				
Rural	414.10	8.49	685.10	9.30
Urban	778.30	9.24	1,269.90	9.50
Residential regions				
Red River Delta	414.10	8.49	685.10	9.30
Northeast	778.30	9.24	1,269.90	9.50
Northwest	414.10	8.49	685.10	9.30
North Central Coast	778.30	9.24	1,269.90	9.50
South Central Coast	414.10	8.49	685.10	9.30
Central Highlands	778.30	9.24	1,269.90	9.50
Southeast	414.10	8.49	685.10	9.30
Mekong River Delta	778.30	9.24	1,269.90	9.50

Source: Giang (2010a)

Methods of treatment and the attitude of medical staff are other important factors likely to influence the accessibility of healthcare services for the elderly. VNCA (2007) shows that 47.7 percent of the surveyed elderly said the attitude of staff seemed normal, but 2.2 percent said their attitude was disagreeable.

As a final point although the number of elderly people has increased significantly over time, healthcare services for the elderly have not changed and a shortage of medical staff with specific skills appropriate for elderly care has now become evident. Dam et al., (2010) suggest that only very small improvements in the existing elderly care system, as well as minimal investments in a new system have been made: Viet Nam as a whole has only 22 central and provincial hospitals housing Gerontology Departments with 1,049 staff and 2,728 beds - a negligible amount when considering the millions of elderly people needing and seeking elderly care services.

One of the most critical gaps in research about the health status of elderly pertains studies regarding the reproductive health of the elderly, including trends in this particular area as well as treatment costs. The increasing trend to contract illnesses such as prostate and breast cancer requires responsive research-to-policy activities and related healthcare services.

4. ECONOMIC ACTIVITIES, INCOME SOURCES, AND POVERTY INCIDENCE OF THE ELDERLY

Table 15 presents labour force participation rates of the elderly by their characteristics. The data make clear that, over time, participation of the elderly in the labour force has reduced. Their rates of participation in particular diminish substantially as their age progresses. More than 60 percent of the elderly are engaged in agriculture, forestry and fishery production, followed by a high percentage of self-employment in household business and services. The percentage of elderly working for a wage has increased but still remains low, in part because wage earners usually will not continue working after the normal retirement age. The elderly living in rural areas have higher participation rates than their urban counterparts, which can be partly explained by economic differences. There are no significant differences between regions, but the results generally show that the elderly living in regions with a higher socio-economic status usually have lower participation rates than the elderly living in regions with a lower socio-economic status (e.g. the Red River Delta versus the Northwest).

Table 15. Labor force participation rates of the elderly in Viet Nam

Year	1992/1993	1997/98	2002	2008
All elderly	54.25	50.91	45.30	42.75
By age (% of each group)				
60-69	63.41	63.02	61.97	61.91
70-79	39.39	37.48	35.02	34.50
80+	11.56	9.83	8.74	7.84
Type of work (% elderly in each type)				
Wage/salary earners	5.94	6.47	6.99	9.30
Self-employed in agriculture, forestry and fishery production	84.90	81.29	77.49	60.73
Self-employed in business and services	9.16	13.22	15.52	29.97
By area (% of each area)				
Urban	32.22	31.10	28.01	25.96
Rural	57.48	55.38	50.51	49.09
By regions (% of each region)				
Red River Delta	44.15	46.34	43.70	41.88
Northeast	48.65	48.91	49.32	48.50
Northwest	58.71	52.30	45.51	44.35
North Central Coast	36.82	45.98	51.69	47.48
South Central Coast	51.22	53.56	58.87	52.97
Central Highlands	34.91	45.43	50.25	39.92
Southeast	44.24	34.22	26.20	30.25
Mekong River Delta	44.15	41.28	41.34	43.25

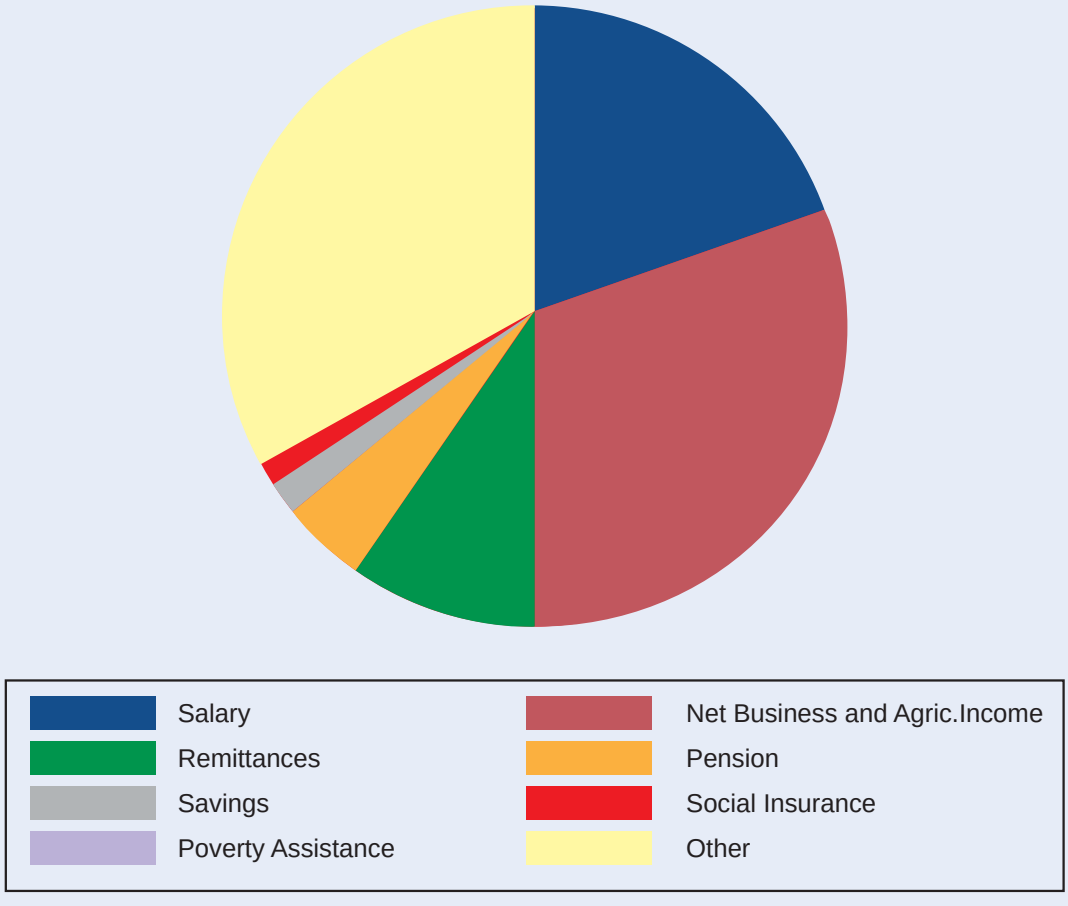
Source: V(H)LSS 1992/93 – 2008

In terms of elderly household income components, data from the VHLSS 2008 indicate that agricultural production and wage/salary are the main sources of income (Figure 5). However, such income sources account for only a small proportion of long-term saving for a pension and other social insurance benefits in the elderly household. Pfau and Giang (2010) show that pensions and other social insurance benefits are even much lower than remittances.

