Current Barriers in Healthcare Access of the Rural Elderly

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Abstract: *Health care is one of the most fundamental human rights. Together with the social and economic development, the peope's living standard and life expectancy have improved, resulting in a rapid increase of the elderly population. Recent studies reveal many health issues of the old people in Vietnam, especially ones living in rural areas, which is attributed to the insufficient health facilities and health care quality. Based on the primary data and the data from the 2016 Vietnam Household Living Standards Survey by the Vietnam General Statistics Office, the article describes the current situation of both physical and mental health of the elderly in Vietnam and analyzes the barriers in their healthcare access. It then suggests some policy implications for the improvement of healthcare accessibility for the rural elderly under Vietnam's current context.*

Keywords: elderly, rural areas, physical health, mental health, healthcare access

1. Introduction

After more than 30 years of renovation, rural Vietnam has experienced drastic socioeconomic changes. Along with the development process, the increasing average life expectancy coupled with the declining fertility rate have accerlarated Vietnam's population aging. According to the General Office for Population and Family Planning (Ministry of Health - MOH), Vietnam has officially entered its population aging phase since 2011. There are currently about 10.1 millions of the older people[1], accounting for 11% of the country's population, and among which 65,7% of them living in rural areas and working in agriculture with low incomes (MOLISA, 2019).

The elderly population is growing quickly increase in Vietnam in general and in rural Vietnam in particular. The older adults accordingly face many life issues, particularly in health care. Most of the rural elderly do not have pensions and have to depend on their children or earn a living by themselves. Meanwhile, the traditional forms of support to the elderly are now declining and social security is not good enough to provide them with a secured living. The situation raises many

[1] As prescribed in Article 2, Law on the Elderly 2009, the elderly are Vietnamese citizens aged 60 years or above.

research questions for the old people's physical and mental health as well as the obstacles in their healthcare access in the rural areas. These are, therefore, the focus of the article's examination that is backed with an analysis of the indicators such as self-awareness of health care, financial conditions and support from family members. Thereby, policy implications for enhancement of health care for the older people in rural areas are as well provided.

2. Overview of the health situation of the rural elderly

Physical health

Currently in Vietnam, despite a comparatively high average life expectancy of 73 years, the healthy life expectancy of the older people is relatively low (Le Xuan Cu, Pham Hai Hung, 2018). The older people in Vietnam in general and in rural areas in particular are not as healthy as expected. According to the MOH's report, about 95% of the old adults have multiple diseases (2.69 diseases per peson on average), which are mostly chronic and non-communicable ones. The number of those with good health only makes up around 5%-7%; poor health 23%; and the remaining for decent health (Lê Ngọc Lân, 2010). Thus, there is a very high proportion of the older people suffering chronic diseases.

Chronic and common diseases such as hypertension, diabetes, cancer and chronic obstructive pulmonary disease (caused by prolonged respiratory diseases) are major non-communicable diseases that the elderly in both urban and rural areas are experiencing. The incidence of cancer in the elderly has increased and contributed 20% of the disability rate among the age group of 60-64 years (UNFPA, 2019). The older the age, the greater the incidence of cancers among the older adults due to the concurrent influence of many other diseases. Moreover, diseases such as cardiovascular, osteoarthritis, and hearing or eye diseases also affect greatly the health and the quality of life of the older people (Pham Thang, 2007).

Age is considered a factor that is closely correlated to the health status. The analysis of the data from the 2016 Vietnam Household Living Standards Survey (VHLSS 2016) reaveals that 17.4% of the rural elderly having serious illness/injuries that require rest in motionless and need caregivers in the 12 months previous to the survey. Among the three age groups of the elderly, such diseases happened most to the people aged 80 years and above (26.2%). This age group also has the highest frequency of suffering severe illnesses (2.05 times/year) against 1.93 times/year for the 60-69 age group and 1.83 times/year for the 70-79 age group. Most of the older adults aged 60-69 years in rural areas are still working in agriculture while some seek employment at construction sites and other side jobs. They have limited time and access for medical services and appears to be more susceptible to serious diseases/injuries than the people of 70-79 years old.

