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Institutional and Cultural Perspectives in Elder Care in Rural Vietnam

Abstract: Traditional norms of filial piety in Asian societies, including Vietnam, emphasize care roles of children for their elderly parents. In particular, caregiving is often the responsibility of women, who are increasingly migrating and participating in the labour market, leading to an increasing withdrawal of family caregivers from caring for their parents. In collaboration with local mass organisations and stakeholders, Vietnam is enhancing institutional care and changing the balance of care towards home, community-based services and marketisation to provide alternative care options for its elderly population. The community is playing a key role in emotional support for the elderly. Taking into account the traditional Confucian-influenced family structure, the responsibility for elderly care is still a family matter. Using a dataset from a collaboration survey of 307 elderly people in 2017, the paper aims to examine and analyse roles, challenges and difficulties of family, community, private and public social services and policy in care provision to the elderly and the gaps in it, to understand the processes of the reconstruction of those formal and informal sectors in order to bear the increasing care responsibilities, and the ways they provide care to the elderly and the linkages with policies and institutional in Vietnam, using the care diamond model. The paper also raises issues of increasing left-behind elderly people in the rural areas and identifies various initiatives to sustain Asian cultural values, family relationships, and continuous development of care policies and potential implications in developing a better care mode for the elderly.

Keywords: elder care, Vietnam, care provision, care diamond, culture, institution.

1. Introduction

In 1954 Vietnam followed the Soviet model of centralised planning, state ownership of capital and means of production. In 1975, Vietnam was reunified and entered a new period of peace and reconstruction. During this period, it embarked on

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developing the reunified country and coped with a socioeconomic crisis caused by the long period of war (i.e. three-quarters of the 20th century), failed development policies (i.e. emphasis on heavy industry and neglect of agriculture and consumer goods; food production did not keep pace with the requirements of the rising population, and the crisis after the currency reform in 1984) and international isolation (i.e. until 1995). With the Renovation in 1986, the country underwent a rapid transition from a wholly centrally planned economy to a socialist-oriented market economy. The economy of Vietnam is transforming from a command, subsidised, bureaucratic centrally planned economy with a closed-door policy towards a market-oriented economy and an open-door policy. After more three decades, the economy has taken off strongly and in 2011 Vietnam achieved low middle-income status.

Vietnam is observing changes in demographics and family structure, such as increase in the population aged over 65, the extension of life expectancy, which is linked to an increase in the number of elderly in need of care, a fall in the fertility rate, dramatic change in family structure from co-residence of multiple generations to nuclear family residences, and now even to increasing single-member households (living alone) and delaying marriage, resulting in a shrinking supply of family caregivers. Elderly care has received increasing attention in recent years, both from a theoretical perspective and practical research, because of the increase in the elderly population and increasing social issues related to provision and typologies of elderly care. Vietnam has an ageing population. In 2018, Vietnam had 11.3 million people over 60 years old, accounting for 11.95% of total population. There were two million people over 80 and 7.2 million elderly women (MOLISA 2019). Older people in Vietnam are estimated to make up 18% of the population by 2030 and to reach 26% by 2050 (Vietnamese Ministry of Health 2018). The government is planning to enhance institutional care in each community in collaboration with local mass organisations and stakeholders, and to seek lessons from other societies. Also taking into account the traditional Confucian-influenced family structure, the responsibility for elderly care is still a family matter. However, given the increasing number of elderly people, the changes in family structure and gender equality, how are families negotiating with other sectors such as the state, the community and the market in caring for their elderly parents?

2. The state, market, family and community in elderly care

G. Espring-Andesen (1990) distinguishes "*three radically different principles of risk management*": *state*, *market* and *families*. Moreover, welfare states can be differentiated according to the way they make risks socially manageable and how

the relations between the principles underpinning these risks are institutionally defined. Social risks are therefore essential and core elements of welfare regimes, and they can "*be internalised in the family, allocated to the market, or absorbed by the welfare state*". And "*where the state absorbs risks, the satisfaction of need is both 'de-familialised' (taken out of the family) and 'decommodified' (taken out of the market)*" (Esping-Andersen 1997). "Defamilialisation" is now an equal partner of the category of "de-commodification" within the analysis. These two categories are in turn closely influenced by the participation of women in the labour market as well as by work allocation within the family.

The relationship between family networks and service systems is significant in retaining autonomy in old age. The way different welfare states support the family is particularly important. Previous research has shown that elder care is a shared responsibility between the public and private spheres. But the balance differs between countries, depending upon three factors: family norms and preferences for care; family culture, which guides the level of readiness to use public services; and the availability, accessibility, quality and cost of services. In the Asian context, social norms of filial piety add another dimension to the intergenerational care diamond for the elderly.