Table 16 presents retirement and social allowances for an elderly household. It thus becomes obvious that these two sources of income play a minor role in household expenditure. As the elderly reach higher ages, their production capacity will diminish, and the fact that precautionary income sources such as retirement and social allowances are very low will result in income insecurity for the elderly. A report by VNCA (2007) indicates that the average income of an elderly is just

about 59 percent of the country's per capita income. Social allowance benefits for the elderly living alone or for disabled elderly are also only just equal to 60-70 percent of the poverty threshold.

Figure 5. Income components of an elderly household



Source: VHLSS 2008

Table 16. Retirement and social allowances for an elderly household, 2008

	Pension (VND 1,000)	As % of household per capita expenditure	Social allowances, including cash transfer (VND 1,000)	As % of household per capita expenditure
All elderly	4,957.20	16.56	954.50	5.47
Age group				
60-69	6,119.70	18.94	922.20	4.70
70-79	4,106.80	14.02	887.60	5.48
80+	3,533.20	15.24	1,172.40	7.52
Ethnicity				
Kinh and Chinese	5,354.70	17.82	998.10	5.63
Ethnic minorities	1,043.10	4.13	525.30	3.88
Poverty				
Non-Poor	5,635.10	18.26	1,004.50	5.19
Poor	535.40	5.51	628.70	7.33
Residence				
Urban	10,890.20	26.38	744.30	2.71
Rural	2,706.10	12.84	1,034.30	6.52
Region				
Red River Delta	9,167.10	27.66	1,032.20	6.20
Northeast	5,881.40	23.43	711.50	3.93
Northwest	3,369.50	11.37	379.20	2.28
North Central Coast	5,930.30	27.53	1,437.50	8.98
South Central Coast	2,082.00	5.85	1,223.80	8.92
Central Highlands	2,549.80	9.81	373.20	0.78
Southeast	3,840.60	8.63	718.90	2.63
Mekong River Delta	1,129.20	3.15	811.60	4.32

Source: VHLSS 2008

Poverty incidence and vulnerability of the elderly are critical for some groups. Table 17 shows the variation of the official poverty line, which is measured by real per capita expenditure: (i) 50 percent of the official poverty line indicates a situation of extreme poverty which is very difficult to get out of; (ii) 100 percent of the official poverty line shows a poverty status which is current; (ii) 125 percent of the official poverty line indicates a near-poverty status, in which people are currently not poor, but are vulnerable to becoming poor; and (iii) 200 percent of the official poverty line describes a non-poverty status, in which people may never have to be subject to poverty.

Table 17. Poverty rate and vulnerability of the Vietnamese elderly to poverty, 2008

Elderly group	50% poverty line	Official (100%) poverty line	125% poverty line	200% poverty line
All elderly	0.90	13.30	26.50	58.20
By age				
60 – 69	0.60	10.20	22.80	54.90
70 – 79	1.10	16.30	29.30	60.50
80+	1.50	15.70	31.00	62.30
By gender				
Male	0.80	11.70	23.50	55.70
Female	1.00	14.40	28.70	59.90
Ethnicity				
Kinh (Vietnamese)	0.40	12.40	24.50	53.10
Ethnic minorities	6.90	43.20	63.80	78.70
Residential areas				
Rural	1.20	17.00	33.50	68.50
Urban	0.10	3.70	8.20	31.00
Living arrangements				
Alone	1.20	14.70	25.10	52.40
With children	0.90	14.40	26.00	57.80
Others	1.10	13.60	24.80	54.10

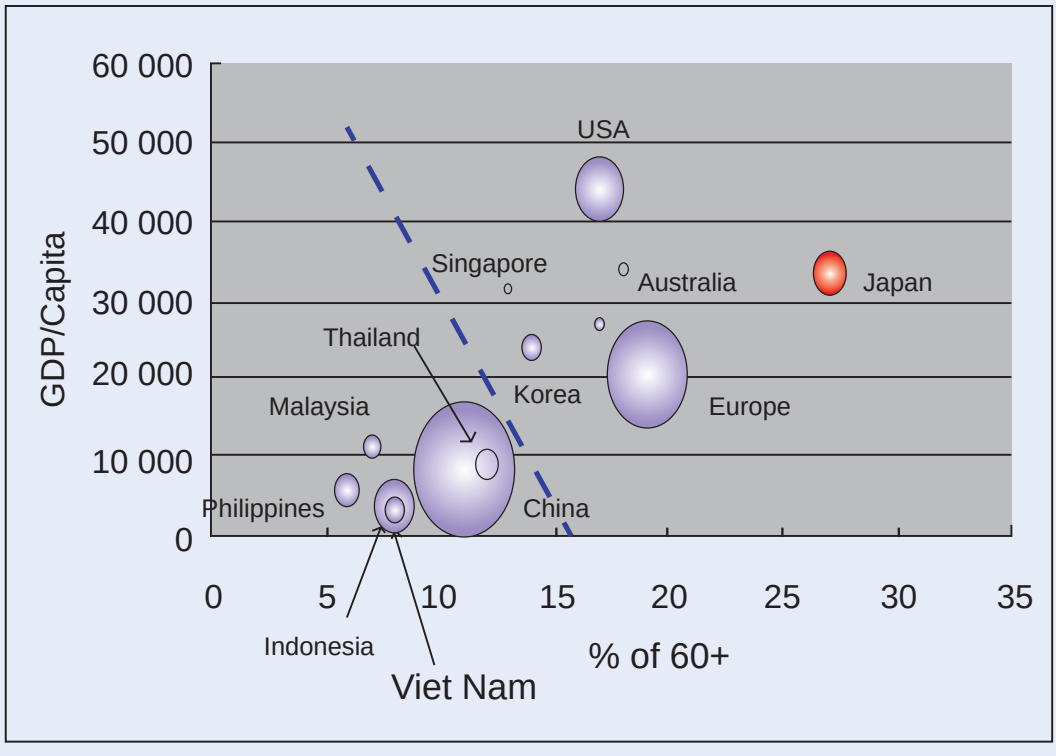
Note: The official poverty line was measured by real per capita expenditure in 2008, which was VND 3,360 thousand per person per year at the time. The poverty rate for the elderly is estimated by the percentage of per capita expenditure of the elderly which is lower than the official poverty line.
Source: VHLSS 2008

Results from Table 17 show that in terms of living conditions, a large number of the elderly are nearing the official poverty line. Their situation can be described as vulnerable to poverty but their poverty rate would be higher once the official poverty line is set at higher levels. For example, the elderly aged 60-69 had a poverty rate of 10.2 percent, but this rate would be 11 percentage points higher (22.8 percent) if the near-poor poverty line is used. The elderly at more advanced ages generally experience higher poverty

rates than do the younger elderly. Female elderly have a higher poverty rate than their male counterparts. Ethnic minority elderly are much poorer and more vulnerable to poverty than are Vietnamese elderly. Similar differences in results were found for rural and urban elderly; the former had significantly higher poverty rates and were more vulnerable to poverty than the latter.

The results mentioned above imply that dealing with poverty and vulnerability to poverty of the elderly is an urgent policy issue. Poverty of the elderly will become an even more critical challenge once Viet Nam falls into the trap of "getting old before getting rich" similar to some other countries in the region (Figure 6), i.e., that the per capita income remains low while the population is aging at a high pace. Figure 6 implies that if the trend in Viet Nam will move horizontally rather than vertically (i.e., a high aging rate along with a low per capita income growth), the government will be faced with many serious challenges with regard to economic development policies and strategies.

