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Compatibility of Vietnamese Law and International Law on The Right to Health Care for The Elderly

Dr. Mai Thị Mai[1], Do Nhat Quang[2]
[1]Hanoi Law University
[2]Quang Ninh Provincial Inspectorate

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Corresponding Author:
Dr. Mai Thị Mai

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ABSTRACT: Population ageing has emerged as a structural demographic trend worldwide and is becoming increasingly pronounced in Viet Nam, leading to a substantial and sustained rise in the demand for health care services for older persons. Within this context, the right to health care of older persons should be recognised as a fundamental human right and an integral component of the broader right to health. This right entails corresponding obligations on the part of the State to ensure the availability, accessibility, acceptability, and quality of healthcare services, while also underscoring the complementary roles of families and communities in providing care for the elderly.

This article conducts a normative and comparative legal analysis of international human rights standards relating to the right to health, with particular emphasis on core human rights treaties and international instruments specifically addressing the rights of older persons. These international norms are systematically examined in relation to the existing Vietnamese legal framework governing health care for the elderly. Through this analysis, the article identifies both areas of convergence and normative gaps between international standards and domestic law. On this basis, the article proposes a set of legal and policy recommendations aimed at strengthening the protection of older persons' right to healthcare in Vietnam in a sustainable and rights-based manner, in response to the challenges posed by population ageing.

1. INTRODUCTION

Viet Nam is entering a period of rapid population ageing, while the health system's welfare resources and capacity remain under pressure. The increase in the number of older adults poses an urgent need to shift the healthcare model from a treatment-based approach to a more holistic approach, emphasising prevention, chronic disease management, rehabilitation, and long-term care. In this context, ensuring the right to healthcare of the elderly is not only a medical issue, but also a legal issue associated with the protection of human rights and the State's responsibility in public service organisation, resource allocation, and social justice assurance.

2. LEGAL FRAMEWORK

2.1 International policies and laws on health care for the elderly

2.1.1 Universal Declaration of Human Rights 1948 (UDHR)

The Universal Declaration of Human Rights, adopted in 1948, is a fundamental document that affirms universal human rights. Article 25(1) of the Declaration states that everyone has the right to a standard of living sufficient to ensure health and welfare, including medical care and necessary social services. In particular, this clause emphasises the right to be guaranteed in the event of

"unemployment, sickness, disability, widowhood or old age" when a person suffers an unintended loss of a source of livelihood[1]. Although the UDHR is not a legally binding treaty, Article 25 lays the important groundwork for recognising that older people, like all people, are entitled to health care and social protection in old age. This provision has subsequently influenced the development of binding human rights legal instruments, such as the United Nations Convention on Economic, Social and Cultural Rights.

2.1.2. International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR)

The 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) is a binding treaty that specifies the right to health care. Article 12(1) of the ICESCR recognises *"the right of every person to the highest attainable standard of physical and mental health".*[2] Although the Convention itself does not specifically mention the elderly, the rights outlined in the Convention apply to all people, regardless of age. The United Nations Commission on Economic, Social and Cultural Rights (CESCR) has affirmed that older persons have the right to fully enjoy all the rights enshrined in the Convention[3]. This means that member states have an obligation to ensure that older persons have equal access to health care in an age-appropriate manner. In addition, ICESCR Article 9 implicitly recognises the right to old-age benefits through the right to social security[4], suggesting that the protection of the elderly in terms of both health and social security is part of a country's human rights obligations.

2.1.3. General Comment No. 6 (1995) of the CESCR Committee

In 1995, the CESCR Committee issued Joint Comment No. 6: "Economic, Social and Cultural Rights of Older Persons". This is a formal interpretive document, emphasising the country's responsibility for the rights of older persons within the framework of the ICESCR. The Committee notes that there is no comprehensive international convention on the rights of older persons. Therefore, countries must pay special attention to promoting and protecting the economic, social, and cultural rights of the elderly, in accordance with their existing obligations[5]. General Comment No. 6 makes it clear that although the ICESCR does not explicitly list age as a criterion for prohibiting discrimination, older people are still indirectly protected through the phrase "other status" in the prohibition clause, and the general tendency is to eliminate discrimination based on age.

Notably, regarding the right to healthcare, the CESCR Committee urged countries to prioritise implementing comprehensive measures to ensure that older people enjoy the highest standard of health. Specifically, General Comment No. 6 refers to recommendations 1–17 of the Vienna International Plan of Action on Older Persons (1982) on health policy for the elderly, emphasising a holistic approach from prevention, treatment, rehabilitation, to care for the terminally ill. [6]The Commission emphasizes that in the face of the rise in chronic diseases and The cost of treatment is high in the elderly, the country cannot only focus on cure, but needs to invest in lifelong prevention (proper nutrition, exercise, avoidance of tobacco, alcohol, etc.), periodic age-appropriate health check-ups, as well as rehabilitation services to maintain the viability of the elderly. These measures both implement the elderly's right to healthcare and contribute to reducing the long-term burden of health and social costs[7].

2.1.4. UN Resolution 46/91 on Principles for the Elderly

On December 16, 1991, the United Nations General Assembly adopted Resolution No. 46/91 promulgating the "United Nations Principles for Older Persons". This is considered the first specialised international document focusing on the rights of the elderly, declaring the orientation for countries to develop policies towards the elderly. The content of the Resolution lists 18 basic principles,

[1] Article 25(1), Universal Declaration of Human Rights, 1948 (UDHR) – provides for the right to an adequate standard of living for health and welfare, including medical care, and the right to be guaranteed in cases of unintended loss of income such as old age

[2] Article 12(1), the International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR) – recognizes the right of all people to the highest achievable standard of physical and mental health. Article 12(2) requires countries to take measures such as improving sanitation, prevention and treatment, and ensuring that people receive medical care when they are sick

[3] CESCR Committee, General Comment No. 6 (1995), paragraphs 10–12 – affirms that the ICESCR applies to all ages, and that the elderly are entitled to the full rights of the Convention. Although "age" is not specified in the grounds for prohibiting discrimination, the Commission considers that the phrase "other status" can be understood to include age, and that countries should eliminate all forms of discrimination due to old age to the maximum.

[4] CESCR, General Comment No.6: The economic, social and cultural rights of older persons (1995), U.N. Doc. E/1996/22, para. 10. The committee interpreted Article 9 of the ICESCR as "the right to social security" to include old-age benefits, which are retirement benefits or other forms of income support for the elderly who are no longer able to work.

[5] CESCR Committee, General Comment No. 6 (1995), para. 13 – emphasizes that States Parties have a special duty to promote and protect the rights of older persons. The Committee noted that there is currently no comprehensive international convention on older persons, so monitoring the implementation of the rights of older persons relies heavily on existing mechanisms such as the ICESCR and relevant UN principles.