Vern L. Bengtson and Robert E.L. Roberts have developed a conceptual framework for studying intergenerational relations called the "Intergenerational Solidarity Model" (Bengtson, Roberts 1991). The model conceptualises intergenerational family solidarity as a multi-dimensional phenomenon with six components reflecting exchange relations: *structural* solidarity, *associational* solidarity, *affectua*l solidarity, *consensual* solidarity, *functional* solidarity and *normative* solidarity. These six dimensions can be further reduced to three. These are the *structural and associational* elements of solidarity, giving opportunities for interaction; *affectual* solidarity, which is the closeness and warmth felt between individuals; and *functional* solidarity, which includes a range of helping behaviours. Intergenerational solidarity can exhibit *both* high levels of solidarity and conflict, and low levels of solidarity and conflict. The combination depends on family dynamics and circumstances (Bengtson et al. 2000).

Research has shown that in most societies, family care is substantial. Although the family still undertakes a wide range of care tasks, some responsibility for elder care is now entrusted to the welfare state and market. Social care has come to mean both formal and informal care networks existing side by side (Daatland 1997). One of the basic policy debates in this area is whether formal services *substitute* or *complement* informal family care. Social policies for older people in most countries tend to treat families and service systems as alternatives that substitute each other (Lowenstein, Katz 2003). Many functions of the traditional family have been taken

over by social institutions. Some researchers believe this decline of the traditional family to be an unavoidable outcome of modernisation and the modern economy. Another factor influencing this debate is that the ability of women (the traditional caregivers) to provide care for older family members has been undermined by their increasing participation in the labour market. Changes in family structure, particularly high rates of divorce and single parenthood, are further dimensions of the perceived decline of the family.

Many studies of caregiving use the terms "informal care" to refer to the care provided by families and "formal care" to refer to that provided by trained health and social service staff. Informal care includes three tasks: (i) personal care, such as dressing, bathing or showering, eating; (ii) help with practical household tasks, such as gardening, transport, shopping, household chores; and (iii) help with paperwork, such as filling out forms and settling financial or legal matters. Informal care also includes emotional care such as talking to elderly parents, listening to their concerns etc. State-provided (formal) home care includes three tasks: (i) professional or paid nursing or personal care, (ii) professional or paid home help, and (iii) meals-on-wheels (Kalwij, Pasini, Wu 2009). Elin Palm (2013) reported that although professional care is suitable for elderly people requiring advanced care, cost-effectiveness is often an impeding factor. Informal caregiving, which is thought to be more cost-effective than formal care, can only be a viable alternative if the home caregivers can provide it.

The terms "community care" and family care are related to the term "ageing-in-place", which has been defined as "remaining living at home in the community, with some level of independence" (Davey et al. 2004). The literature on ageing-in-place is often about how the home can be made more functional and less risky for the older adult by providing various home aids for various aspects of daily life (Cutchin 2003) and maintaining independence and privacy. This suggests that older people's homes are increasingly becoming spaces of consumption of short- and long-term care provided by formal and informal professionals and lay caregivers. However, the term place relates not only to older people's homes but also to their community through family members, friends, neighbours, religious congregations or service agencies (Iecovich 2014).

In age-friendly communities, older people are not only consumers of services but are also a social capital that contributes to the well-being of the whole community. The idealised vision of ageing-in-place presumes that staying at home in old age is in all ways the best and ultimate option. However, recognising that ageing in their homes is not a feasible option for some older people, Stephen M. Golant (2011) presents a much broader view on the meaning of ageing-in-place to also include retirement communities or assisted living, where older people can

feel competent and have mastery of their environment despite their functional disabilities. Thus the concept of ageing-in-place also includes transitions between levels of care within multilevel institutional settings, such as relocation from assisted living to nursing care (Iecovich 2014).

The concept of "community care" in Vietnam focuses more on the participation of the community in elderly care. The care providers are usually neighbours and family friends. Elderly care is mainly the responsibility of their family; however, the community-based care model has recently been adopted by almost all the provinces. The activities include communication, medical treatment for the elderly, encouraging nourishing movements, elderly clubs, interventions, consultancy for reduced alcohol and tobacco consumption etc.

3. Role of norms, obligations and social identities in the Asian context

The traditional family support for the elderly is traditional filial duty: it is the moral obligation in Confucianism for the adult children to care for their elderly parents. Filial piety comes with a strong feeling of obligation to care for older adults (Laidlaw et al. 2010). According to Tsai, Chen and Tsai (2008), filial piety is the root of all morals and social values in Asian society and has played a part in influencing the care between children and parents. Filial piety focuses on the belief that care for older adults is the responsibility of the adult children in the family, therefore making elder care a family not a governmental issue (Nguyen Huu Minh et al. 2019).

It is believed that because the state lacks adequate welfare and public services, the responsibility of care for elders rests with their adult children, daughters in particular (Trinh Duy Luan, Tran Thi Minh Thi 2017). However, modernisation has forced a reconstruction of the traditional views of filial piety, with the significance of the family support model being challenged and undermined to some extent. The younger generation is more likely to move to and live in cities, leaving their parents behind. As a result, the family support model is substantially challenged. The family support model exposes not merely the intergenerational relation of supporting the old (Chow 2006; Shang, Wu 2011). Along with having fewer children, women are more likely to work outside the home and earn their own incomes. Working women also are less likely to be able to provide care for an elderly parent. Because women have been the primary caregivers, this trend could imply a shift to a more equal division of caregiving between sons and daughters or to the use of more paid care.