Figure 6. Challenge for securing elderly income: "getting old before getting rich"



Source: World Health Statistics 2008, as quoted by Ogawa and Toshihiro (2009)

As indicated in Figure 6, Viet Nam will enter the "aging phase" soon, while still being a low middle-income country. Without policies encouraging the elderly to continue working as well as promoting the working-age population to get well earning employment, the government of Viet Nam will have to carry very heavy burdens when forced to find solutions for long-term socio-economic issues with regard to its rapidly aging population.

5. SOCIAL PROTECTION FOR THE ELDERLY

The social protection system in Viet Nam has been expanded in recent years, specifically to cover more of the elderly population. An effort has been made to develop a number of policies and programmes with special focus on the elderly, but most of them are integrated within social insurance policies (retirement and survivorship), social health insurance, and social allowances.

By 2009, 1.9 million elderly (or 22 percent of the elderly population) were receiving retirement benefits; about 140,000 poor elderly living alone, without any support (or 1.7 percent of the elderly population), were having social allowances; about 5.6 million elderly (or 60 percent of the elderly population) were having social health insurance, out of which more than 60 percent have free health insurance cards. The coverage rate by the social protection system is nevertheless generally low, and only some specific elderly groups have access to it (Table 18).

Table 18 presents the percentages of elderly covered by contributory pensions and social allowances in 2004 and 2008. For social allowances, the results show that the more vulnerable elderly groups (e.g., older, poor) generally tend to have higher coverage rates than the less vulnerable elderly groups. Such an encouraging fact can be explained by the introduction of several specific policies such as those in Decree 67/2007/NĐ-CP (currently amended as Decree 13/2010/NĐ-CP) for vulnerable elderly groups. Nevertheless, coverage rates for these groups are still low.

In contrast, there are substantial differences regarding access to the contributory pensions between elderly groups where by the less vulnerable groups tend to have higher access rates than the more vulnerable groups. This gap has remained stable over time. For example, in 2008, the percentages of Kinh and ethnic minority elderly receiving contributory pensions were 23.3 percent and 8 percent, respectively; the percentages for non-poor and poor were 24.5 and 4.8 percent; and for urban and rural 37.5 percent and 16 percent. Added to this situation of contrasts can be the fact that according to the current strict regulations the contributory pensions are mostly reserved for formal sector workers, and are less favourable to informal sector workers. Differences in participation rates between formal and informal sector workers are explained in a recent report by the World Bank (2007), i.e., the current contributory pensions in Viet Nam are not pro-poor since the two richest quintiles only already use up 50 percent of the total contributory pension expenditures, while the poorest group get to spend only 2 percent. Meanwhile the voluntary contributory pension scheme has been set up, but its coverage is also limited (62,000 participants as of 2009). Furthermore, most participants in this scheme are members of the former social insurance scheme for farmers.

With regard to social allowances, inequality in access and benefits is also apparent, since people living in regions with a higher socio-economic status usually have higher benefit levels than those living in regions with a lower socio-economic status. Evans et al., (2007b), for instance, show that the average income of people living in the Red River Delta was about 1.02 times the national average level and the amount of per capita social allowances in this area was VND 460 thousand per annum, while the respective numbers in this regard for the Northern mountainous region were 0.52 and VND 160 thousand.

Table 18. Coverage of the contributory pensions and social allowances for the elderly

	2004		2008	
	Contributory pensions	**Social allowances**	**Contributory pensions**	**Social allowances**
All old-age	23.00	14.90	21.90	18.50
Age group				
60-69	26.70	11.60	25.80	15.60
70-79	19.50	16.10	18.80	16.20
80+	18.90	22.90	17.70	30.60
Ethnicity				
Kinh and Chinese	23.80	14.30	23.30	19.10
Ethnic minorities	14.60	21.20	8.00	12.60
Poverty				
Non-Poor	26.20	13.20	24.50	18.50
Poor	8.40	22.70	4.80	18.00
Urbanity				
Rural	19.30	16.60	16.00	20.10
Urban	33.00	10.50	37.50	14.20
Region				
Red River Delta	39.70	18.70	38.90	22.40
Northeast	33.30	15.10	30.30	13.30
Northwest	26.40	10.80	20.50	16.20
North Central Coast	31.10	19.40	28.80	26.50
South Central Coast	11.30	17.70	7.60	19.20
Central Highlands	13.90	22.70	10.90	6.10
Southeast	15.80	6.60	15.50	13.80
Mekong River Delta	4.50	11.40	4.30	15.50

Source: Giang (2010a)

III. POLICIES AND PROGRAMMES FOR THE ELDERLY IN VIET NAM

III. POLICIES AND PROGRAMMES FOR THE ELDERLY IN VIET NAM

Taking care of the elderly with regard to both their material and spiritual lives is an important policy component which the Communist Party and the government of Viet Nam have emphasized at all stages of the country's development. In terms of a general policy direction, it was confirmed by Article 14 in the Constitution of 1946 that "All citizens who are old or unable to work need to be supported" Article 32 in the Constitution of 1959 similarly emphasized to:"Assist all citizens who are old, ill, and disabled. Expand social insurance, health insurance and social relief". In the Constitution of 1992, Article 64 encouraged that"… children are respectful to and responsible for taking care of parents, grandparents", while Article 87 added that "elderly people are one of the population groups whom the government and society are responsible for providing support".

On 27 September 1995, the Central Committee of the Communist Party of Viet Nam issued the Directive No. 59-CT/TW emphasizing that "the elderly people need to be appreciated for their contributions by giving birth, nurturing children, and teaching the younger generations of Viet Nam; most of the elderly have also contributed to build up and protect the country" and that therefore taking care of the material and spiritual aspects of life for the elderly is the responsibility of the Communist Party, the government, and society as a whole. The Directive further advises that the government needs to allocate a budget for dealing with social issues, including elderly care and that, in particular disabled, and homeless elderly, as well as old people who live alone should be prioritized.

On 28 April 2000, the Standing Committee of the National Assembly issued the Ordinance on the Elderly (No. 23/2000/PL-UBTVQH10) in order to give more specific direction to the plans for the elderly as already mentioned in the Constitution of 1992 and the Decision from the sixth meeting of the National Assembly X. In

