

Mental Healthcare for the Elderly in the Context of an Aging Population: Public Governance and Ai Data Gap in South Vietnam

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ABSTRACT: Population aging is placing increasing pressure on Vietnam's health, social security, and public service delivery systems. However, while recent policy discussions have focused heavily on physical care, social assistance, and economic development, the mental health of the elderly has yet to be placed as a sufficiently well-defined component of public governance, with corresponding data, indicators, and enforcement mechanisms. This paper analyzes this issue using qualitative policy-oriented documentary analysis combined with thematic analysis. Sources include standard documents from the World Health Organization, Vietnamese policy documents and official data, peer-reviewed domestic studies on depression and anxiety in the elderly, and several international overviews on service access, information systems, and inter-sectoral coordination. The results reveal four main bottlenecks: a weak specialized public data system; Mental health among the elderly has not yet emerged as a clear policy component; community services for elderly mental health care are underdeveloped; and a traceable inter-sectoral coordination chain from early detection to ongoing support has not yet been established. Based on this, the article proposes a data-governance-service integration model and the concept of “data-service coupling failure” to explain why available evidence has not yet translated into actionable public system capabilities. On a broader level, the case of Vietnam suggests an analytical logic that can be applied to middle-income countries simultaneously facing population aging, service fragmentation, and pressure for digital governance.

KEYWORDS: mental health; elderly; public governance; data governance; evidence-based policy; Vietnam.

1. INTRODUCTION

Vietnam is entering a period of population aging with a rapidly increasing number of elderly people. According to the General Statistics Office, the average population in 2025 is estimated to reach 102.3 million people and the average life expectancy will reach 74.7 years (General Statistics Office, 2026). Simultaneously, domestic policy documents and scientific discussions show that people aged 60 and over already account for over 14% of the population, and Vietnam is projected to officially become an aging nation around 2036 (Vietnam Association of the Elderly et al., 2025). This scale and speed of transition create additional pressure on the healthcare system, social security, and public policy design geared towards the elderly.

In this context, policy discussions in Vietnam are shifting strongly towards adapting to population aging, promoting the role of the elderly, and developing services suitable for this population group. Nevertheless, the majority of policy discourse still leans towards physical care, social assistance, income, long-term care, and the silver economy, while mental health has not yet been defined as a public governance issue with its own data, indicators, and enforcement mechanisms (Ministry of Justice, 2022; Politburo, 2025). In Ho Chi Minh City, scientific conference documents from 2024 show that the number of people aged 60 and over already accounts for more than 12% of the city's population and could reach approximately 20% by 2030, indicating that the need for specialized policy components for the elderly will increase rapidly in the coming years (Ho Chi Minh City Department of Health & Ho Chi Minh City Institute for Development Research, 2024).

From an international perspective, this is a notable gap. The WHO reports that approximately 14.1% of people aged 70 and over are living with a mental disorder; Simultaneously, important risk factors in later stages of the life cycle include loneliness, social isolation, abuse, functional decline, income loss, and age stigma (WHO, 2025b). Within the WHO framework, care for the elderly should not be organized around individual diseases but should be integrated, centered around individual needs and linked to social support from the primary care level (WHO, 2025a, 2025b).

In Vietnam, field evidence shows that mental health in the elderly is not a secondary topic. Community studies in Hanoi and Quang Binh recorded 7.6% of the elderly having depressive disorders (Pham et al., 2023). A study in Huong Khe, Ha Tinh recorded a depression rate of 46.9% (Dinh & Dam, 2023). A study at Can Tho University Medical Center Hospital showed that the prevalence of depression among elderly inpatients was 23.6%, with 21.7% experiencing mild depression and 1.9% experiencing severe

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depression (Nguyen, D. H. G., et al., 2024). Meanwhile, a study at the Central Geriatric Hospital showed that 61.9% of elderly inpatients had anxiety according to the Hamilton A scale (Nguyen, T. H. C., et al., 2023). A study in the Ky Anh resettlement area, Ha Tinh province in 2022 also recorded 34.4% of elderly people showing signs of depression according to GDS-15 (Pham, Q. T., et al., 2023).

The problem in Vietnam today is not the lack of evidence, but rather that the evidence remains mainly at the research level and has not yet been incorporated into the policy data infrastructure. When data is not organized according to governance logic, inter-sectoral coordination is difficult to operate stably, services are difficult to design based on risk groups, and implementation responsibilities are difficult to clearly define. This article answers the following central question: What gaps in public governance and data governance are undermining the ability to integrate mental health care for the elderly into the public policy system in Vietnam?