The meaning of filial piety is changing as well. Rather than the absolute obedience to and sacrifice for parents, it focuses more on other factors, such as reciprocal exchange. Compared with the social pension fund to support the old, the family support model has its unique advantages and suits the basic realities (Shi

2013). Hence the importance of filial piety and the family support model should be emphasised.

4. Data and methods

The paper used a dataset of the survey of 307 elders in 2017[1] in rural communes in Ha Tinh and Quang Ngai provinces and in-depth interviews with a group of caregivers, representing the state, family, community, social organisations and the elderly themselves to learn the experiences and expectations of elder care in local contexts.

In addition to fundamental analysis, logistic regression analysis was also used to clarify factors affecting how often children support their elders by elder demographic characteristics, the roles of family, involvement in community activities and the role of the state (source variable income from salary, allowance, health insurance) and the role of the community (variables with participation in associations and clubs).

5. Care provision for elders in institutional settings

The state provides care for the elderly via institutional settings of care policies and services, including social insurance, social health insurance (priority when seeking healthcare at health facilities, providing a health insurance card, healthcare clubs for elderly) and social allowances (ensuring a minimum material living for vulnerable groups, such as monthly allowance and housing support), spiritual care, such as a longevity ceremony, longevity celebration, funding funeral costs, peer support groups and social services such as privileges for seniors on public transport, visiting cultural or historic relics. In general, there are two groups of policy: non-conditional care policies for all elders, such as fee reduction, and conditional care policies for over 80s, such as a free health insurance card and a monthly allowance.

5.1. Social insurance

Social insurance is mostly for formal-sector workers, and is less favourable for those in the informal sector. Meanwhile a voluntary contributory pension scheme has been set up, but its coverage is also limited. Furthermore, most participants in this scheme are members of the former social insurance scheme for farmers.

[1] Dataset of the project: "*Strengthening Social Engagement in Elderly Care in Changing Economic and Family Structure in Asia: Policy and Practical Dialogues between Local Communities in Vietnam and Japan*", implemented by Institute for Family and Gender Studies (IFGS) (2017), funded by Toyota Foundation.

Inequality in access and benefits is also apparent, since people in regions with a higher socioeconomic status usually have higher benefit levels than those in regions with a lower socio-economic status (Giang 2010). In 2018, about 3,1 million were receiving pension and social insurance (Vietnam Social Insurance 2018), about 27.4% of the total elderly population.

5.2. Healthcare

The government set up the public care centre organised via geriatric departments of hospitals of the health sector and care centre of the social affairs department. In addition, the Ministry of Labour, Invalids and Social Affairs (MOLISA) established a Social Support Centre and Elder Centres both for children and the elderly of a special curriculum and target group of social policies. In 2018, there were 418 social support centres and 182 of which provide services to the elderly (MOLISA 2019). In addition, there are rehabilitation centres and health care for the elderly. These are run under government subsidy, but normally with insufficient facilities and funding.

In the universal social security system, health insurance is a very important policy tool to help people access health services when needed, ensuring equity in healthcare. At the same time, health insurance can also protect people from the financial risks related to large medical expenses affecting households' economic status. For elders, the role of health insurance is more important because of the frequency of illness, especially dangerous diseases, increases and and becomes more costly with age. Two categories of elders are provided free health insurance. This is the result of reduced salaries during working life. The role of state is to establish a social insurance system, including health insurance for employees – in this case, retired people are entitled to the corresponding services. The second group includes elders receiving social support policies and the vulnerable group over 80 years old without any kind of allowance, the poor, the disabled, etc.

In Vietnam, health insurance coverage increased quickly from 65% of population in 2011 to 87.2% in 2018[2]. The data in Figure 1 show that 90.2% of the elderly had some form of health insurance, which is higher than the national rate. The highest proportion of people with health insurance was among those with the highest standard of living. The higher the level of education, the higher the health insurance coverage. It can therefore be said that living standards have a great influence on health insurance coverage of the elderly. A similar tendency is evident for main income. The elderly who have a pension and allowances have

[2] Annual Review Report of the Health Sector 2018, Ministry of Health 2019.

higher proportion of health insurance coverage, showing its important role in health protection and gaps in the provision of universal health insurance for all elderly and social support for the elderly who have not retired. Involvement of the private sector and market in care for the elderly are limited in Vietnam and there is no specific support for the development of the market and private sector in care. People with higher levels of health insurance are more likely to have more modern characteristics and a higher standard of living. Of those who do not have health insurance, the main reason is their limited economic ability. There is a higher proportion of health insurance coverage among those who are married, and among elderly people with fewer children.