[6] General Comment No. 6 (CESCR, 1995), paragraph 34 – recommends that countries enforce the right to health of older persons through a comprehensive strategy. Specifically, it is necessary to refer to the recommendations on health policies for the elderly in the 1982 Vienna Action Plan, ensuring the full implementation of disease prevention, treatment, rehabilitation and end-stage care activities for the elderly.

[7] General Comment No. 6 (CESCR, 1995), paragraph 35 – emphasizes that maintaining health in old age requires investment in prevention and lifelong health promotion. Countries should promote healthy lifestyles (nutrition, exercise, no smoking, alcohol, etc.), organize appropriate periodic health check-ups for the elderly, and develop rehabilitation services. These measures help older adults maintain their ability to take care of themselves, reduce the need for costly treatments, and thus reduce long-term socio-health costs.

divided into 5 value groups: Independence, Participation, Care, Self-Improvement and Dignity. Each group consists of a specific set of principles, reflecting important aspects of the lives of older people[8]:

Independence: Principles 1–5 emphasise that older people have the right to have the highest possible level of autonomy in their lives. Specifically, they need to be assured of basic needs, such as food, clean water, housing, clothing, and healthcare services, through income, family, and community support. They have the right to work or generate income, to decide when to retire, to access education, and to live in a safe environment that accommodates their individual abilities and interests. These principles promote the autonomy and independence of the elderly, including autonomy in healthcare (choosing where to live and how to take care of themselves).

Participation: Principles 7–9 affirm that older people have the right to be integrated and actively participate in social life. They must be involved in the formulation and implementation of policies that affect their well-being; be given opportunities to contribute to the community and volunteer activities in accordance with their abilities; and form associations and movements of the elderly. With regard to the right to healthcare, these principles imply that the voices and experiences of older people should be heard in the planning of health and wellbeing services; they should not be just passive subjects, but also active participants in the decision-making process related to their health.

Care: Principles 10–14 directly address the right to care. Accordingly, the elderly have the right to be cared for and sponsored by their families and communities in accordance with socio-cultural values. In particular, Principle 11 states: "Older persons need health care to help them maintain or restore their physical, mental, and emotional health, and to prevent or slow the decline of health." This is a strong affirmation of the elderly's right to medical care, including aspects of rehabilitation and disease prevention. In addition, older people need to have access to social and legal services to increase their autonomy and protect them (Principle 12); need to be cared for in appropriate settings when self-care is not possible (Principle 13); and human rights are guaranteed even in nursing homes or treatment facilities (Principle 14). These principles form the basis for countries to establish social-health care systems that are friendly to the elderly, respecting their needs and dignity.

Self-Fulfilment Group: Principles 15–16 address the need to realise one's potential, satisfying one's own aspirations even in old age. The elderly have the right to access educational, cultural, spiritual, and recreational activities to enhance their well-being. Regarding health, this indirectly emphasises the mental health aspect and the rich spiritual life of the elderly. Participating in social and cultural activities is also an integral part of comprehensive healthcare, helping the elderly live happily and healthily.

Dignity: Principles 17–18 affirm the right to live in dignity and safety, free from exploitation and ill-treatment. Older people must be respected, protected from any form of mental or physical abuse, and treated fairly in the legal system as well as in the community. This is a fundamental moral principle: at any age, people possess dignity. For health care, this group of principles reminds us that when providing services to older people, there should be absolute respect for their dignity, privacy, and self-determination.

The 1991 UN Principles, although not legally binding, are highly influential. The United Nations calls on countries to integrate these principles into their national agendas to the maximum extent possible. Many countries have subsequently relied on these principles to develop laws regarding the elderly, including healthcare. For example, the Law on the Elderly in 2009 of Vietnam also expresses the spirit of these principles: recognising the right to healthcare, the right to respect, and promoting the role of the elderly.

2.1.5. Vienna International Plan of Action on Older Persons 1982

The United Nations was early aware of the challenge of population ageing. In 1982, the First World Conference on Ageing took place in Vienna (Austria) – resulting in the adoption of the Vienna International Plan of Action on Ageing (1982). This is the first comprehensive international document on the field of ageing, guiding thinking and policies on ageing. The 1982 Vienna Plan was approved by the United Nations General Assembly in the same year (Resolution 37/51 of December 3, 1982). This document aims to strengthen the capacity of governments and societies to effectively respond to population ageing and to promote the potential contribution of older persons to development.

The 1982 Vienna Plan comprises 62 specific recommendations that cover various areas related to the elderly. The recommendations call for action on the study, collection and analysis of data on the elderly, training and education on gerontology, as well as key issues: health and nutrition of the elderly; protecting elderly consumers; housing and environment (adapting to old age); supporting families with elderly people; social welfare; ensuring income and employment for the elderly; and education[9]. This can be considered the first comprehensive international agenda on ageing, laying the foundations for the development of later standards and strategies in the field of elder rights. The Vienna Plan became part of the international framework of standards for older persons, closely linked to the standards on human rights, social development, gender equality, welfare, health, housing and welfare that the international community developed in the decades that followed.

In terms of health care, the 1982 Vienna Plan specifically emphasises that the elderly should have access to a full range of health services, both preventive and therapeutic, in accordance with the characteristics of old age. Recommendations 1–17 of the Plan provide comprehensive guidance on health policy for older people, covering prevention, home care, rehabilitation, and the

[8] United Nations General Assembly, United Nations Principles for Older Persons (Resolution 46/91, 1991)
[9] United Nations, Vienna International Plan of Action on Ageing (1982).

treatment of the terminally ill[10]. The document calls on countries to train geriatric specialists[11] and develop community health services and home care to help older people receive treatment in familiar settings, thereby limiting long hospital stays. The plan also proposes to ensure proper nutrition to prolong a healthy life expectancy, while focusing on the mental health of the elderly – for example, detecting and treating neuropsychiatric diseases such as dementia and depression in the elderly. Notably, the Vienna Plan emphasises the need to integrate medical care with social care, recommending that governments coordinate to support families in caring for the elderly and develop volunteer networks and quasi-professional services to assist them in their daily lives. A key recommendation is to encourage countries to ensure that their health insurance and social security systems cover older people, thereby alleviating the financial burden that hinders their access to healthcare. This implies that every elderly person, regardless of economic circumstances, has the right to access basic health services without undue financial pressure.