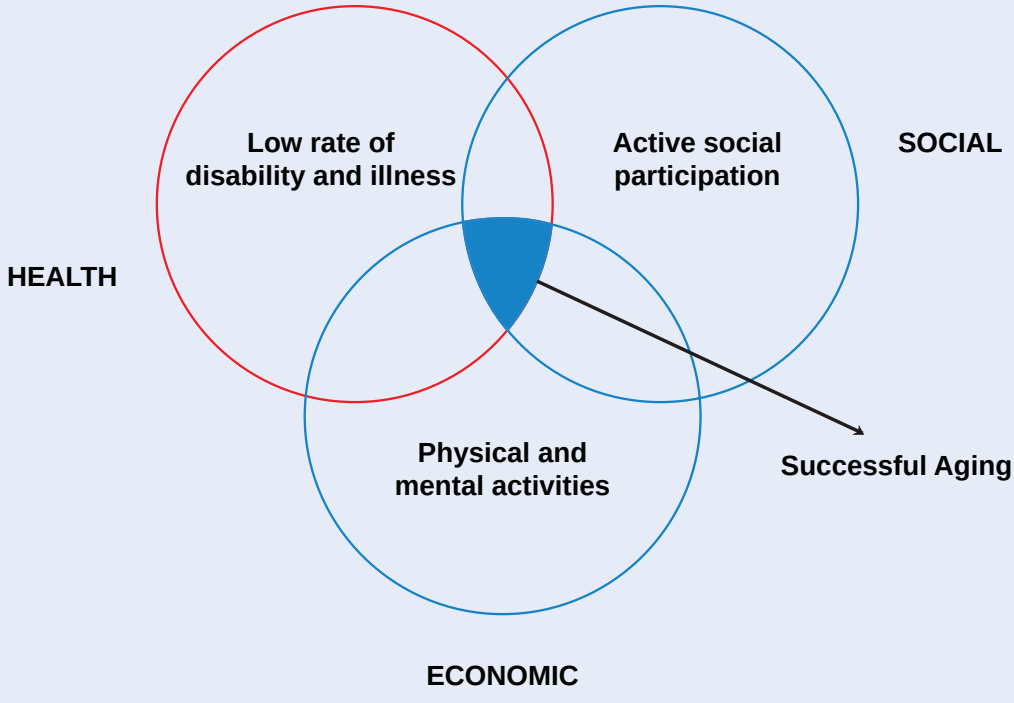
this document the rights and responsibilities of the society to the elderly, as well as the role of the elderly are clearly stated. After 10 years of implementing the Ordinance, at the sixth meeting of the National Assembly XII on 23 November 2009, the Law on Elderly was approved and enacted from 1 July 2010. The Law on the Elderly includes 31 Articles emphasizing the rights and responsibilities of the elderly, and of individuals and communities with regard to taking care of the elderly in detail.

In addition to the instructions by the government mentioned above a number of additional policies were created to guarantee a good quality socio-economic and health status of the elderly. For instance, Article 41 in the Law on Citizen Health Protection indicates that "Priority is to be given to the elderly with regard to health examinations and treatments, and given their health status, their contribution to society is to be facilitated. The Ministry of Health and General Office of Sports is to provide guidance for the elderly to have regular exercise, relaxation, and entertainment to cope with aging". The Law on Marriage and Family regulates that children must be respectful to and responsible for taking care of their parents; adult grandchildren must take care of their grandparents who do not have living children. The Labour Law sets working ages for the elderly. The Criminal Law also determines heavy punishments for maltreatment to parents; reduce punishment for elderly criminals but increase punishment for criminals to the elderly. The objective No. 9 in the draft of the Population and Reproductive Health Strategy 2011-2020 advises to "Improve the overall health status of the elderly; increase the percentage of district hospitals having healthcare services for the elderly to 20 percent by 2015 and 50 percent by 2020; increase the percentage of the elderly having access to community-based care to 20 percent by 2015 and 50 percent by 2020", while the draft of the Social Protection Strategy 2011-2020 emphasizes to improve social insurance, health insurance, and social allowances for the elderly to cope with the economic and health risks associated with their age.

Although the policies mentioned above have subsequently been revised or amended, they still do not take fully into account the current aggravating situation of the elderly and aging. Without more proper policies and strategies with a specific focus on the aging population, Viet Nam will face a growing number of both serious short-term and long-term challenges. Figure 7 summarizes the factors which Rowe and Kahn (1998) consider essential for reaching a state of "successful aging". According to their study, whether a country will be able to adapt effectively to an aging population depends on which policies and strategies for the elderly are in existence to ensure their active participation and have a positive impact on three spheres: health status (by lowering the rates of disability and illness); social life (by encouraging the elderly to actively participate in social activities); and economic life (by securing income and encouraging the elderly to continue putting to use both their physical and mental health through economic activity).

In Figure 7, if the shared part of these three spheres is filled (presented by the triangle), policies concerning the elderly are considered to be successful. If one of three spheres is separated from the others, "successful aging" cannot be reached. For example, policies aiming to result in a better economic life while the health status of the elderly is very bad, are not considered to be successful.

Figure 7. "Successful aging" model



Source: Rowe and Kahn (1998)

For Viet Nam, to reach "successful aging", three policy and programme areas are needed: (i) social protection (to reach income security); (ii) elderly care services (to reach a satisfactory physical and spiritual life); and (iii) institutions (to promote the role of the elderly in the family, community, and society as a whole). Following below are analyses of these policies and programmes.

1. SOCIAL PROTECTION POLICIES AND PROGRAMMES

The main objectives of social protection policies and programmes for the elderly are to mitigate economic and health risks, to secure living standards and to combat poverty. Three main pillars support the social protection policies, including social insurance, social health insurance, and social allowances.

1.1. SOCIAL INSURANCE (SI)

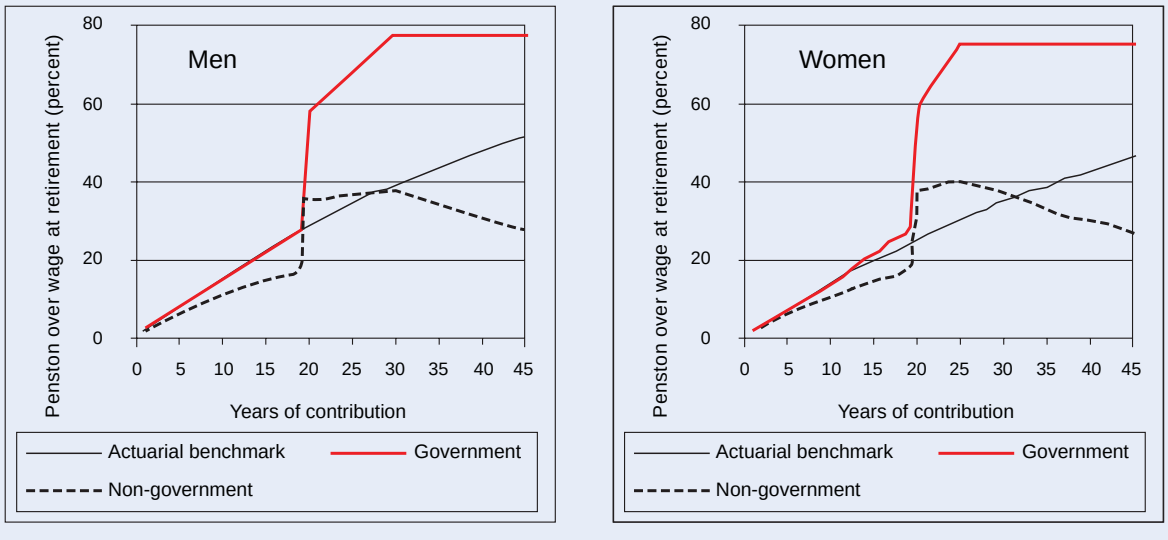
Since the 1960's, the government of Viet Nam has been implementing a social insurance system, in particular a pension scheme, to protect workers when they get older and retire. During more than 40 years of its operation, the pension scheme has been amended a number of times to adapt to recurrent socio-economic changes, the milestone of which was moving from a subsidized scheme to a contributory scheme. A number of legal documents addressing social insurance have been written, the highest level of which became the Social Insurance Law, which was approved by the National Assembly on 26 September 2006 and enacted since 1 January 2007. Along with the SI Law, a number of other relevant legal documents have also been approved to implement the SI Law, in order to guarantee the rights and responsibilities of SI participants, including Decree No. 68/2007/NĐ-CP dated 19 April 2007 to guide the SI Law implementation; Decree No. 184/2007/NĐ-

CP dated 17 December 2007 to adjust benefit levels for retirement and social allowances for retired communal staff; Decree No. 83/2008/NĐ-CP dated 31 July 2008 to adjust the wage/salary for SI contribution of the workers in the private sector. All of these policies aim to encourage workers to participate in the SI scheme, in order to guarantee their living standards.