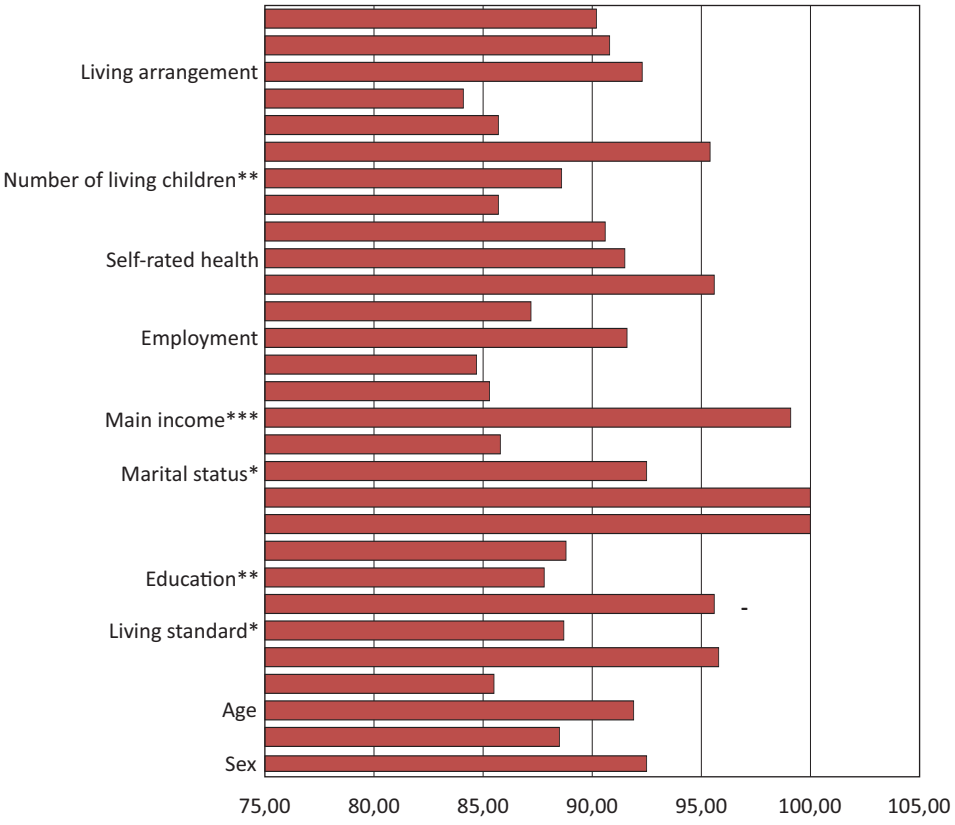

Figure 1. Proportion of the elderly with health insurance (in %)

* Significant at p < 0.01 level.
** Significant at p < 0.05 level.
*** Significant at p < 0.001 level.

Source: IFGS, 2017.

5.3.Social allowances

The first of these, at 22.1%, is support for elderly people who contributed to the national independence wars, including those who are parents of martyrs, invalids, veterans etc. Over time, their numbers will decrease and the age of the beneficiaries will increase. Second is social allowance for the disadvantaged elderly who are lonely, disabled, poor and over 80 years old without other support. Decree No. 06/2011/NĐ-CP regulated the varying amount of financial support for the elderly (180,000 VND/month for the poor elderly aged 60–80; 270,000 VND/month for the poor elderly over 80; 180,000 VND/month for all elderly aged over 80; 360,000 VND/month for the elderly in social welfare institutions). With the current living standards in Vietnam, this social support is low and ineffective, because cost of living and health treatment are much higher, which make this social allowance more a symbol of care than care itself. It should be noted that the retirement age in Vietnam is from 60, but the elderly have to wait until they are 80 to receive the full allowance, unless they are certified as poor or disabled. In other words, many elderly people in the informal sector who have no pension may not receive a social allowance until they pass the age of 80. About 2.8 million elderly, 24.7% of total elderly population, receive monthly social allowances (MOLISA 2019). Hence both social allowances and pension can cover about a half of elderly people with some type of monthly support. The remaining 50% rely on family and self support.

6. Care provision to the elderly from cultural perspectives

6.1. Living arrangements

With limited institutional care for the elderly, care provision in Vietnam often relies on family and the community. Asian societies are known for strong family bonds and filial piety is highly valued in Confucian culture. Traditional norms in Asian societies of filial piety, including Vietnam, emphasise the care roles of children towards their elderly parents. Care provision from the family can be seen in living arrangements and the types of support the family provide for its elderly parents.

However, the proportion of older people living alone has increased. Over two decades, the proportion of the elderly living with children is decreasing while the proportions of those living alone or with spouse or "skip-generation" elderly households are gradually increasing (Table 1). Those living alone are more likely to need outside assistance in the case of illness or disability, and they must turn to people outside their household for the fulfilment of their social and emotional

needs. Nevertheless, living alone should not be equated with loneliness. The literature shows that when poor ill health or other hardships arise, elderly people can be helpless and prone to depression; nevertheless they seem to be in good health and actively engaged in society just recently. In addition, older women who live alone, especially the oldest, are at high risk of poverty. As with other developing countries, most of the elderly still live in rural areas.