From that starting point, the article has three main novel points. First, it shifts the focus from describing clinical burdens to analyzing the capacity of the public system to use data to identify and manage mental health risks in the elderly. Second, it identifies a conceptualized type of disruption as data-service coupling failure, that is, a situation where evidence and data exist but do not enter into the design and operation of services. Third, it places the case of Vietnam within the broader logic of middle-income countries, where health, social security, and administrative data systems are unevenly developed.

2. OVERVIEW OF RESEARCH AND ARGUMENTATIVE BASIS

2.1. Mental Health in Older Adults as a Governance Issue

In international literature, mental health in older adults is no longer viewed as an isolated clinical issue. The WHO places it within the framework of healthy aging and integrated care, where the goal goes beyond treating illness and also aims at maintaining intrinsic capacity, functional ability, social connection, and quality of life (WHO, 2025a, 2025b). The ICOPE guidelines, second edition, emphasize early detection of cognitive decline, individualized care planning, and continuous monitoring in primary care, including in the community (WHO, 2025a). In this logic, mental health in older adults is an interdisciplinary governance issue, not purely a matter for the psychiatric specialty.

A recent body of international literature also shows that the health information system itself must be adapted to support healthy aging. A policy-practice article in the Bulletin of the World Health Organization emphasizes that health information systems serving aging need to go beyond managing isolated diseases to encompass functions, intrinsic capacity, social support, long-term care, living environment, caregivers, and health determinants (Méndez-López et al., 2026). This aligns with the argument of the current article: Vietnam's gap lies not only in services, but also in data architecture and data governance mechanisms compatible with an aging population.

In public administration, data does not inherently create operational capacity. It only becomes meaningful when it is transformed into usable indicators, and more importantly, when agencies can share those indicators in decision-making. From this perspective, the data issue here should not be understood simply as a lack of additional data. More importantly, the existing data is not yet organized in a way that supports risk identification, target stratification, and tracking intervention outcomes over time.

2.2. The Gap Between Medical Research and Public Policy in Vietnam

In Vietnam, research and policy pathways related to the elderly are developing in a relatively separate direction. One pathway focuses on social protection, legal rights, and income security for the elderly; another emphasizes population aging and policy adaptation; and yet another, within medicine and public health, studies depression, anxiety, dementia, and related factors (Ministry of Justice, 2022; Dinh & Dam, 2023; Nguyen, D. H. G., et al., 2024; Nguyen, T. H. C., et al., 2023; Pham et al., 2023). Meanwhile, policy analyses by the Ministry of Justice show that older adults in Vietnam still face economic dependence, low healthy life expectancy, high levels of poor or very poor health, and a lack of substantive support for their mental well-being (Ministry of Justice, 2022). The problem is that there is no sufficiently robust analytical framework to connect these issues into a complete policy chain, from early detection, data management, intervention design, public service delivery to outcome evaluation. This separation makes it difficult for research findings to be translated into systematic policy interventions.

This gap is further widened by the fact that the "older adult" is often treated as a homogeneous group in both research and administration. In reality, differences between older adults in urban and rural areas, between pensioners and those relying on social assistance, or between those who can still use digital technology independently and those who depend on direct support, all have significant implications for policy design. When these differences are not reflected in data design and policy, solutions easily become broad in language but low in operational capability.

2.3. Research Gaps

From verified sources, three main research gaps can be identified. First, domestic research has described the burden of depression and anxiety in the elderly, but most have only focused on epidemiological or clinical levels (Dinh & Dam, 2023; Nguyen, D. H. G., et al., 2024; Nguyen, T. H. C., et al., 2023; Pham et al., 2023; Pham, Q. T., et al., 2023). Secondly, existing policy documents have

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created an important institutional foundation for public health care and the elderly, but they do not yet clearly define the mental health of the elderly as a key policy component with its own indicators and evaluation mechanisms (Political Bureau, 2025; Ministry of Justice, 2022). Thirdly, WHO standards require integrated care and inter-sectoral coordination, while the reality in Vietnam is that policies still mainly operate through fragmented channels (WHO, 2025a, 2025b).

The core deficiency lies not in the sheer quantity of data, but in a governance structure capable of organizing, standardizing, and utilizing existing data for public decision-making. This point allows the article to move from describing the current situation to identifying institutional bottlenecks, considering data fragmentation as the root cause, while service fragmentation and inter-sectoral coordination are operational consequences of the same governance issue.