Besides health, the Vienna Plan also addresses the creation of a favourable physical and social environment to support the health of the elderly. For example, housing for the elderly needs to be designed appropriately (preferably single-storey houses, with stair handrails, non-slip floors, etc.); public transportation must be convenient and safe so that the elderly can easily travel and access necessary services. The community needs to develop socio-cultural institutions that are friendly to the elderly (clubs, living centres for the elderly) to help them maintain a rich spiritual life and social exchange.[12] These environmental conditions indirectly have a positive impact on the physical and mental health of the elderly, helping them to live more independently and actively in the community for as long as possible. It can be said that the 1982 Vienna Plan of Action laid the foundation for an overall approach to addressing the issue of the elderly on a global scale. Regarding the elderly's right to healthcare, the plan affirms the state's responsibility to ensure that the elderly receive adequate medical and social care, as a condition for them to continue contributing to society in old age. The content of the Vienna Plan was later inherited and developed in subsequent international instruments (such as the 2002 Madrid Plan). Particularly in Vietnam, although in the 1980s the proportion of elderly people was still low, many policies later referred to the spirit of the Vienna Plan. For example, the National Programme of Action on Older Persons in 1999 and 2012 emphasised the development of health care networks and social protection for the elderly, in line with international recommendations from the 1982 Vienna Plan.

2.1.6. Madrid International Plan of Action on Older Persons 2002

Two decades after the Vienna Plan, the United Nations convened the Second World Conference on Ageing in Madrid (Spain) in 2002, in the context that the problem of ageing has become more urgent in the 21st century. The conference adopted the Madrid

[10] Vienna 1982, para. 55: "Because they may be among the least mobile, this group (the very old) is particularly in need of primary care from facilities located close to their residences and/or communities. The concept of primary health care incorporates the use of existing health and social services personnel, with the assistance of community health officers trained in simple techniques of caring for the elderly"
See more at:
https://www.humanrights.ch/cms/upload/pdf/070703_Vienna_PlanofAction.pdf#:~:text=be%20vulnerable,caring%20for%20the%20f%20elderly, retrieved 2025-11-20

[11] Vienna 1982, Recommendation 7(c)): "Practitioners and students in the human care professions (e.g. medicine, nursing, social welfare etc.) should be trained in principles and skills in the relevant areas of gerontology, geriatrics, psychogeriatrics and geriatric nursing."
See more at:
https://www.humanrights.ch/cms/upload/pdf/070703_Vienna_PlanofAction.pdf#:~:text=,geriatrics%2C%20psychogeriatrics%20and%20geriatric%20nursing, retrieved 2025-11-20

[12] Vienna 1982, Recommendation 19:
"Housing for the elderly must be viewed as more than mere shelter. In addition to the physical, it has psychological and social significance, which should be taken into account. To release the aged from dependence on others, national housing policies should pursue the following goals:
a) Helping the aged to continue to live in their own homes as long as possible, provision being made for restoration and development and, where feasible and appropriate, the remodeling and improvement of homes and their adaptation to match the ability of the aged to get to and from them and use the facilities;
(b) Planning and introducing--under a housing policy that also provides for public financing and agreements with the private sector--housing for the aged of various types to suit the status and degree of self-sufficiency of the aged themselves, in accordance with local traditional and customs,
(c) Co-ordinating policies on housing with those concerned, with community services (social, health, cultural, leisure, communications) so as to secure, whenever possible, an especially favourable position for housing the aged vis-à-vis dwellings for the population at large;
(d) Evolve and apply special policies and measures, and make arrangements so as to allow the aged to move about and to protect them from traffic hazards;
(e) Such a policy should, in turn, form part of the broader policy of support for the least well-off sectors of the population"
See more at:
https://www.humanrights.ch/cms/upload/pdf/070703_Vienna_PlanofAction.pdf#:~:text=a,homes%20as%20long%20as%20possible", retrieved 2025-12-01

Political Declaration and the Madrid International Plan of Action on Ageing (MIPAA) 2002. The Madrid Plan is considered an update and strategic direction for international policy on the elderly in the new century. The document emphasises the need to change attitudes, policies and practices at all levels to adapt to an ageing population, and outlines specific action priorities to support older people.

The Madrid Action Plan 2002 has 3 key priorities[13]: (1) Ageing and development; (2) Promote health and well-being in old age; (3) Create a supportive and favourable environment for the elderly. All three of these directions are closely related to the elderly's right to health care:

Priority 1: Older and Developmental. This content refers to the integration of ageing into all socio-economic development policies. When older people are facilitated to participate in development, they have the opportunity to improve their lives, thereby having better access to healthcare. The Madrid Plan recommends that countries ensure social security for the elderly (pensions, social benefits), poverty alleviation for the elderly, and encourage suitable employment for older people who want and can work. In particular, it emphasises gender equality and the empowerment of older women, as women often live longer but are poorer and have poorer health in old age. Implementing these policies will reduce the financial and social burden, enabling the elderly to receive better healthcare conditions.

Priority 2: Promote Health and Well-being in Old Age. This is a focus directly related to the right to healthcare. MIPAA 2002 calls on countries to develop health systems with life-cycle access, ensuring that older people receive a continuum of care from prevention, treatment, rehabilitation, to long-term and end-of-life care[14]. Emphasise the transformation of the health system to adapt to chronic and multi-pathological diseases in the elderly, and the training of health workers in geriatrics and elderly care[15]. MIPAA recommends building community- and family-based care so that older adults can receive care at their homes, avoiding prolonged hospital stays. At the same time, promote the model of "healthy ageing" (as proposed by WHO) – that is, create conditions for the elderly to exercise their bodies, live in moderation, and participate in social activities to maintain mental and physical health. In terms of mental health, the Madrid Plan pays special attention to the prevention of dementia and depression; combating stigma against the elderly with mental illness; and the development of counselling and psychological care services. In addition, this document also addresses the issue of HIV/AIDS and the elderly, the health of the elderly in humanitarian emergencies (natural disasters, conflicts) – new contents that have arisen in the early 21st century. Overall, priority 2 clearly affirms that the right to care and health promotion of older persons must be placed at the heart of public health policy.

Priority 3: A Supportive and Conducive Environment. This part is associated with creating a social and material environment to help the elderly live a healthy and safe life. The Madrid plan calls for the development of "age-friendly cities", adaptive housing and public transport; building social security networks and long-term care for vulnerable elderly people; supporting families in aged care through skills training, financial assistance, or alternative services to reduce the burden on caregivers[16]. The document also emphasises the prevention of violence and abuse of the elderly, and the development of laws to protect the elderly from abuse. A non-violent, non-discriminatory, adequately supported environment will ensure older people enjoy the right to better healthcare. For example, when the community offers a mobile periodic health check-up service, a health club for the elderly, and a fund to support the elderly in need, it is clear that the healthcare of this group is significantly improved.

The Madrid Action Plan 2002 updated the new challenges and offered a more comprehensive solution than the 1982 Plan. It reflects a shift in perspective: from seeing older people primarily as passive, to seeing them as people who have rights and can contribute (active) if cared for and facilitated. The Madrid Plan urges governments to build societies that adapt to old age, in which the elderly's right to health care is key to their "successful ageing". The recommendations of the Madrid Plan are oriented to the United Nations Commission on Ageing for periodic monitoring and evaluation. Viet Nam has also developed a national action plan based on the 2002 MIPAA framework, which aims to improve health and promote the role of the elderly in the period of rapid population ageing.