In overall, the rural elderly are experiencing physical health problems that would affect them seriously without prompt and proper treatments, regardless of whether it is common or chronic diseases. The statistics above-provided imply also a currently high demand for health care of older persons in rural areas.

Mental health

In rural Vietnam, the older people mostly live with their families. However, the

number of households with parents living with their children has dropped significantly due to the changes in family structure. Nuclear families has become more popular, resulting in higher proportion of the elderly living in loneliness and isolation (UNFPA, 2019). In 2017, the number of small families accounted for 74% (GSO, 2017). Among the older people living alone, 80% are women and 80% live in rural areas (Pham Thang and Do Thi Khanh Hy, 2009). A study by Nguyen Duc Chien and Nguyen Thi Huyen Giang (2018) reveals the rural elderly encounter mental health problems due to their children working and living away from home. These changes in the cohabitation model might bring more difficulties to the older people in rural areas in terms of both physical and mental health. Elderly loneliness in rural areas tends to increase with age. At a certain age, the older people more or less suffer psychological disturbance, low mobility, communication issues and anxiety disorder due to life changes. The mental problems of the elderly are often manifested in inferiority complex or WHEN they have to rely on other people's help. Sharing joy means a lot to the older people. The psychological differences, however, obstruct the sharing between the elderly and the youth. While older adults live more in the past, young people are more future oriented. It is the reason for arguments and conflicts to sometimes happen among family members of different generations.

Vietnam Aging Survey (VNAS) (2012) shows the older people experienced typical types of psychological violence such as defamation and argument (38%) and verbal abuse (23%) (Vietnam Women's Union, 2012).

Thus, changes in family size and family behaviors has caused psychological and emotional problems to the rural elderly. If not emotionally taken cared of for a long time, the older people would experience direct mental breakdowns that indirectly affect their families. In addition to physical health, the elderly's mental health should be nourished also for their happy and healthy meaningful lives.

3. Barriers in healthcare access of the rural elderly

According to Ann and Ronald (1973), medical services include all services of diagnosis and treatment or advanced programs for health improvement and rehabilitation. Healthcare access is comprehended as the access to the best available health services within the capacity of the patients that allow them to obtain the services when medical examination/ treatment needed. Relying on that, the barriers to healthcare access of the rural elderly would be further clarified.

The above analysis shows the rural older people's health issues, both physically and mentally. The need for elderly healthcare is extremely urgent in rural areas where the infrastructure and quality of medical examination and treatment remain underdeveloped. In consequence, patients overflow to higher-level hospitals, leaving the medical centers in rural areas unfilled.

First, the elderly's awareness and recognition of their health and diseases

According to the analysis on 5-year implementation of the Labor Law by of the Ministry of Labor, War Invalids and Social Affairs (MOLISA) and United Nations Population Fund (UNFPA) (2016), more than 90% of the total elderly had health insurance cards (of which, 30%

was purchased insurance and the rest was provided) (Nguyen Quoc Anh, 2018). Thus, the majority of elderly had improved their recognition of health care at their later stage of life. However, it is important to keep in mind that about 10.3% of elderly is not having insurance cards and this rate in rural areas is twice as much as in urban areas (12.5% in rural areas versus 5.5% in urban areas) (MOLISA, UNFPA, 2016). It can probably be explained by the fact that most of elderly people in Vietnam are residing in rural areas (twice as much as their urban counterparts) (MOH, 2018).