3. RESEARCH METHODOLOGY

This paper uses qualitative policy-oriented documentary analysis, combined with thematic analysis, to identify gaps in public administration and data regarding mental health care for the elderly in Vietnam. The data were deliberately selected from four groups of sources: international standard documents from the WHO; official Vietnamese policy documents and statistical sources; peer-reviewed domestic studies on depression and anxiety in the elderly; and several international review articles on service access, information systems, and inter-sectoral coordination in low- and middle-income countries.

The documents were searched between 2015 and 2026 and updated to April 2026. For international documents, searches were conducted on Scopus, Web of Science, PubMed, and Google Scholar, and compared with official WHO publications. For Vietnamese literature, the article uses sources from official policy portals, state statistical data, and peer-reviewed domestic scientific journals. A predefined keyword list and search scope were used to minimize selection bias; key search clusters included mental health of older adults, aging population, integrated care, health information systems, Vietnam, elderly depression/anxiety Vietnam, public governance, and data governance.

The literature selection process followed three steps: initial source identification, title and abstract screening, and full-text reading for relevance assessment. From 68 initially identified documents, 37 were retained after the title and abstract screening. After full-text reading and elimination of documents that did not meet the analysis criteria, 18 were retained for in-depth analysis. The article does not adhere to PRISMA standards as this is not a complete systematic review, but it maintains a controllable and traceable sampling logic.

The screening process was conducted according to four criteria. First, the source had to be highly reliable or peer-reviewed. Second, the content had to be directly relevant to at least one of the three axes: “older adults – mental health – policy/governance.” Third, the document had to contain sufficient information to draw evidence on data, institutions, or public services. Fourth, for the group of domestic field studies, priority was given to studies using standardized measurement tools or designs that could be compared across contexts. Rejected documents included mainstream articles, public consultations, studies without clear methodological descriptions, studies not using adequately standardized measurement tools, documents not directly relevant to the three axes of analysis, and unstable links.

The retention of only four field studies in Vietnam does not reflect a rejection of other studies, but stems from the objective of comparison and the requirement for methodological consistency. The selected studies all utilize standardized and comparable tools to derive evidence on the level of mental health impairment among the elderly in different contexts. Therefore, they are more suitable for identifying governance gaps than single descriptive reports or documents lacking sufficient methodological information.

The analytical unit of this paper is not individual patients or treatment facilities, but rather policy statements, data structures, service designs, and coordination mechanisms reflected in each group of documents. In terms of analytical strategy, the paper combines cross-source triangulation, pattern matching, and framework-based synthesis. Data are coded according to four themes: data and measurement; policy and institutions; public services and access; and inter-sectoral coordination. The coding process combines inductive and deductive coding: the first round identifies recurring meaningful units in the text; the second round groups these units into four main themes; The third round involves cross-referencing the topics with the WHO/ICOPE framework to identify governance gaps. Coding was performed by the author through two rounds of literature review; in cases of overlapping topics, the analysis unit was retained at the topic more directly relevant to the research question, and then cross-checked with the remaining source groups. To limit interpretive bias, the paper does not rely on a single source to conclude on a systemic gap, but only retains topics that appear repeatedly across various sources.

This approach does not aim to estimate a new national proportion or test the effectiveness of a specific intervention. Its objective is narrower: to identify recurring governance bottlenecks between research evidence, administrative data, and institutional structures. This methodological limitation also helps to define the scope of the paper's assertions at the policy analysis level, rather than at the epidemiological inference level.