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[13] United Nations, Political Declaration and Madrid International Plan of Action on Ageing (2002)

[14] Madrid 2002, Objective 2, action (a)-(b)): "Take measures to provide universal and equal access to primary health care and establish community health programmes for older persons; (b) Support local communities in providing health support services to older persons" Xem thêm tại: https://social.un.org/ageing-working-group/documents/mipaa-en.pdf#:~:text=,support%20services%20to%20older%20persons, truy cập ngày 27 tháng 11 năm 2025.

[15] Madrid 2002, Objective 2: Primary health care, action (d)): "Train primary health-care workers and social workers in basic gerontology and geriatrics". Xem thêm tại: https://social.un.org/ageing-working-group/documents/mipaa-en.pdf#:~:text=,in%20basic%20gerontology%20and%20geriatrics, truy cập ngày 29 tháng 11 năm 2025.

[16] Madrid 2002, Objective 1: Promotion of "ageing in place" in the community with due regard to individual preferences and affordable housing options for older persons.
Objective 2: Improvement in housing and environmental design to promote independent living by taking into account the needs of older persons in particular those with disabilities.
Objective 3: Improved availability of accessible and affordable transportation for older persons.
See also at: https://social.un.org/ageing-working-group/documents/mipaa-en.pdf, accessed 22 November 2025.

2.1.7. Regional regulations on the right to health care for the elderly

In addition to global instruments, a number of regional instruments have complemented and concretised the rights of older persons, in particular on health care and protection in old age:

- Europe – European Social Charter (amended) 1996

The Council of Europe adopted the European Social Charter (amended) in 1996, which for the first time introduced a separate provision on the rights of older persons. Article 23 of the Charter (amended) provides for the right of older persons to be socially protected. Accordingly, Member States commit to taking appropriate measures to help older persons continue to be full members of society for as long as possible, by ensuring adequate resources for decent living and opportunities to participate in social activities; at the same time, it creates conditions for them to choose their own lifestyle and live independently in a familiar environment for as long as possible. In particular, Article 23 requires the provision of housing that is suitable for the needs and health conditions, supports the improvement of living conditions, as well as ensures medical care and services that are appropriate to the health status of the elderly. In addition, for elderly people living in nursing homes, Article 23 requires appropriate support, respect for their privacy, and facilitation to enable them to participate in decisions about their living environment within the facility. The European Social Charter (amended) thus embodies the progressive perspective of the European region: moving from a "dependent, passive" approach to ensuring dignity, autonomy and inclusion for older people, including full access to health and care[17].

- Americas – San Salvador Protocol 1988

In the American system, the San Salvador Protocol (1988) – a supplementary protocol to the American Convention on Human Rights of Economic, Social and Cultural Rights – clearly recognises the rights of older persons. Article 17 of the Protocol, entitled "The Right to Special Protection in Old Age", affirms that "everyone has the right to special protection in old age". In order to realize this right, States Parties undertake to take the necessary measures step by step, in particular: (a) to provide appropriate facilities, as well as food and specialized medical care, to the elderly who are deprived and unable to provide for themselves; (b) implement dedicated employment programs, creating opportunities for the elderly to participate in activities in accordance with their abilities and aspirations; and (c) promote social organizations to improve the quality of life of older people. Regulation (a) emphasises the state's responsibility to ensure intensive health services and meet the essential needs of vulnerable elderly people – a core component of the right to healthcare. The San Salvador Protocol, which came into force in 1999, marked an important step forward at the regional level when it included the rights of older persons (including health care) for the first time in a legally binding regional human rights treaty in the[18] Americas.

2.2. Vietnam's policies and laws on health care for the elderly

2.2.1. The 1992 Constitution (amended and supplemented in 2001) and the 2013 Constitution (amended and supplemented in 2025)

Although the 1992 Constitution (amended and supplemented in 2001) does not use the term "elderly", it has recorded the term "elderly" in the group of social objects in need of assistance. Specifically, the Constitution stipulates: "The elderly, the disabled, and helpless orphans shall be assisted by the State and society". This regulation early expresses the orientation of social protection, laying a constitutional basis for the responsibility of the State and society towards the elderly, especially in difficult and helpless situations. However, it can be seen that the term "elderly" is a qualitative term, which does not specifically express the priority group of people. Along with that, in the 1992 Constitution (amended and supplemented in 2001), "the elderly" was classified as a group of disadvantaged people along with the disabled and helpless orphans, [19]showing that the Constitutional thinking at that time only focused on supporting disadvantaged groups in general, including the "elderly", but did not consider identifying the elderly as a group the subject knows so that he can take measures to ensure his rights in the best possible way. In addition, the 1992 Constitution (amended and supplemented in 2001) emphasises the obligation in the family in Article 64: *"Children and grandchildren have the duty to respect and take care of their grandparents and parents".* From a constitutional legal perspective, this content shows that at this stage, the constitutionalists determined that the care of the "elderly" is first of all placed within the framework of "morality, family responsibility" and "social assistance policy", but it has not been determined that this is the responsibility for ensuring human rights from the State, directly the rights of the elderly.

On that basis, the Constitution of the Socialist Republic of Vietnam, adopted in 2013, clearly established for the first time the status of the elderly. Specifically, Clause 3, Article 37 stipulates: *"The elderly are respected, cared for and promoted by the State, family and society in the cause of building and defending the Fatherland".* This regulation establishes the highest legal foundation, laying down the responsibility of the State, the community, and the family in caring for the elderly. In addition, Article 38 of the

[17] The European Social Charter (amended), 1996, Article 23 – requires European countries to ensure the right of older people to be socially protected. Article 23 highlights measures to help older people socially integrate and live independently to the maximum, including the provision of suitable housing, as well as health care and services necessary according to their status

[18] The San Salvador Protocol (1988) supplements the American Convention on Human Rights, Article 17, which recognizes the right to special protection of the elderly. Clause (a) of Article 17 requires States to provide facilities, food and specialized medical care to needy elderly persons who are unable to meet their own needs

[19] Article 67 of the 1992 Constitution (amended and supplemented in 2001)

2013 Constitution recognises that everyone has the right to health protection and care, as well as equality in the use of health services. Thus, the right to healthcare of the elderly, in particular, is guaranteed based on both the general principle of citizens' right to health and the specific principle of respect and care for the elderly as stated in the Constitution. This is the basis for concretisation in specialised laws related to the elderly.