Rural-urban migration is one of the main causes for this skewed distribution of the elderly population, as well as the increasing number of "skip-generation" households where grandparents live only with their grandchildren. Family members have traditionally been the main caregivers, responsible for providing instrumental care as well as affective and emotional support to older relatives (Tran Thi Minh Thi, Trinh Thai Quang, Nguyen Minh Sa 2014). Family caregivers in Confucian culture are usually women (daughters or wives) who receive little outside help and perform most of the caregiving tasks themselves. However, women are increasingly migrating and participating in the labour market. Consequently, there is an increasing reduction of family caregivers caring for their parents, especially in the rural villages near big cities and industrial zones. The change in family structures and labour distribution has led to increasing number of left-behind elderly people in the rural villages. This faces them with a double burden. They have to manage and restructure their lives, care for themselves if living alone and/or help migrating couples in caring for grandchildren. Care work includes daily activities, domestic work, care and educational work in the families and social services, which pose great challenges for the left-behind elderly. These are more serious for the left-behind elderly in rural villages with poor public social services.

Table 1. Living arrangements of the elderly in Vietnam

Year	1992/93	1997/98	2002	2004	2006	2008	2015	2017
Living with children	79.73	74.48	74.27	70.65	63.74	62.61	47.9	24.8
Living alone	3.47	4.93	5.29	5.62	5.91	6.14	10.8	20.5
Living as a couple	9.48	12.73	12.48	14.41	20.88	21.47	37.7	50.4
Living with grandchildren	0.68	0.74	0.82	1.09	1.16	1.41	2.3	3.6
Other	6.64	7.12	7.14	8.23	8.31	8.37	2.3	0.7
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.0

Source: GSO 1993, 2008; Trinh Duy Luan, Tran Thi Minh Thi 2017; IFGS 2017.

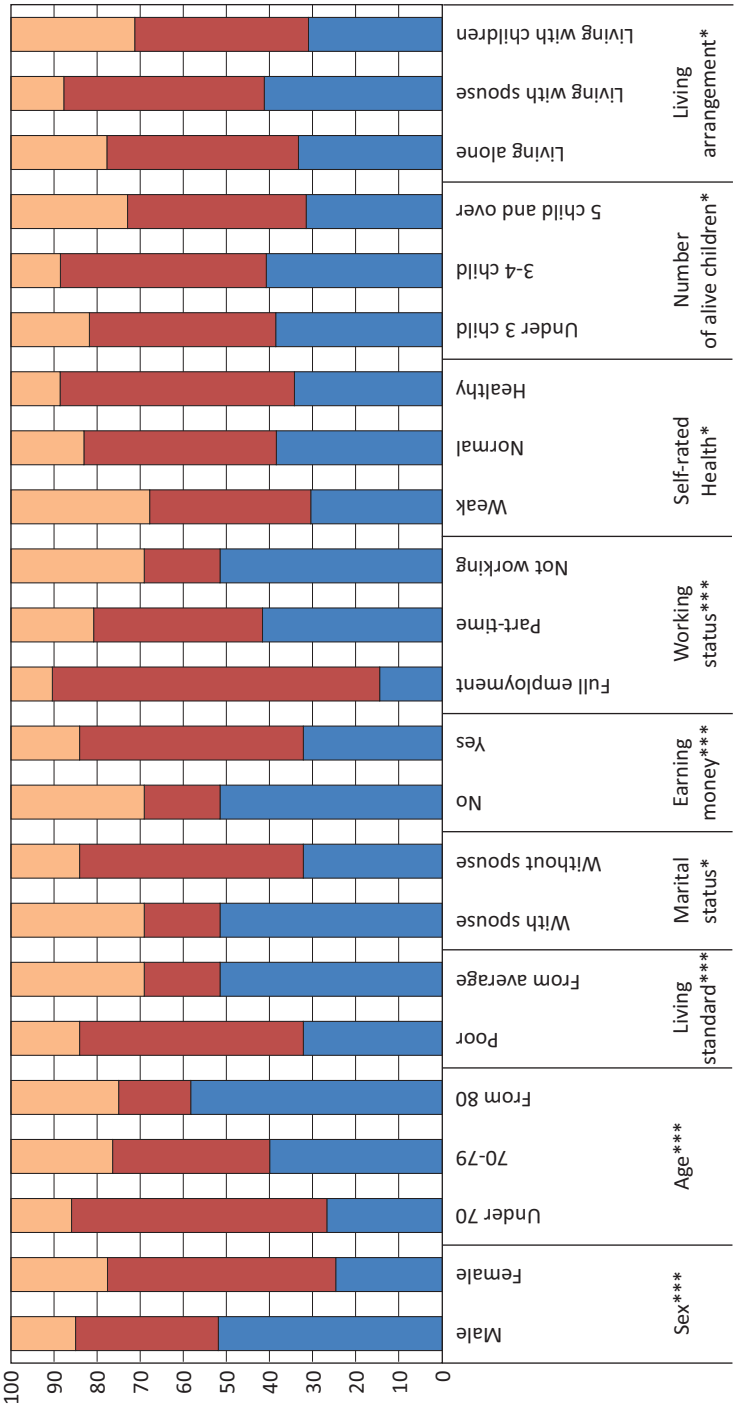

Figure 2. Main source of income of elder by residence, sex, living standard and education (in %)

* Significant at p < 0.01 level.
** Significant at p < 0.05 level.
*** Significant at p < 0.001 level.