Of the various social insurance schemes, the long-term retirement scheme has the most significant influence on the SI system in terms of finance. According to the current regulations, male and female workers can retire at age 60 and 55, respectively, after a certain period of contribution. The current contributory pension scheme in Viet Nam is a PAYG DB, and as such it is not financially balanced and causes generational inequity under the aging population. The following are some emerging policy issues:

1) According to the current regulations of the contributory pension scheme gender and economic sector are distinguished which automatically results in inequality of contributions and benefits for these groups of workers. The World Bank (2007) points out that public sector retirees will have significantly higher benefits than private sector workers, even when they have the same level and period of contribution (Figure 8). In detail, this research shows that it would be better for private sector female and male workers to stop their contribution in the 22nd and 28th year of their participation, in order to get the highest possible level of benefits, since if continuing, they will obtain lower benefits for each additional year of contribution. For the same reason, public and private sector retirees are currently subject to significant retirement benefit differences.

Figure 8. Unfair contributory pension scheme

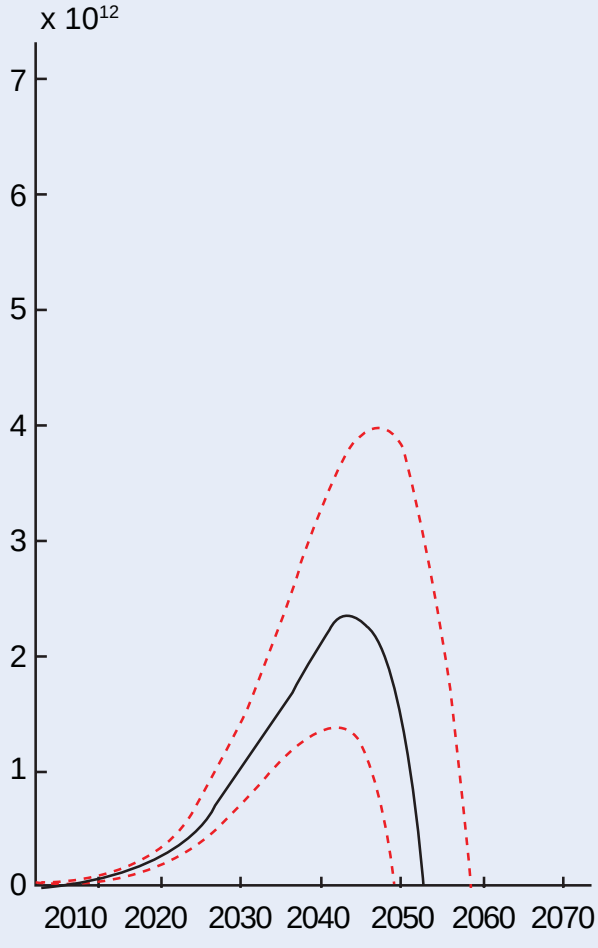


Source: World Bank (2007)

2) In terms of financing the contributory pension fund will face huge deficits while operated through the PAYG DB mechanism if no systematic policy options exist to deal with the aging population and low efficiency of current regulations. Recent studies (see, for instance, Nguyen Thi Tue Anh, 2006; Giang and Pfau, 2009c; Gian et al., 2010) shed light on the fact that with policies such as the one as outlined to increase contribution rates, expanding coverage will only be temporary and the problem of deficits will not be solved completely. For example, the status-quo projections by Giang and Pfau (2009c)

obtained through stochastic simulation techniques[7] with a 4-year gap and at a 90 percent confidence interval point out that the current contributory pension scheme in Viet Nam will be completely depleted by 2052 (Figure 9). More essentially, the current contributory pension scheme will also create a large amount of implicit pension debts, which in turn will have a negative impact on the government budget as well as create a heavier burden of contribution to future generations. The estimates by Giang (2008) and the VSS (2009) both find that, assuming other factors remain constant, the contribution rate must be increased from the current 20 percent to about 35 percent during the coming 20 years. This is a critical challenge in terms of operating the current pension scheme requiring transformations towards a system with financial sustainability and generational equity.

Figure 9. Stochastic projections for the contributory pension fund in Viet Nam



Note: The solid line shows median values of projections; the dotted lines show alternative values of projections with a 90-percent confidence interval
Source: Giang and Pfau (2009c)

7. Stochastic projection technique is a probabilistic approach to estimate median values of the indicators in projections and their alternative values with a confidence interval of, usually, 90 percent. This type of projection can provide more precise results than scenario-based projections, since the latter's results are always calculated with a 100-percent confidence interval, a difficult situation to occur given the uncertain nature of macroeconomic environments.

3) Given the increasing life expectancy of the elderly in Viet Nam, the slow adjustment to the now extended retirement years will make contributions and benefits unbalanced. Retirees may even expect to receive lower benefits or for a shorter period of time than expected. The VSS (2009) shows that for an amount accumulated after 30 years benefits will be paid of in 8-10 years, while the expected number of years to receive benefits is about 19 years. This is not only a challenge with regard to pension fund imbalance, but also to secure retirement income for the elderly.

4) Slow adjustment to and amendments of the voluntary pension scheme make it ineffective in terms of coverage and impact on welfare (MoLISA, 2010). In addition to its limited number of benefits, the voluntary pension scheme is just a "copy" of the compulsory pension scheme. For a developing country with a dominantly informal sector, a voluntary pension scheme is an important channel to increase coverage by the SI system. However, the current regulations of the voluntary pension scheme in Viet Nam seem to constrain such a role.

1.2. SOCIAL HEALTH INSURANCE (SHI)

The first legal document about SHI was Decree No. 299/HĐBT of the Ministers' Council (now the Government), dated 15 August 1992. This Decree was issued by the Social Health Insurance Charter, and was in due time replaced by Decree No. 58/1998/NĐ-CP to adapt to socio-economic changes over time. During the same time, an additional number of legal documents regarding care for the elderly were issued, including Decree 95/CP dated 27 August 1994, indicating that the category of elderly living alone would now be considered social transfer programme beneficiaries and therefore would be provided a free health insurance card which would ensure free treatments at public hospitals, or in some circumstances allow only partial payment for the treatment fees; The Ordinance on the Elderly dated 28 April 2000 stated that free healthcare would be provided to the elderly living alone and without any support or sources of income; Decree No. 30/2002/NĐ-CP dated 26 March 2002 regulated that any elderly aged 100 and above would be provided a health insurance card valued VND 50,000, or free health treatments on a "pay-as-you-go" basis; Decision No. 139/2002/QĐ-TTg dated 15 October 2002 by the Prime Minister about health treatments for the poor ruled that specifically the elderly poor had to be included as a target group. Similarly, as already indicated in Decree No. 07/2000/NĐ-CP Item 9, Article 3 of Decree No. 63/2005/NĐ-CP dated 16 May 2005 regulated that the elderly living alone in a poor household and without any support must be one of 14 vulnerable groups to participate in the mandatory SHI. The Health Insurance Law - legal document of the highest order - in which prioritized groups, including the elderly, are mentioned, was approved at the fourth meeting of the National Assembly XII, dated 14 November 2008.

There are, however, many unresolved issues resulting from the current regulations, one of which is the weak synchronization between legal documents causing a very limited access to healthcare services via SHI for some groups of elderly.