2.2.2. The 2000 Ordinance on the Elderly and the 2009 Law on the Elderly

Before the promulgation of the law, our State had an ordinance on the elderly, approved by the Standing Committee of the National Assembly (Ordinance No. 23/2000/PL-UBTVQH10) in 2000. This Ordinance, for the first time, systematically stipulates the support, care, and promotion of the role of the elderly. The Ordinance has affirmed: *"The elderly are supported, cared for and promoted by their families, the State and society in accordance with the law. All citizens must respect and have the responsibility to help the elderly".* [20]Article 3 of the Ordinance clearly states that the responsibility to support the elderly first belongs to the family, and at the same time, the State and society will assist the lonely and helpless elderly. Notably, Article 4 of the 2000 Ordinance stipulates that the State shall adopt appropriate policies on health care for the elderly, improve their material and spiritual life, and create conditions for the elderly to "live healthy, happy and useful lives". This is the first legal principle affirming the right to health care of the elderly, demonstrating the morality of "respecting the elderly" and the State's responsibility for this class of people. The 2000 Ordinance set the stage for the promulgation of the law later. From the effective date of the 2009 Law on the Elderly, the 2000 Ordinance shall cease to be effective, and the contents of the rights of the elderly (including the right to healthcare) shall be transferred into law.

The Law on the Elderly, enacted in 2009, is a comprehensive legal document that regulates the rights and obligations of the elderly, as well as the responsibilities of the family, the State, and society in supporting the elderly. This Law concretises the constitutional principles and inherits the 2000 Ordinance, which provides for many direct provisions on the right to health care of the elderly:

- The right to be protected for health care needs: Clause 1 of Article 3 lists the rights of the elderly, of which first of all is the right *to "be guaranteed basic needs for food, clothing, accommodation, travel, health care...".* Thus, the law defines health care as one of the top basic needs that the elderly enjoy. Article 4 of the State's policy regulations also emphasises the development of geriatrics to meet the needs of medical examination and treatment for the elderly and train elderly care staff. This is an important orientation to realise the right to appropriate medical examination and treatment for this specific population.

- Priority in medical examination and treatment: The Law on the Elderly in 2009 devotes Section 2, Chapter III to regulations on health care for the elderly. The law stipulates specific priorities for the elderly regarding medical examinations and treatment. Accordingly, people aged 80 years or older are prioritised for medical examination and treatment before other patients (except for emergency cases, children under 6 years old, and people with severe disabilities).[21] This regulation aims to prevent very elderly people from having to wait for a long time to see a doctor, particularly in cases where their health condition is deteriorating. Also in Article 12, the law requires hospitals (except children's hospitals) to organise geriatric departments or set aside a number of hospital beds to treat elderly patients. This creates a legal basis for the health system to develop geriatric units, better serving the needs of treatment and rehabilitation for the elderly. In addition, the hospital is also responsible for integrating traditional medicine and modern medicine, guiding appropriate non-drug treatment methods for the elderly, and continuing to monitor and restore the health of elderly patients after acute treatments – all to ensure that the treatment process for the elderly is continuous and effective. The law also encourages organisations and individuals to provide free medical examinations and treatment for the elderly as a way to mobilise social resources to care for the health of this group.

- Primary health care in the community: In addition to priority at hospitals, the Law on the Elderly 2009 emphasises the role of grassroots health care in health care for the elderly. Article 13 stipulates that commune and ward health stations are responsible for compiling health monitoring records for each elderly person and organising periodic health check-ups for the elderly in their localities (at least once a year). Health stations must also disseminate knowledge about healthcare and guide the elderly in developing self-care and disease prevention skills. In particular, for the elderly who are lonely and seriously ill and cannot go to medical facilities by themselves, health stations are tasked with sending staff to examine and treat them at home. This regulation shows humanity, ensuring that the most vulnerable elderly also have access to health services. The funding for these periodic examinations, health management records and home examinations is paid by the state budget, affirming the State's responsibility in caring for the health of the elderly community.

- Health insurance and social assistance policies: The Law on the Elderly 2009 has Section 4 on social protection for the elderly, associated with ensuring medical care. Articles 17 and 18 of the Law define the subjects of the elderly who are entitled to social benefits – these are mainly poor, lonely or elderly people aged 80 or over who have no pension or social insurance income. Specifically, Clause 2 of Article 17 clearly states that people aged 80 years or older, who do not receive a pension or a monthly social insurance allowance, will be entitled to social benefits. At the same time, Clause 1 of Article 18 stipulates that the elderly who are eligible for social benefits (as per Article 17) are granted free health insurance cards and are entitled to monthly social

[20] Article 2, Ordinance No. 23/2000/PL-UBTVQH10 Elderly
[21] Clause 1, Article 12 of the 2009 Law on the Elderly

allowances, as well as support with funeral expenses upon death. Thus, the Law has tied the right to healthcare to the fact that the elderly are financially guaranteed by the State through health insurance and subsidies if they belong to a disadvantaged group. In addition, the Law also stipulates that in the case of poor and lonely elderly people admitted to social protection establishments, they will be entitled to comprehensive care regimes, including nurturing allowances, medical treatments, provision of rehabilitation support tools, and health insurance provided by the State. In case these people have individuals or organisations receiving care in the community (surrogate families), the adoptees will be supported by the State, while the elderly are still issued health insurance cards and monthly allowances to ensure care. The above regulations demonstrate that the law prioritises ensuring all elderly individuals, particularly those in need, have access to healthcare through social security networks and health insurance.

- Incentives in related services: Although focusing on direct medical care, the Law on the Elderly 2009 also mentions the facilitation of the elderly in their lives to indirectly support their health. For example, Article 15, Clause 2 stipulates that when participating in public transportation, the elderly are assigned convenient seats. Article 16 stipulates that the elderly are entitled to discounts on ticket prices and service fees when using certain public services, as per government regulations. In fact, many localities have exempted or reduced bus tickets, sightseeing tickets... for the elderly in the spirit of this law. These are priorities to help the elderly travel and live more conveniently, enabling them to easily access medical facilities, participate in health training activities, and live more actively.

In addition to the above provisions, to guide the implementation of the Law on the Elderly, the Ministry of Health has issued Circular 35/2011/TT-BYT dated October 15, 2011, on healthcare for the elderly. This Circular details the prioritisation of medical examination and treatment for the elderly at hospitals (such as arranging appropriate wards, making separate monitoring records for inpatient treatment, etc.) as well as health care for the elderly in the community (periodic health check-ups, disease prevention counselling, etc, establish home care volunteers...). These guidelines help implement the elderly's right to health care as provided for by law.