A majority of the rural elderly hardly take regular medical check-up and thus when disease is found, it has already been at the late stage, causing difficulties in treatment. As pointed out in several studies, taking care of their own health becoming problem for the older people in rural areas because they do not perceive the importance of early treatment for common and chronic diseases. Stepping into their 60s, the older people need to do regular check-up at medical centers so that potential health-risk and diseases can be foreseen and cured in time. However, due to a variety of reasons, the early detection and timely medical examiniaton for older people in rural areas still have shortcomings. Those reasons include people's awareness of their own health protection, anxiety arises when knowing about the disease, difficulty in accessing health-care centers, medical cost, and so forth (Le Van Kham, 2014). Even for people who are often sick, their medical examination and treatment also have certain obstacles.

The educational level of the elderly is generally low, especially for those from the countryside. More than 59% of older persons do not have adequate education conditions and 0.21% have secondary education or higher, so their knowledge of basic medicine, exercise methods, disease prevention, and access to health services are limited (Le Van Kham, 2014). Poor awareness makes it difficult to access and use health services for older persons in rural areas.

Second, lack of support from family members.

The cohabitation model is considered one of the factors affecting the psychology and awareness of older people in choosing healthcare services to use. In the traditional model, most of the elderly in rural areas living with their descendants in multi-generational families. In the opinion of the majority of older people, living with descendants is natural and they have no other choice (Bui The Cuong, 2005). This is more evident for the elderly in rural areas and for the elderly with low living standards. The older they are, the more they wish to live with their children. However, under the impact of urbanization and modernization along with the migration process, Vietnamese families have a tendency to nuclearize and reduce the scale, the proportion of older persons living with their children tends to decrease accordingly (Nguyen Thi Ngoc Ha, 2016).

The process of industrialization and urbanization taking place strongly in big cities and attracts migrant workers from rural areas. More and more young people are leaving the countryside in search of higher-paying jobs in urban areas, whereas older people living back in the countryside in incomplete families are very vulnerable due to lack of regulate care and support from their children. Lonely older people are one of the groups facing difficulties,

because many of them fall short of material and mental care.

With limited and insuficient incomes, lonely elderly spend very narrowly, mostly for basic needs. Most of them live very difficult lives (Nguyen Thi Ngoc Ha, 2016). This problem directly affects the awareness of healthcare of the elderly in rural areas as well as in the country as a whole. Traditional family caring giving towards the elderly is declining while the income of most households with the elderly is low, which makes the elderly financially ineligible for health care services and public health facilities. At the same time, life challenges have made the elderly pay less attention to healthcare knowledge. Instead of going to health facilities, self-care is considered as a popular form for today's elderly in rural areas. Most elderly in rural areas lack knowledge of health care and disease prevention, especially ones living alone without children.

Third, financial difficulties

According to the MOLISA's statistics, still one-third of the elderly are poor and near poor with difficult lives, especially in rural and mountainous areas. About two-thirds of the older people do not have regular social assistance and do not have health insurance. Only 35.6% in urban areas and 21.9% in rural areas have pensions or allowances from the State. A majority of the older persons are in poor health, but mostly due to inadequate medical care owing to lack of financial conditions and also access to quality health services (Tran Thi Minh Thi, 2014).

Economic challenge are one of the factors affecting the choice of health care of the elderly in rural areas. In 2016, the proportion of the elderly living in poverty and severe poverty (less than half of the poverty threshold) increased gradually with age. However, the poverty rate in the group aged 80 and older is lower than that in the age group of 70-79. This may probably be explained by the higher proportion of the elderly group aged 80 and older receiving social assistance. Older people are a special target group, who do not always have wages and social

Table 1: Health services accessed by rural elderly by income group (%)

Income group	**Types of health services establishment**						**N**
	Communal station	District/ city level hospital	Provincial level hospital	Central level hospital	Private health service	Others	
Poor	28,3	47	19,7	8,9	23,7	4,8	575
Near poor	23,9	45,2	24,2	7	23,3	2,6	569
Average	19,3	49,2	22,5	7,1	32,9	1,9	579
Decent living	14,2	42,5	24	6	39,7	1,9	552
Rich	12,2	43,6	24,7	10,5	31,5	2,4	404
Total	23,6	51	22,2	7,2	26,7	2,5	2679