1) Policies regarding hospital fees are determining different payments for certain healthcare services such as operations or capital consumption allowances, which in turn has an impact on the rights of patients to use health insurance. Changes in the district hospitals due to Decree No. 172 are furthermore creating various difficulties for healthcare stations, given their limited resources (Dam et al., 2010).

2) Policies for SHI are slowly adjusted, so that the rights of SHI users become limited and high social costs are being incurred. For instance, certain types of diagnosis and early treatments, which can reduce social costs, are not included in the SHI service package.

At the same time, co-payments are putting burdens on the low-income groups of elderly. A study by Dam et al., (2010) even shows that SHI elderly users seem to be "discriminated" when accessing healthcare services because healthcare stations do not want to get in trouble with payments.

3) The implementation of healthcare services via SHI at the grassroot healthcare stations is extremely difficult due to their minimal investment in infrastructure, facilities and human resources. In particular, most of the existing grassroot healthcare stations at present do not have any staff with expertise regarding gerontology or skills pertaining to care for the elderly. There are also no separate spaces allocated to examine and treat the elderly. Travelling to hospitals where SHI cards are accepted is an equally big problem for the elderly in ill health. Moreover, the Healthcare Fund, which is an important financial resource organization, has not been utilized efficiently due to the low quality of healthcare services at the communal level, the limited knowledge regarding the health status and healthcare of local people, as well as to limited communication (Dam et al., 2007).

1.3. SOCIAL ALLOWANCES

In terms of ensuring minimum living standards Decree No. 67/2007/NĐ-CP (in short, Decree 67) dated 13 April 2007 and its amended version Decree 13/2010/NĐ-CP (in short, Decree 13) dated 27 February 2010 has been one of the most comprehensive regulations focusing intensively on the vulnerable and poor elderly. Even though recent studies (see, for example, ILSSA and UNFPA, 2007; Giang and Wesumperuma, 2011, forthcoming) show that social allowances have contributed significantly to reducing poverty of the elderly and to improving their access to social protection services, a number of limitations are still inherent in the design and implementation of such allowances:

1) Identification of elderly beneficiaries is subjective and thus both inclusion and exclusion errors are still large. For instance, for all social transfer programmes in Viet Nam, the poverty line set by the Ministry of Labour, Invalids and Social Affairs (MoLISA) is considered as benchmark for identifying beneficiaries and poor households, as well as for deciding how much the beneficiaries will receive. Households are considered poor households if their per capita income is lower than the poverty line. A recent study by the World Bank (2010), however, shows that MoLISA's poverty line is usually based on the availability of budget from the central and local governments rather than based on the income for basic living standards: MoLISA's poverty line has thus always been much lower than the poverty lines set by the World Bank. Although MoLISA's poverty line has been changed over time since its first announcement in 1993, only reflects demand for food, but not for non-food. This is mainly caused by the perception that poverty goes along with lack of foodstuff, so that foodstuff shortage becomes a synonym for poverty reduction. The poverty line is furthermore identified separately for urban and rural areas, but over time it is only slowly adjusted. Also, in some localities, exclusion errors for the elderly occur due to the fact that the poverty rate has been set in advance (Giang et al., 2011, forthcoming).

Similarly, regulations based on living arrangements to identify the poor elderly living alone and without any support are not proper, since living arrangements in Viet Nam are based on household residential registration. Additionally, some disabled elderly are not receiving any social allowances because they do not have a disability certificate, as it is difficult for them to go to hospitals or health centres to get such a certificate.

2) A number of programmes have been in existence which aim at the elderly as beneficiaries, but most of them are small,

overlapping, and have little impact on their living standards. For example, the monthly social allowance for a poor elderly person living alone without any support is only VND 180,000, while costs of living and health treatments are much higher.

3) The mode of delivery of the allowance (in-kind or cash) is sometimes not suitable for the elderly. Usually a cash transfer is made to all beneficiaries, but for disabled elderly living alone, an in-kind contribution for their daily life may be more useful and appropriate.

4) Even with the increasing number of beneficiaries, resources with regard to the design and implementation of policies about social allowances do not change significantly over time. Social policy staff therefore cannot update the information to precisely identify beneficiaries. In addition, compensation for social policy staff is also low and slowly adjusted, especially in regions with little socio-economic development, which in turn causes minimal incentives to work and improve working efficiency.

2. POLICIES FOR ELDERLY CARE SERVICES

Up to date, there are two types of elderly care services: services in social protection centres, and healthcare services based on free SHI cards. In order to encourage the private sector to provide such services, the government has issued various important policies, such as the Ordinance on the Disabled and Decree No. 55/1999/NĐ-CP dated 10 July 1999 regulating in detail the additional compensation for staff directly taking care of the elderly and the disabled in the public social protection centres; Decree No. 25/2001/NĐ-CP guiding the establishment and operation of social protection centres; and Decree No. 68/2008/NĐ-CP regulating conditions and procedures regarding the establishment, operation and closure of social protection centres.

In addition, a number of policies have been issued as well to call for participation of political, social, economic, and professional associations in taking care of the elderly and the disabled in the social protection centres. The Ordinance on the Elderly (later Law on the Elderly) and Decree No. 30/2002/NĐ-CP dated 26 March 2002, provide detailed regulations on actual caretaking of the elderly; Decree No. 07/2000/NĐ-CP dated 9 March 2000 discusses social relief programmes for vulnerable groups, including the elderly. In particular, Decree No. 67 (in 2007) and Decree No. 13 (in 2010) legal documents outlining instructions with regard to policies and programmes for elderly care.

However, as the living arrangements, health risks, and types of diseases of the elderly have changed substantially over time, the current policies and programmes obviously have limitations which need to be amended:

1) As already mentioned above, policies are slowly adjusted and not adaptive to the demands for elderly care, especially to those of the most vulnerable groups of elderly, such as the poor and disabled. For instance, benefits to be allocated as described in Decree 13 are too low in comparison with the current costs of living, and it is thus difficult for social protection centres to keep their costs of care for the elderly to a minimum.

2) The demand for elderly care is great, but elderly care services have not been developed to meet this demand. For example, as also already mentioned above, the number of gerontology departments and the number of beds allocated for health treatments of the elderly are too small given the current demand for elderly care. One of the key issues here is that the total public expenditure on health is still low (the total health expenditure in Vietnam was about 6 percent of GDP in 2008, or US$ 46 per capita), so that e.g. investments in and necessary facilities and maintenance are below standard. Overall, the infrastructure is not elderly-friendly.

3) Due to limited investment, human resources are also limited, which in turn has a negative impact on quality of care. A study by Pham and Do (2009) in Hanoi, Hue and Ba Ria-Vung Tau shows that most elderly people are not cared for at home, and that therefore there is a big shortage of staff with the appropriate knowledge and skills pertaining to care for the elderly. Another issue is that currently no policy documents exist to regulate the number and type of staff and medical doctors to run an elderly care centre (Dam et al., 2010).

4) The development of private elderly care centres is difficult, partly due to minimal consensus from society. Differences in elderly care between different socio-economic regions and between urban and rural areas, combined with limited resources are making this more difficult as well. Most important to note here is that no specific support is granted by the government for the development of private elderly care centres, besides such private care being mentioned as a possibility in a few legal documents (Nguyen Quoc Anh et al., 2007; Dam et al., 2010).