2.2.3. Law on Marriage and Family 2014

The right to health care of the elderly is also associated with the legal obligations of family members. The Law on Marriage and Family 2014 clearly stipulates the responsibilities of children and grandchildren in supporting and caring for elderly parents and grandparents. The 2014 Law on Marriage and Family states: "*Children have the obligation and right to care for and nurture their parents, especially when their parents are sick, old, disability. In case the family has many children, the children must take care of and nurture their parents together."*[22] This regulation emphasises that adult children must ensure that supporting their parents in old age and illness is a mandatory legal obligation, not just a moral obligation. In addition, the Law also stipulates the obligations of grandparents to grandparents: *"Grandchildren have the obligation to respect, care for and support their paternal grandparents and maternal grandparents; in case of grandparents... if they do not have children to raise themselves, they are adults and have the obligation to nurture* [23]them". Thus, the law on marriage and family creates a binding obligation for the elderly in the family to be cared for by their children and grandchildren in terms of their physical and mental well-being. If children and grandchildren evade this obligation, the law has sanctions: according to Decree 141/2021/ND-CP on sanctioning administrative violations in the field of domestic violence prevention and control, the act *of "neglecting to take care of family members who are elderly, weak, disabled..."* can be fined up to VND 20,000,000.[24] More seriously, the Criminal Code 2015 (amended and supplemented in 2017) stipulates crimes for acts of abusing or torturing grandparents and parents; If children are often treated badly, neglecting their elderly parents, leading to serious health damage, the violator can be sentenced to imprisonment, with the highest penalty frame of up to 5 years in prison when the victim is an elderly person. These regulations indirectly protect the right to care for the elderly within the family, deterring and preventing children and grandchildren from neglecting to support their parents and grandparents[25].

2.2.4. Law on Health Insurance and financial policies for health care for the elderly

Ensuring the right to healthcare for the elderly is inseparable from the State's health insurance policy and financial assistance, as the cost of medical examinations and treatment increases with age. The Law on Health Insurance in 2008 (amended and supplemented in 2024) and its guiding documents have established a strong system of incentives for the elderly to participate in health insurance. Firstly, the law stipulates that the majority of elderly people are eligible to obtain health insurance cards free of charge from the State. According to the Law on Health Insurance and the current guiding Decree, vulnerable groups of elderly people are supported by the budget to pay health insurance, for example: the elderly are enjoying monthly pensions or social insurance benefits; the elderly with meritorious services to the revolution, veterans; the elderly belonging to poor households and ethnic minorities in disadvantaged areas; and especially people aged full 80 years or older without pensions or allowances are also issued health insurance cards under the category of social protection. The provisions of Decree 20/2021/ND-CP (amended and

[22] Clause 2, Article 71 of the Law on Marriage and Family 2014.
[23] Clause 2, Article 104, Law on Marriage and Family 2014.
[24] Article 53, Decree 144/2021/ND-CP dated December 31, 2021 stipulates the sanctioning of administrative violations in the field of security, social order and safety; prevention and control of social evils; fire prevention and fighting; prevention and control of domestic violence.
[25] Article 185, Criminal Code 2015 (amended and supplemented in 2025).

supplemented by Decree 76/2024/ND-CP amending and supplementing a number of articles of Decree 20/2021/ND-CP stipulating social assistance policies for social protection beneficiaries) clearly state: people aged 80 years and over without pensions or monthly allowances will be entitled to social benefits and be issued health insurance cards issued by the State closed. Thanks to this policy, most elderly people in Vietnam have health insurance (estimates suggest that over 95% of the elderly have health insurance cards), providing financial peace of mind when[26] they are sick.

In parallel with health insurance coverage, the law also prioritises high levels of health insurance benefits for the elderly. According to Clause 1, Article 22 of the Law on Health Insurance 2008 (amended and supplemented in 2024), the elderly who are entitled to monthly social protection allowances (i.e. poor, lonely, over 80 years old without a pension mentioned above) will be paid 100% of the cost by the health insurance fund within the scope of benefits. This is the maximum benefit, ensuring that vulnerable elderly people receive free medical examination and treatment. In addition, other groups of elderly people are also entitled to very high levels of health insurance: for example, the elderly are enjoying pensions, the elderly from poor households are covered by health insurance for 95% of the cost, and the majority of other elderly people are covered by 80% of the costs according to the general provisions of the Law on Health Insurance. Thus, the financial burden of old-age healthcare has been largely borne by the health insurance system.

In addition to health insurance, the State also provides social benefits for the elderly to support life and medical care. According to Decree 20/2021/ND-CP (amended and supplemented by Decree 76/2024/ND-CP amending and supplementing a number of articles of Decree 20/2021/ND-CP stipulating social assistance policies for social protection beneficiaries), the elderly aged 80 years and older without pensions or poor elderly people, loneliness... will be entitled to monthly social allowances in the locality. When enjoying this allowance, they are also issued a health insurance card as stated. On the other hand, the law encourages a community-based model of elderly care: if there are organisations and individuals who take care of the elderly in difficulty at home, in addition to the elderly being provided with health insurance and subsidies, the State also supports funds for caregivers. This is a humane policy that helps the elderly live in a familiar family environment while still receiving attentive medical care, thereby reducing pressure on public nursing facilities.

2.2.5. Other relevant legal provisions

In addition to the above-mentioned specialised documents, the Vietnamese legal system has many other provisions that contribute to ensuring the right to health care of the elderly indirectly, through the protection of the elderly and creating a favourable environment for their health:

- *Law on Prevention and Control of Domestic Violence 2022:* The elderly are identified as objects that need protection in the family; the law strictly prohibits acts of torturing, abusing or neglecting the elderly. The Law on Domestic Violence Prevention and Control 2022 lists acts of domestic violence, including insulting, mistreating or neglecting to take care of elderly and infirm relatives. As mentioned, Decree 141/2021/ND-CP on sanctioning administrative violations in the field of domestic violence prevention and control, and newer documents have administratively sanctioned these acts. This regulation aims to deter and prevent the elderly from being abandoned by their children and grandchildren, thereby protecting their right to care. If the act of violence is serious, the Criminal Code 2015 (amended and supplemented in 2025) has Article 185 prosecution for criminal liability for the crime of abusing and torturing grandparents, parents, etc., considering the fact that the victim is an elderly and infirm person as an aggravating circumstance to be strictly handled (imprisonment for up to 5 years)

- *Law on Persons with Disabilities 2010*: The law recognises that many elderly people will become disabled due to illness and functional impairment. The Law on Persons with Disabilities 2010, therefore, also applies to elderly people with disabilities, ensuring that they are rehabilitated, supported with assistive devices (such as wheelchairs, hearing aids, canes, etc.), and provided with appropriate healthcare services. This regulation helps the elderly reduce difficulties in mobility and living, thereby improving their health and better integrating into the community.

- *Other preferential policies:* Many specialised laws have provisions that give preference to the elderly, facilitating their health care. The Road Traffic Order and Safety 2024 stipulates that when participating in public transportation, the elderly are given priority seating. In fact, in large cities, people aged 60-70 years and older are exempt from or receive a reduced fare when riding the bus, according to local policies. The 2023 Housing Law and social housing support programs also prioritise households with elderly people who are lonely and elderly people subject to policies (such as people with meritorious services to the revolution) to improve living conditions. This indirectly helps the elderly have a safe and convenient living environment for their health (solid housing, with suitable auxiliary works for the elderly). In addition, the preferential policy for people with meritorious services to the country is also for many elderly people (war invalids, elderly sick soldiers receiving periodic health care, nursing annual health rehabilitation).