Source: IFGS 2017.

6.2. Sources of income

The data shows that the female elderly mostly live on their own by working for pay, while the male elderly have their main source of income from state via pensions and allowances. This confirms the current nature of the labour market in Vietnam, with more women working in the informal or self-employed sectors yet not receiving in any social insurance. Those aged under 70 often live by themselves by working, but the proportion decreases with age. Conversely, the older the elderly person, the higher is the proportion living with their children's support. Children's roles are more important in providing support for children with lower educational attainment – which means there is no employment in the formal sector when young and consequently no old-age pension. Thus the elderly in low socio strata are more likely to depend on children's support as they grow older. People who are divorced, widowed or have never married mostly live from their own work. The majority of the elderly poor often have to work, while the better off have institutional support such as a pension and allowance as repayments for their contributions to social insurance when they were in work, and this group have higher educational attainment. A higher proportion of the elderly who do not work also have pensions and allowances as their main income, relieving them of the need to work much. Healthy older people are more likely to work while the weak rely on their children. Higher proportions of older people who live alone or with children receive support from their children. In short, elderly people with vulnerable characteristics such as becoming older, living alone, in poor health, not working and not having a spouse are more likely rely on their children's support as a source of income (Figure 2).

6.3. Types of family care

The care dimension from children to the old parents can be financial support, care support and listening to problems. The level of child support for parents and vice versa is measured on four levels: often, sometimes, rarely and never.

The data in Figure 3 show relatively close intergenerational ties between parents and children in general. In particular, financial support from the children is the most common form of care provision to elderly parents. More than 50% of the elderly receiving emotional support from their children and 23.5% receiving daily care work. This finding shows a current change in the concept and meaning of filial piety. Traditionally, children are expected to show their filial piety by direct care daily for their parents. Due to migration and high participation in the labour market, filial piety can be performed via material care such as financial support and indirect care via emotional support such as talking to and listening to each other

by the phone and mass media. These figures show the important role of the family in elderly care in Vietnam.

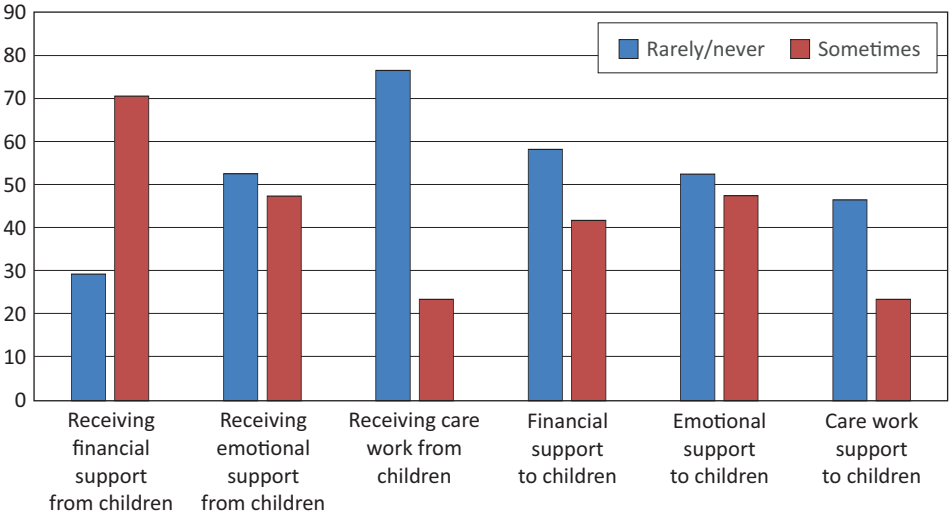

Figure 3. Types of support between elders and children

Source: IFGS 2017.

The data in the logistic regression in Table 2 show predictors of receiving care support from children of the elder. Regarding the possibility of receiving financial support from children, the number of children including sons and daughters, age, having health insurance and sources of income are statistically significant predictors. Elders with more children report higher possibility of receiving various kinds of support from them, which reconfirm the roles of the family in elder care and the value of children as a security net for elderly parents as social norms in Vietnam.

The older the parents, the more often they get financial support from children because with increasing age they may need more healthcare expenses and cannot work for a living. Elders with health insurance receive more financial support from children compared to those without. Given that health insurance coverage is high, elders without health insurance may be from poor circumstances and hence have no financial support from their children. Sources of income are statistically significant predictors of financial support from children. Elders who have institutional support (i.e. pensions and allowances) are more likely to be receiving financial support from children than those still working. It seems likely that if elders still have to work it also means they do not have a good security net.

Living arrangements and working status of the elders are significant predictors of the level of emotional support from the children (Model 2). This is highest among elders who live with children compared to other living arrangements. The number of children is also positively related to emotional support to parents. This finding shows the close intergenerational solidarity between children and parents in Vietnamese culture and the high value placed on filial piety. This finding also reconfirms the important role of family in care provision for elderly parents. Elders receiving daily care support from their children are those who live with them (Model 3).