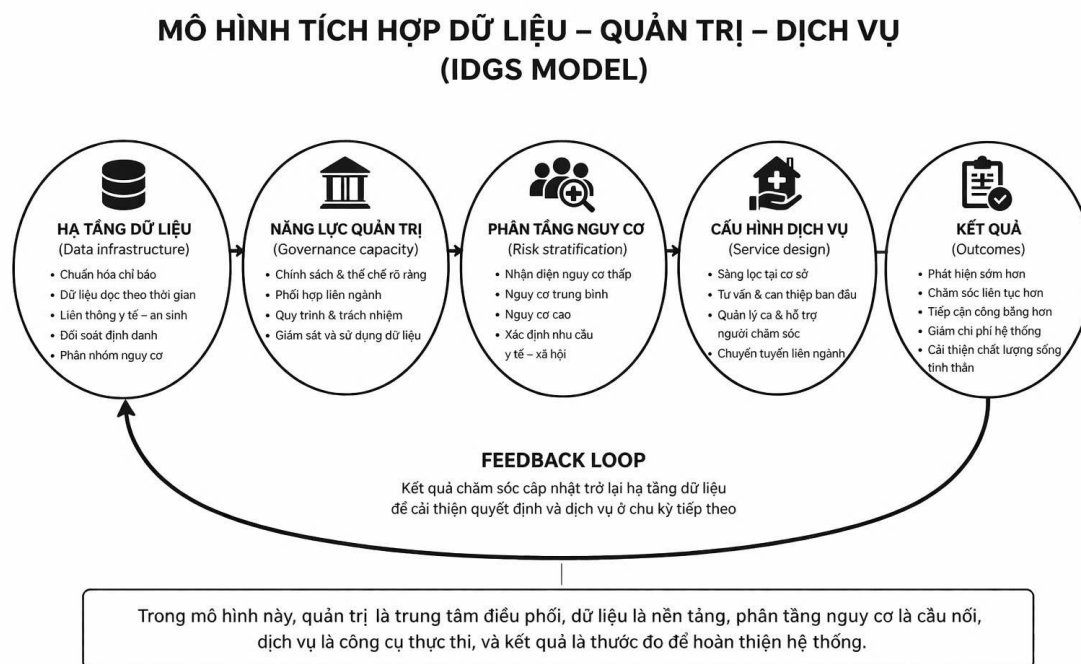


Figure 1. Data – Governance – Service Integration Model

4. RESEARCH RESULTS

4.1. Data Gap: Research evidence exists but a complete policy data infrastructure has not yet been established.

Domestic studies show that Vietnam has field evidence on depression and anxiety in the elderly, but this evidence mainly exists in the form of local surveys or clinical studies. They use relatively standardized tools such as GDS-15, GDS-30, DSM-5 or Hamilton A, but have not been standardized into a unified set of public indicators to serve policy planning (Dinh & Dam, 2023; Nguyen, D. H. G., et al., 2024; Nguyen, T. H. C., et al., 2023; Pham et al., 2023; Pham, Q. T., et al., 2023). Therefore, the current problem is not a complete lack of data, but rather the lack of a fully developed standardized, interconnected, and directly usable policy data infrastructure for planning mental health policies for the elderly.

This gap becomes even clearer when compared to WHO/ICOPE standards. ICOPE focuses on early detection of cognitive decline, continuous assessment, and the development of individualized care plans (WHO, 2025a). Meanwhile, the Vietnamese sources analyzed have not yet shown a publicly available national set of indicators specifically for depression, anxiety, loneliness, cognitive decline, caregiver burden, or access to mental health services in the elderly. More importantly, the existing data also does not allow for the classification of the population along meaningful governance axes such as urban – rural, pensioner – non-pensioner, single – living with family, or digitally independent – digitally dependent. At the same time, the current data system does not yet ensure a longitudinal timeline to track the progression from stable to mild functional decline, and then to significant disorder, making it difficult to assess the effectiveness of early interventions.

4.2. Policy gap: mental health of the elderly has not been adequately represented as a key policy component.

Resolution 72-NQ/TW of 2025 creates a very important institutional foundation for strengthening the protection, care, and improvement of people's health (Political Bureau, 2025). However, when compared with policy documents on the elderly and population aging, it can be seen that the majority of discourse still revolves around social security, physical health, legal assistance, digital transformation, and adaptation to aging (Ministry of Justice, 2022; Vietnam Association of the Elderly et al., 2025; Ho Chi Minh City Department of Health & Ho Chi Minh City Institute for Development Research, 2024). Mental health is often included in the general concept of healthcare, but is not yet clearly defined as a policy component with specific goals, targets, and implementation tools for the elderly.

This makes the issue easily shifted to the family or specialized treatment system when clear disorders appear, instead of being recognized as a regular task of public administration at the grassroots level. As a result, the gap between the general direction of public healthcare and the very specific needs of the elderly remains large. At the institutional level, this is a fundamental bottleneck: when an issue is not identified as an independent policy component, it is difficult to link it to corresponding indicators, budgets,

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coordination processes, and accountability. Simultaneously, the overlap between health and welfare approaches increases the risk of shirking responsibility at the grassroots level.

4.3. The Public Service Gap: The Paradox Between Technical Capacity and Community Implementation

The WHO emphasizes that mental health care for the elderly must be community-based, integrating health and social services and supporting caregivers (WHO, 2025a, 2025b). In Vietnam, the current system presents a "capacity paradox": although the Ministry of Health has issued in-depth technical guidelines (Decision 2058/2020 and Volume 2/2025 with 64 procedures, including the GAS scale), these tools remain primarily within the scope of clinical treatment. The gap between "professional guidance" and "community-based service organization" remains very large.