5) Self-care of the elderly should be considered a most important concept to understand, especially in within the context of the health risks associated with it as well as of illness and disease prevention. As such, consultation services are very much needed yet at present do not meet the demand and up to now there have been no policy directions to develop such services. Taking care of the elderly furthermore generates a need for human resources with good communication skills and knowledge in gerontology, but such requirements are not paid attention to within the current medical training system. More importantly, most of the elderly do not realize such services may exist: Dam et al., (2010) show that more than 60 percent of the elderly do not know about elderly care services, and do not know where they can receive such services. Communication activities should therefore become a critical part of policies and services in the future.

3. POLICIES ON INSTITUTIONS FOR THE ELDERLY

To encourage the active participation of the elderly in social activities as well as to protect their rights, Prime Minister issued Decision No. 523/TTg dated 24 September 1994 to establish the Vietnam Association of the Elderly (VAE). On 5 August 2004, Prime Minister issued Decision No. 141/2004/QĐ-TTg to establish the Vietnam National Committee on Aging (VNCA). Both these policies were important steps towards institutionalizing social associations to support the elderly and promote their active role in society. In 2002, Viet Nam also signed the Madrid International Plan on Aging (MIPA). In addition to the VAE and VNCA, other political, social, economic and professional associations at different levels are also engaged with policy design and advocacy for the elderly, including the Vietnam Fatherland Front, the Vietnam Women Union, the Vietnam Veterans Association, and the Vietnam Farmers Association. Their involvement has already encouraged and facilitated the active participation of many elderly in social activities. Currently, among 9 million elderly, 92.5 percent are members of the VAE and participating in various social activities. Studies by the VNCA (2007), Nguyen Quoc Anh et al., (2007) and Dam et al., (2010) show that these institutions are providing a variety of social activities for the elderly with the aim of encouraging them to stay connected to their families, communities, and the society as a whole. However, to play an even more important role, these institutions need to pay attention to the following issues:

1) Activities of the VAE, VNCA and other institutions are still limited. One of the most critical causes for such a situation is that these do not have their own funds, and most of the financial resources are coming from central and local government budgets.

2) These institutions have played only a minor role in advocating, and monitoring policies for the elderly. They also do not participate in policy design, and just provide comments on policies and programmes for the elderly that have been put together already. The advocacy of policy is not paid enough attention to, again partly due to limited human resources with expertise in aging and elderly.

IV. POLICY RECOMMENDATIONS

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The analyses mentioned above prove that the fast growing aging population in Viet Nam will create a variety of challenges with regard to ensure a good quality of life for the elderly, both in terms of physical and spiritual health as well as income. In other words, without a solid preparation for an expected aging population right now, Viet Nam will incur very high costs for care of the elderly population in the coming decades, as this will be the population group with highest rate of increase.

Keeping in mind the characteristics of care for the elderly in Viet Nam at present, the following policy responses are recommended in order to reach "successful aging":

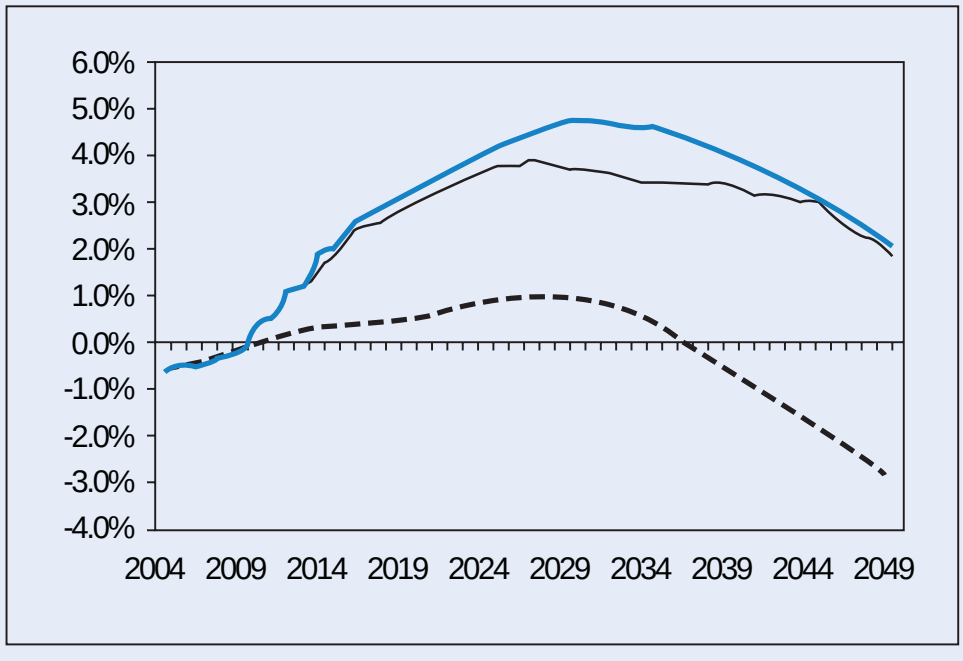
Recommendation 1: To improve the attitude and awareness of policy makers and the society as a whole regarding the challenges faced by the aging population and current living standards of the elderly.

In actuality, without a good attitude and thorough awareness of policy makers and all members of society regarding a policy issue, it will not be possible to change current conditions. If aging is not considered as an important socio-economic and health issue, no studies, policies and programmes to deal with aging will be generated. The current problems occurring in aged countries like Japan, Italy and Western Europe can provide valuable lessons for Viet Nam when preparing strategies, policies and programmes for an aging population, based on its current economic development level.

Recommendation 2: To promote economic growth and development along with social protection provision, in order to guarantee and improve the income of the elderly via their employment and retirement.

1) The status of "getting old before getting rich" hampers the mobilisation of resources to deal with an aging population. Given such a status, the promotion of economic growth and social development must be considered as the most important strategy. In this context, Viet Nam is having a unique opportunity, i.e., "demographic bonus" (UNFPA, 2010b). If taking advantage of the on-going "demographic bonus" Viet Nam will be able to have an aging population with high income in the future. Also, the most stable income source for the elderly will be the retirement benefits which they accumulated during their working lives. In consideration of the expected challenges mentioned above, the current contributory pension scheme should gradually be reformed from PAYG DB to a system of individual accounts with a notional defined-contribution (NDC) scheme as a transitional step because such a transformation will guarantee generational equity and the long-term pension fund balance along with the current development of financial markets in Viet Nam. Figure 10 clarifies that, in addition to having a better contribution-benefit balance, such a transformation will also make the pension fund more stable in the long term, especially if the pension fund investments are more efficient.

Figure 10. NDC versus PAYG DB



Note: The dotted line shows the financial balance of the PAYG DB scheme, while the other two lines show two cases of accumulating rate of returns of the NDC.
Source: Giang (2010b)

Types of insurance should also be diversified, in order to improve accessibility of different population groups, and to articulate voluntary insurance as well as link it to mandatory and other insurance schemes based on affordability of participants.

2) To encourage the elderly, especially those who have specialized skills, to continue participating in the labour force. In particular for the manufacturing industries where 'learning by doing' is the main mode of training, such training will be cost-saving.

3) Social allowances for the vulnerable elderly should be expanded towards a universal system. Simulation results by Giang and Pfau (2009a) and Giang (2011, forthcoming) suggest that cash transfer programmes with a special focus on rural and female elderly will be most influential with regard to poverty reduction. Benefit levels and modes of delivery need to be considered carefully, to guarantee proper living standards and health for the elderly. Inclusion and exclusion errors in identifying beneficiaries should be mitigated.