National program on healthcare for the elderly: To implement legal regulations, the Government has issued long-term action plans. Recently, the Prime Minister issued Decision No. 1579/QD-TTg dated October 13, 2020, approving the Elderly Health Care

[26] Government Office (2020), Elderly Health Care, Population Aging Adaptation,
See also at: https://vpcp.chinhphu.vn/cham-soc-suc-khoe-nguoi-cao-tuoi-thich-ung-voi-gia-hoa-dan-so-11524844.htm, accessed December 01, 2025

Program to 2030. This program sets specific goals: by 2025, at least 70% of the elderly will receive annual health checks, 95% of the elderly will have health management records (and reach 100% by 2030); striving for 100% of the elderly to have health insurance cards; 100% of provincial and municipal general hospitals have geriatric departments; 100% of commune health stations implement the health care program for the elderly. At the same time, it develops a long-term care model for the elderly, strengthens the network of nursing facilities and elderly healthcare clubs in the community, and trains human resources in gerontology[27]. These goals and solutions demonstrate the State's commitment to implementing the right to healthcare for the elderly through practical initiatives.

Vietnamese law has developed a fairly adequate framework to ensure the right to health care of the elderly. From the 2013 Constitution affirming the responsibility to respect and care for the elderly, to the Law on the Elderly 2009 detailing priority benefits for medical examination and treatment, and the Law on Health Insurance and welfare policies to help most elderly people be covered by health insurance when they are sick – all have shown the State's interest in the health of the elderly age. In addition, the provisions of the Law on Marriage and Family, the Prevention of Domestic Violence, and the Protection of Persons with Disabilities form a legal network to protect the elderly in the family and society, preventing acts of abuse or neglect of the elderly, thereby indirectly protecting their right to care. Through this comprehensive legal and policy system, Vietnam has gradually adapted to the ageing population, aiming for all elderly people to "live healthy, happy, and useful lives" under the care of their families, communities and the State.

3. DISCUSSION

3.1. Assessment of the conformity of Vietnamese law and international law on the right to health care for the elderly

The assessment of the appropriateness between Vietnamese law and international law regarding the right to healthcare for the elderly should be based on a rights-based approach, encompassing the principles of equality, substantive access, and the State's responsibility. On the basis of comparing international standards with the current legal system of Vietnam, it is possible to identify the compatibility points and gaps that need to be improved as follows:

Firstly, in terms of principles, Vietnamese law has a relatively clear level of compatibility with international standards when it jointly places the right to health within the framework of human rights and recognises the State's responsibility for ensuring this right. Starting from the Universal Declaration of Human Rights and codified in the ICESCR, it emphasises that everyone has the right to the highest achievable standard of physical and mental health, without exclusion for the elderly. At the national level, the 2013 Constitution (amended and supplemented in 2025) recognises everyone's right to health protection and care, and at the same time, constitutionally establishes the responsibility to respect, care for and promote the role of the elderly. The combination of the universal principle of the right to health and the principle for the elderly group demonstrates that Vietnamese law has adopted a similar approach to the international approach, considering the elderly as rights-bearing subjects and not just recipients of assistance.

Secondly, in terms of the content of rights and measures to ensure implementation, Vietnamese law has incorporated many important elements that are internationally recommended, especially ensuring access to services and prioritising medical examination and treatment. The Law on the Elderly in 2009 places health care as a basic need; at the same time, it stipulates priority mechanisms such as pre-medical examination and treatment for people aged 80 years and over, organising geriatric departments or arranging hospital beds for the elderly at appropriate facilities, as well as encouraging the socialisation of medical examination and treatment activities. These provisions are compatible with the spirit of the CESCR Committee's General Comment No. 6 on the national requirement to take comprehensive measures to ensure that older persons enjoy the highest standards of health, and are compatible with the orientations on age-appropriate care highlighted in documents such as the Resolution on Principles for Older Persons and international action plans on older persons.

Third, a key point of compatibility lies in the orientation of strengthening primary care, prevention, and health management within the community. International standards, particularly those established through Vienna in 1982 and Madrid in 2002, emphasise the continuity of care throughout the life cycle, prioritising prevention, screening, rehabilitation, and the development of home and community-based care services to reduce hospital overcrowding and ensure quality of life. The Law on the Elderly 2009 and its guiding documents have recognised the responsibility of grassroots health in making health monitoring records, organising periodic health check-ups, disseminating self-care knowledge, and providing medical examination and treatment at home for vulnerable elderly people. In addition, Decision 1579/QD-TTg in 2020 on the Elderly Health Care Program to 2030 sets goals to cover health management records, periodic examinations, geriatric development, and increase grassroots medical capacity. In terms of policy orientation, this is quite close to international recommendations on healthy ageing and community-based care.

Fourth, in terms of financial guarantee mechanisms, Vietnamese law demonstrates a significant level of alignment with international requirements for access to services without cost barriers. The ICESCR and related interpretations emphasise the national obligation to implement measures that make health services both available and accessible, with affordability being a key condition. The practice of ageing shows that healthcare costs increase with age, especially for individuals with chronic and multi-

[27] Government Office (2020), Elderly Health Care, Population Aging Adaptation,
See also at: https://vpcp.chinhphu.vn/cham-soc-suc-khoe-nguoi-cao-tuoi-thich-ung-voi-gia-hoa-dan-so-11524844.htm, accessed December 01, 2025

pathological diseases. Therefore, health insurance and social assistance are important tools to ensure rights. Vietnamese law, through the Law on Health Insurance and social assistance mechanisms, has significantly expanded insurance coverage for the elderly and designed preferential benefits for disadvantaged groups. This aligns with the international message that ensuring the health rights of the elderly should be integrated with welfare policies and financial risk sharing.

Fifth, however, the level of compatibility remains incomplete due to gaps in long-term care and integrated health and social care, which is at the heart of the international trend of rapidly ageing populations. International instruments, notably the Madrid 2002, consider long-term care, community-based care, hospice care, and caregiver support to be essential components of ageing health policy. Vietnam's legal framework is currently strongly reflected in the medical examination and treatment and primary care, but lacks a separate, uniform and detailed legal regime for long-term care, including service standards, licensing and accreditation mechanisms, rights of the elderly in care facilities, etc and the coordination mechanism between health, social assistance, sponsorship and rehabilitation. The lack of a unified framework makes long-term care models rely heavily on families and some socialised facilities, leading to quality disparities, difficulty in ensuring equal access, and increasing the risk of vulnerable older people being left behind.