Source: Author's calculation based on the data from the VHLSS (2016).

allowances to pay for their own medical examination and treatment, particularly for those in rural areas. Therefore, the current models of health services provision at different levels still depend on affordability and accessibility (Nguyen Quoc Anh, 2018). For common diseases, the elderly in rural areas tend not to go to the hospital for medical treatment, but buying medicine by their own or going to the communal health station. However, for infectious or chronic diseases, the elderly still have to go to district and city health facilities or private hospitals/clinics for examination at a high cost, particularly for older people who do not have health insurance. This really causes great difficulties for the poor elderly and the elderly who live in difficult and remote areas.

The analysis based on the data from the VHLSS 2016 shows that there is a big difference in the selecion and utilization of health services by economic groups of elderly. For instance, 8.9% of the elderly living in poverty choose to go to central-level hospital whereas that rate of rich counterparts is 10.5%. Similarly, for provincial hospital, the rate are 19.7% and 24.7% respectively. On contrary, while communal stations was chosen by 28.3% of the poor elderly, only 12% in the rich group and 14.2% in the decent living group choose it for their health treatment. In addition, the difference in the use of private health facilities is also observed between economic groups of the elderly in rural areas, in the way that the richer are more likely to choose private health services or hospital at higher levels. With that given, it is clear that economic difficulties have greatly hindered the access to health services of the older persons in rural areas at the present time.

4. Conclusion

The above analysis has focused on the current health situation of the older people in the rural areas and their difficulties in accessing today's health services. Regarding physical health, the elderly today mainly suffer from both chronic and common diseases, i.e. diseases of the joints, blood pressure, cardiovascular, hearing, vision, etc. On average, each elderly in Vietnam is suffering from three types of disease. Also, the older the age, the higher the incidence of disease occurs.

In terms of mental health, the elderly in rural areas are affected by changes in family structure since the proportion of households with parents living with their children has decreased significantly. This change in cohabitation patterns can make elderly's life more difficult, both in terms of physical and mental health. The older people are having mental problems such as loneliness and inferiority complex when it comes to other people's help. The rate of lonely older people tends to increase with age. Lonely lives increases the risk and harmness to the mental health and general health of the elderly.

The elderly still face many difficulties in self-care due to their lack of knowledge about health problem and limited awareness of the importance of early treatment of common and chronic diseases at an old age. Most of the elderly in rural areas are still working for their lives. Their educational level is generally low, so their understanding of health, practice methods, prevention, access to health services is limited. Their poor awareness and reluctance to visit hospitals due to the high cost and complex procedures have made access to and use of health services by older people more difficult in rural areas.

In terms of health care, the change in cohabitation model has made a part of the elderly in rural areas falling short of support from family members. Lonely older people are one of the groups facing difficulties due to their material and spiritual shortage. Low income and lack of attention both physically and mentally from the family members make the elderly living alone (or the elderly living with their grandchildren) a vulnerable group who cannot take care of their own life, especially when they are sick or having problems with health.

Regarding economic resources, the current pattern of using health services at different levels is still affected by the affordability of the elderly. Older people in rural areas have low living conditions and still have to work to earn their incomes. Currently, the main source of incomes for the elderly in rural areas is still from agricultural work or support from their descendants. This directly affects the awareness of health self-care of the elderly. Older people with higher living standards are more likely to choose private health services and higher level health services than their poorer counterparts in rural areas.

The current situation of health and barriers in accessing health services of the elderly in rural areas shows that communication and guidance on health care for the elderly need further attention. The grass-root health network should be more developed with an appropriate organizational model so that older people can have convenient access to health services. The state needs to focus on expanding the types and size of coverage of social insurance and health insurance. Activities to support the elderly, such as poverty reduction, business loans, financial and physical donations from communities, etc., need to be further promoted so that they can be taken care of and guaranteed in the context of Vietnam's current aging ❑

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