Table 2. Logistic of typologies of children support to children

	Model 1: Receiving financial support from children (B)	**Model 2: Receiving emotional support from children (B)**	**Model 3: Daily care support for parent (B)**
Intercept			
Cox&Snell R square	.179	.90	.175
N	302	302	302
Sex			
Male (ref)			
Female	-.094	-.219	-.053
Living arrangements			
Living alone (ref)			
Living with spouse	.345	.612	-2.018***
Living with children	.662	1.101***	1.955***
Marital status			
With a spouse (ref)			
Without a spouse	-.166	-.293	
Number of sons	.335**	.062*	-.042
Number of daughters	.190*	.079*	-.053
Age			
< 70 (ref)			
70–79	1.268*	-.253	-.088
> = 80	1.141*	-.469	-.195
Health status			-.132
Weak (ref)			

Table 2 – continued

	Model 1: Receiving financial support from children (B)	Model 2: Receiving emotional support from children (B)	Model 3: Daily care support for parent (B)
Normal	-.111	.335	.659
Good health	-.043	.256	.768
With health insurance	1.013*	-.366	1.531
Working status			
Full-time (ref)			
Part-time	.020	-.364	.068
Not working	-.345	.429	-.101
Main income			
Pension and allowances (ref)			
Work for payment	-3.547***	-.555	.655
Children's support	3.445***	-.426	.629
Participation in at least two social organisations	.001	-.120	.648*
Education			
Below primary (ref)			
Secondary	.536	.276	-.743
High school	.248	.537	-.282
From college	-.638	.825	-.177

Note: statistically significant *** p < 0.001 ** p < 0.05 * p < 0.01; ref – reference variable

Source: IFGS 2017.

6.4. Social participation

Social participation adds another, cultural dimension to mental care for the elderly in Vietnam, especially in rural areas. There are several types of social participation, including participation in an old people's association, mass social organisations such as the Veterans' Association, Women's Union, Farmer's Union, and voluntary clubs. Involvement in an old people's association is most common with almost all elders being members. Active social participation can be seen from the proportion of elders who join at least two social organisations/clubs. Living standards strongly influences social participation by the elderly. Those from higher social strata, who will have pensions and allowances, are more actively involved

in community activities, while elders who still have to work are the least involved. In-depth interviews showed that elders with pensions often have a better standard of living and do not have to work much, especially for a living. Thus they have more time to participate in community activities for spiritual well-being. Marital status is also an influence. Elders living with a spouse are more active. Personal factors such as good health and lower age also correlate with more active involvement in community activities.

Younger elders participate in various community activities more actively than older ones. An interesting gender difference is that women are less active than men as members of formal social organisations such as the Communist Party and are more involved in their own organisations such as the Women's Union and especially participating in voluntary social and cultural clubs.

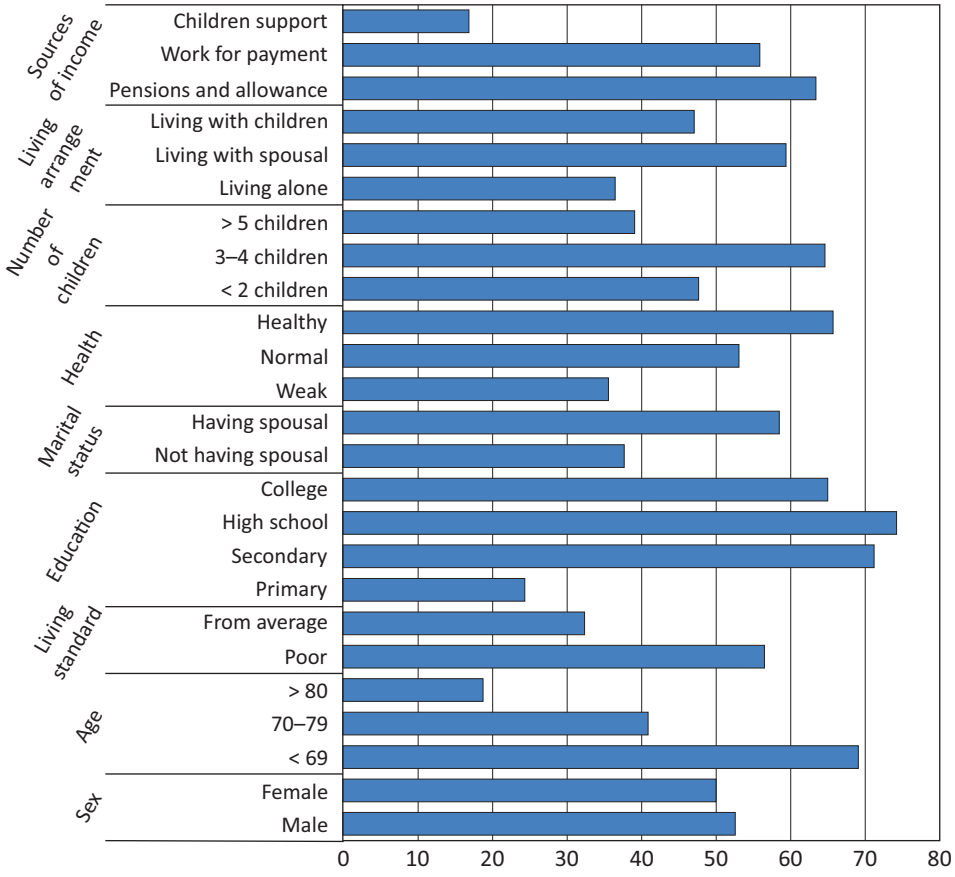

Figure 2. Elderly care in community via involvement of elders in social organisations

Source: IFGS 2017.