Sixth, the gap is also reflected in the uniformity in implementation and the issue of equal access. International norms not only require the recognition of rights, but also emphasise anti-discrimination and ensure substantive access, including addressing regional, economic, gender, and vulnerability disparities. Vietnamese law already has a mechanism of prioritisation and assistance, but access to geriatric services, rehabilitation and care in the community is still affected by resource distribution, grassroots capacity, traffic conditions, as well as differences between urban and rural areas. mountainous areas. The priority of medical examination and treatment at hospitals may also be reduced if medical facilities are overloaded or do not organise the priority examination flow well, while the elderly have difficulties in travelling, waiting and communicating medically.

3.2. To propose the improvement of Vietnamese policies and laws on the right to health care for the elderly

Based on the points of compatibility and gaps identified, the improvement of policies and laws on healthcare for the elderly should aim to ensure rights in a substantive manner, in line with the rate of population ageing and the capacity of the healthcare system. Accordingly, some key recommendations can be proposed according to the following groups of solutions:

Firstly, it is necessary to establish a comprehensive legal framework to clarify the connotation of the right to healthcare for the elderly. Currently, the provisions of the Constitution and the Law on the Elderly have affirmed responsibility and outlined several important priorities, but they remain biased towards policy orientation and scattered measures. Viet Nam can amend and supplement the Law on the Elderly in the direction of clearly defining the core powers of the elderly in the field of health, including the right to access preventive services, routine check-ups, chronic disease management, rehabilitation, mental health care, etc palliative and hospice care; and emphasized the principle of equal access and no restrictions on services due to age. When the content of rights is "standardised" at the legal level, the development of programs, quality criteria and resource allocation will have a stronger legal basis, and at the same time create a foundation for monitoring and accountability mechanisms.

Second, it is necessary to develop a unified legal framework for long-term care in the spirit of international recommendations, closely linking health and social assistance. Long-term care encompasses not only medical care but also support for daily living, rehabilitation, emotional care, and caregiver assistance. Therefore, the legal framework needs to clearly define the types of long-term care services (home, community-based, in-facility), minimum conditions and standards for service providers, personnel capacity, safe care procedures, and mechanisms to protect the privacy and dignity of older people. In particular, it is necessary to clarify the rights of older people living in care facilities, including the right to information, the right to consent in medical interventions, the right to respect for privacy, the right to protection from abuse and the right to complain effectively. This framework can be institutionalised by a separate chapter in the revised Law on Older Persons or by a separate legislative/thematic text on long-term care.

Third, it is necessary to adjust financial policies and health insurance to ensure that the elderly have access to essential services. Despite high health insurance coverage, cost barriers exist for some services that seniors need on a regular basis, such as extended rehabilitation, assistive devices, home care, mental health counselling, or palliative care. The state can study expanding the benefit package to prioritise cost-effective services in the long term, such as community-based chronic disease management, early rehabilitation, and home care for the functionally impaired group to reduce hospitalisation and complications. In addition, it is necessary to design a reasonable co-payment mechanism that provides strong protection for disadvantaged groups, thereby avoiding the situation where the elderly, who are poor or reside in disadvantaged areas, have to delay treatment due to costs outside the scope of payment. If conditions allow, it is possible to study mixed financing models for long-term care, combining budgets, health insurance, social benefits and contributions according to capacity, with quality control and anti-profiteering mechanisms.

Fourth, it is necessary to improve the capacity of grassroots health and develop a community-based care network, considering this as a pillar of enforcing the health rights of the elderly in the context of rapid ageing. This requires synchronous investment in people, equipment, processes, and data. In terms of human resources, it is necessary to have a policy that trains geriatricians at all levels, while also developing skills in chronic disease management, basic rehabilitation, mental health screening, and health counselling for grassroots medical teams. In terms of data, electronic health records and elderly health management need to be

standardised and interconnected to ensure continuous monitoring, reduce test duplication, support reasonable referrals, and increase administrative efficiency. In terms of the community model, it is necessary to develop home visiting services and community-based care teams in coordination with the elderly association, volunteer networks and social organisations. Supporting caregivers in the family is also important, possibly through caregiving skills training, psychological counselling, alternative rest support, and partial cost support, in order to reduce the risk of caregiver burnout and improve the quality of care at home.

Fifth, it is necessary to strengthen the mechanism to ensure the exercise of rights in the direction of transparency, supervision and clear accountability. Firstly, it is necessary to develop a set of quality criteria for healthcare services for the elderly that applies to both medical and long-term care facilities, encompassing patient safety, abuse prevention, privacy protection, satisfaction, accessibility, and continuity of care. Next, it is necessary to establish a mechanism for inspection, information disclosure, and enforcement at an appropriate level, so that people have a basis to choose services and management agencies have a basis to handle violations. At the same time, the mechanism of complaints and legal support for the elderly should be more accessible, in accordance with the limited characteristics of physical fitness and technology; It can be through a hotline, the social work department at the hospital, or the legal representation mechanism when the elderly lose their behavioural capacity. The clear delineation of responsibilities between health, social security and local authorities in each link of the care chain will help limit the situation of scattered and pushed responsibilities, thereby increasing the effectiveness of ensuring rights in practice.

Sixth, it is necessary to strongly integrate the principles of equality and anti-discrimination according to age. This is not only a general regulation but must be concretised by professional guidance, service processes and professional attitude training. The health system should limit practices that can lead to adverse discrimination, such as downplaying the symptoms of the elderly, disrespectful communication, or restricting access to services because of age. At the same time, the policy should prioritise narrowing regional disparities by allocating resources according to needs, strengthening grassroots health in disadvantaged areas, deploying appropriate mobile and telehealth services, and supporting medical transportation when necessary. Older women, older adults with disabilities, and older adults who live alone or without caregivers also need to be identified as priority groups in intervention programs.

4. CONCLUSION

The comparison between international standards and the Vietnamese legal system reveals that Vietnam has made significant strides in ensuring the right to healthcare for the elderly. The constitutional foundation for health rights and responsibilities in caring for the elderly, together with the Law on Older Persons and health insurance policies, has created a relatively clear legal framework for prioritising access to services, primary care in the community, and financial protection against health cost risks. Targeted programs, especially those oriented towards 2030, also contribute to promoting health management, routine check-ups, and geriatric development.

However, compatibility is not complete as the demand for long-term care grows rapidly, the legal framework and financing mechanisms for this sector are inconsistent, community-based care is not developed evenly, and access disparities between regions. The income group still exists. At the same time, limitations on geriatric human resources, service quality standards and mechanisms for supervision, complaints and accountability also reduce the effectiveness of the guarantee of rights in practice. Therefore, the requirement is to continue improving the law in the direction of clearly defining the content of rights, establishing a long-term care mechanism, strengthening grassroots healthcare, expanding the coverage of essential services, and enhancing inter-sectoral coordination. These solutions will help ensure the right to healthcare for the elderly in a comprehensive, equitable, and sustainable manner as the population ages.

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