Recommendation 3: To strengthen healthcare services and specifically to establish and expand care services for the elderly with active participation from all sectors, in order to improve national capacity for such care:

1) Communication in health education and improvement of the awareness of and knowledge about healthy aging needs to be emphasized, in order to avoid illnesses and disabilities in later life. Management and control of chronic diseases as well as the application of new consultation techniques for the early and long-term treatment of chronic diseases need to be intensified, especially with regard to cardiac problems, high blood pressure, joint deterioration, diabetes, and cancer. An elderly-friendly living environment is very much needed. In addition, there should be a comprehensive national strategy for elderly care with quantifiable and gender-based targets, in order to reduce chronic diseases, disabilities and deaths before reaching old age.

2) The establishment and enhancement of health care and elderly care networks are important, especially of those related to chronic diseases. Such networks need to ensure and improve the accessibility care of the most vulnerable elderly groups, such as those living in rural areas, elderly females or ethnic minority elderly. In particular, it is necessary to help these vulnerable groups of elderly access healthcare services via the provision of free SHI.

3) Strong support from the government is needed for elderly care activities at public social assistance centres and private elderly shelters. Elderly care at the social assistance centres needs to be combined with community-based elderly care, and home care for the elderly should also be encouraged. In the long-term, when high quality human resources are available, Viet Nam will be able to provide elderly care services to other countries as well.

4) Priority needs to be given to investment in and development of the gerontology system nationwide. The unified network of elderly nursing centres needs to be gradually developed and managed based on the actual needs and conditions of each locality. Training courses in gerontology need to be formulated and conducted for nurses in line with the demand for human resources for the elderly care network and based on the actual local conditions in each period. Basic principles and approaches of elderly healthcare need to be incorporated into training programmes for medical students, nurses, and other medical staff. Training programmes for non-official caregivers need to be formulated and implemented. Information and training need to be provided for family members and non-official caregivers regarding appropriate care for the elderly. These policy actions should all be community-based.

Recommendation 4: To improve the roles of political, social and professional associations with regard to the design and advocacy of policies and programmes on aging and for the elderly:

These institutions, particularly the VAE and VNCA, need to work more closely together with other institutions, in order to promote coordination and cooperation between professional entities in proposing various types of living arrangements for the elderly whether at home with children and grandchildren, or in social shelters. Community-based activities are necessary for the elderly to stay up-to-date and actively contribute their opinions to policies and communities.

Recommendation 5: There is an urgent demand for the establishment of a nationally representative data profile for comprehensive studies on aging and the elderly population. Such data and studies will give important inputs for proposal and design of proper policies. Lack of coordination and cooperation between researchers and policy makers need to be mitigated, as they are one of the weakest issues when discussing aging and the elderly in Viet Nam. To date, the number of studies on aging and the elderly in Viet Nam conducted for the purpose of policy design and implementation is still limited. For instance, an assessment of Le Vu Anh et al., (2010) regarding 94 documents and 96 research works on elderly care reveals that the number of studies focusing on gender, violence and behaviors conducive to health risks, is rather negligible. This has been caused by a number of cursory studies about the elderly, in which they are considered as burdens rather than important contributors to their country and families through their social and economic activities.

Without a solid database on aging and the elderly, it is difficult to provide proper policy recommendations.

CONCLUDING REMARKS

Aging is a great social achievement of development at both a global and national level. Aging is not a burden, but it will create many serious socio-economic consequences if no efforts are made to design policies and strategies which take into account such a demographic trend. Since Vietnam will enter its aging phase at a high pace, and the preparation time for it is really short, Viet Nam does need realistic and appropriate policies and strategies. Such policies and strategies should be designed and implemented using various quantitative analyses regarding the relationship between "aging population" and economic growth. With realistic and appropriate policies put in place, a "second demographic dividend"[8] can clearly be realized. No policies can be more powerful than the attitude of each individual in "preparing for old-age from a young age onward". Preparing for ourselves is also preparing for families, communities, and future generations.

8. "First demographic dividend" is created by a "demographic bonus", while "second demographic dividend" is from taking advantage of resources provided by the elderly.

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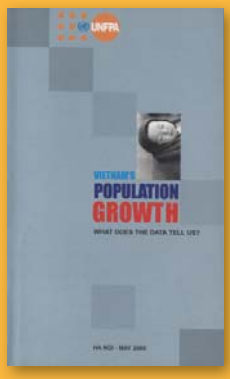

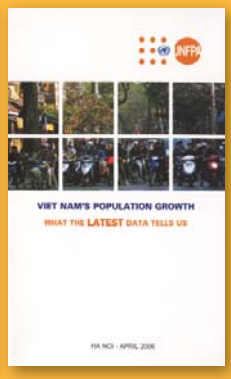

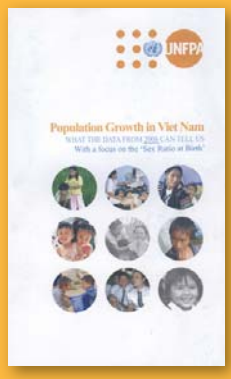

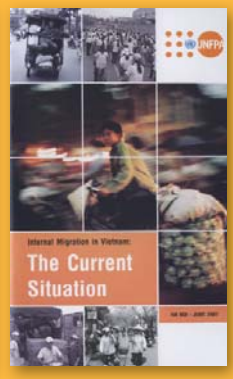

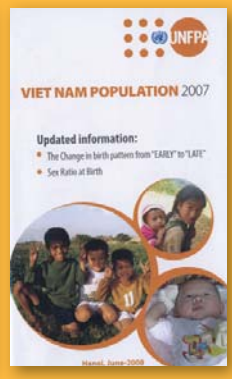

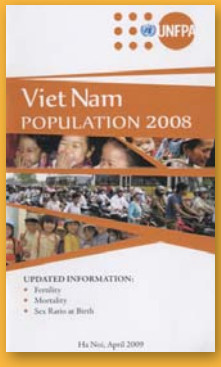

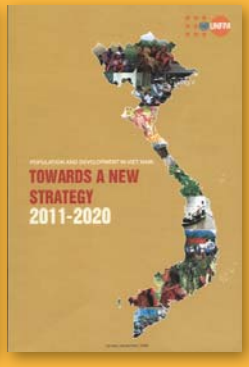

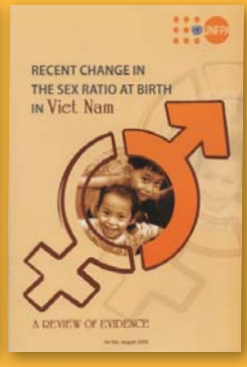

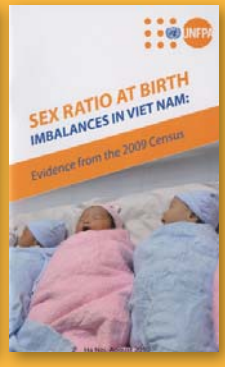

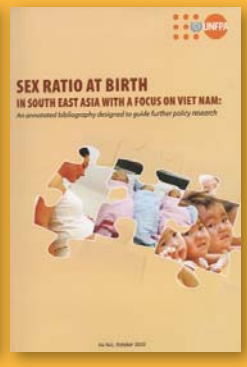

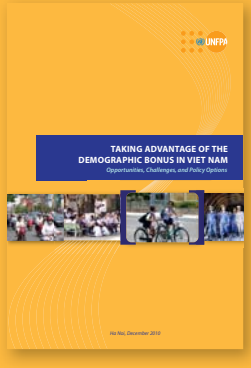

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