7. Concluding remarks

Rapid economic and income growth, urbanisation, and globalisation are leading to a dramatic shift in Vietnam. Rural-urban migration and other demographic and social changes such as more women in the labour force, higher divorce rates, decreasing birth rates, and changing family structures, are leading to increasing numbers of left-behind elderly and increasing numbers of elderly needing care support. The percentage of the elderly living with their children has diminished, while the percentages of those living alone or with spouses or "skip-generation" elderly households have increased. On the one hand, migration can bring economic benefits from remittances and knowledge, which can improve the original family development. In other words, migration contributes to a higher "equality" of income and living standards of the whole family of migrants. On the other hand, there seems to be an emerging "inequality" for the left-behind and elders in terms of acculturation, re-establishing kin networks, care and psychological well-being with increasing care responsibilities to themselves and grandchildren and limited support from a community network. Families maintain an important role in elderly care but their roles and norms have changed and there seems to be confusion and tension of roles and supports between family members. This also means that a considerable proportion of old people have no choice but to depend on their descendants when they cannot care for themselves any longer, or cannot afford the cost of healthcare and medical services. Tight clan relationships mean that the community plays an important role in elderly care due to traditional values and Vietnamese norms, providing them with alternative social integration activities, which is significant for mental health. The community network for the rural elderly is believed to be stronger than its urban counterpart. Communication activities should become a critical part of policies and services in the future (not only change, negative impact, but plus adaptation/ integration to a modernising, market society). In addition, with socioeconomic changes during the Renovation and international integration, elders themselves are adapting to modernisation by participating in the labour market and involving themselves in various community activities. They also have to manage and restructure their lives in order to care for themselves if they live alone and/or helping migrating couples with care for their grandchildren etc.

When state welfare was gradually replacing the traditional form, it was also a time when the state was facing rapidly increasing pressure from the proportion of elderly people in the population structure. This led many states to tend to return to strengthening traditional welfare, relying on this to care for their ageing population. The elderly care policy of the Vietnamese government has also followed

this trend. However, this direction does not promise future success, when the decline of the traditional welfare model, which is only suitable for a purely agricultural society, is an irresistible trend in modern society.

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Instytucjonalne i kulturowe aspekty opieki nad starszymi mieszkańcami obszarów wiejskich w Wietnamie

Streszczenie: Tradycyjne normy nakazujące dzieciom opiekowanie się starymi rodzicami w społeczeństwach azjatyckich, w tym w Wietnamie, wskazują dzieci jako osoby odpowiedzialne za troskę o rodziców po osiągnięciu przez nich sędziwego wieku. Należy podkreślić, że odpowiedzialność ta często spada na kobiety, które obecnie coraz częściej emigrują z obszarów wiejskich i podejmują pracę zarobkową, co sprawia, że coraz wycofują się z roli opiekunów swoich rodziców. We współpracy z organizacjami społecznymi oraz instytucjami zajmującymi się tym problemem, władze Wietnamu rozwijają system opieki nad seniorami w ich miejscu zamieszkania oraz dbają o rozwój komercyjnego rynku takich usług, jednak to wspólnota lokalna cały czas odgrywa kluczową rolę, jeśli chodzi o wsparcie emocjonalne seniorów. Mając na względzie tradycyjną strukturę rodziny, opartą na filozofii konfucjańskiej, odpowiedzialność za opiekę nad starszymi jest nadal obowiązkiem rodziny. Wykorzystując dane z badania 307 seniorów w 2017 r., autor artykułu analizuje rolę rodziny w opiece nad seniorami, stojące przed nią wyzwania i trudności, oraz rolę instytucji lokalnych, państwowych i prywatnych placówek oferujących opiekę dla seniorów, a także politykę w tym zakresie i istniejące luki systemowe, metody i sposoby opieki, powiązania polityki z instytucjami oraz konieczność harmonijnej współpracy wielu instytucji i podmiotów w celu kompleksowego zaspokojenia potrzeb osób starszych (ang. *care diamond*). Autor zwraca także uwagę na problem coraz częstszego pozostawiania seniorów na obszarach wiejskich i wskazuje różne próby podtrzymania azjatyckich wartości kulturowych, powiązań rodzinnych, jak również podkreśla ciągły rozwój polityki senioralnej, mający na celu opracowanie bardziej wszechstronnego modelu opieki nad osobami starszymi.

Słowa kluczowe: opieka nad osobami starszymi, Wietnam, *care diamond*, kultura, instytucja.