Practice in Ho Chi Minh City shows that while home visits and electronic health records have begun, mental health services are still overly "medicalized," lacking light counseling services, social support groups, and interdisciplinary case management. The bottleneck lies not in a lack of technology, but in the absence of a tiered service configuration (Stepped-care model): universal screening for low-risk groups, psychosocial intervention for medium-risk groups, and specialist case management for high-risk groups. Without this configuration, the burden of costs and psychological stress continues to accumulate at the household level, undermining the goals of the "silver economy."

4.4. Inter-sectoral coordination gap: a complete and traceable governance chain is not yet evident.

Mental health in the elderly is closely linked to income, family relationships, loneliness, abuse, chronic diseases, and access to services (WHO, 2025b). WHO therefore considers coordination between health, society, and the community as the foundation of integrated care (WHO, 2025a). Meanwhile, existing Vietnamese resources do not yet show a complete and traceable governance chain from screening, data management, referral to community support. The relevant policy pathways still largely develop through relatively separate channels: public health care, social protection, digital transformation, and population aging.

From a public administration perspective, the crucial question is not just how many elderly people suffer from depression or anxiety, but which agency detects it, where the data is stored, who is responsible for referrals, and who monitors the results after support. Without clarity in this chain, the mental health of the elderly is easily overlooked across systems. From an operational standpoint, data standardization is the starting point. Only then can problems be identified in policy, appropriate services designed, and inter-sectoral coordination organized to ensure continuous system operation. The weakest link currently lies in the interconnection between medical records and social protection records, that is, between the two "data islands" of the health sector and the labor and social affairs sector.

5. Table 1. Comparison of WHO/ICOPE standards and the situation in Vietnam.

WHO/ICOPE standards	The policy statement needs to be	The current situation as drawn from Vietnamese documents.	Management bottlenecks	Priority level
Integrated, continuous, and elder-centered care.	Coordination between health, social, and community services; individualized care planning.	Current policies tend to focus on general healthcare, welfare, and adaptation to aging; mental health for the elderly has not yet been clearly defined as a separate component.	There is a lack of an integrated model at the system level and a lack of a single point of contact responsible for coordination.	Very high
Early detection of cognitive decline and mental health problems.	Indicator set, screening process, periodic monitoring	While there is local research on depression and anxiety, it has not been standardized into a unified national set of public health indicators, and there is a lack of longitudinal data to track progress.	Lack of indicator standardization, lack of object stratification, and lack of data interoperability.	Very high
Community care and caregiver support	Counseling, social support, and community-oriented services.	The system is more evident in medical treatment and administrative assistance; community services for older adults' mental health are still limited and not yet risk-group-based.	Lack of community service configuration based on needs stratified	High
Inter-sectoral coordination	Mechanisms for data	Healthcare, social security, digital transformation, and	Lack of inter-agency	Very high

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towards aging	healthy	sharing, referral, and results evaluation.	elderly care networks remain fragmented; medical records and social welfare records are not yet interconnected.	coordination makes it impossible to trace responsibility.	
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Source: Compiled from WHO/ICOPE, national statistics agencies, official Vietnamese policy documents, and peer-reviewed domestic studies on depression and anxiety in the elderly.

6. DISCUSSION

The most important finding of the paper is that, in Vietnam, the problem lies not in the complete absence of research or policies for the elderly, but in the disconnect between research evidence, public data, policy design, and service organization. Medical studies have described the burden of depression and anxiety; the WHO has provided clear standards for integrated care; and domestic policy has a common institutional framework. The current weakness is not so much in the lack of policy declarations, but in the fact that the layers of evidence, data, policy design, and service organization have not been linked together into a traceable implementation process.

The main contribution of the paper lies in shifting the research question. Instead of continuing to ask about the prevalence of depression or what factors are involved, the paper addresses the capacity of the public system: how to detect it early, how data is organized, how services are designed, and where responsibility is allocated. This approach allows us to view the mental health of the elderly as a subject of public administration, health system governance, and data governance, rather than just a segment of clinical or public health. The novelty of the article, therefore, lies not in measuring an additional percentage, but in explaining why the public system has yet to translate available evidence into organized policy action. In this way, the concept of data-service coupling failure is used to describe a situation where data, evidence, and professional standards coexist but are not connected into a continuously functioning service for the right target group. The mechanism lies in the fact that data is not standardized into usable indicators, does not undergo risk stratification, and therefore does not shape the corresponding service design. The consequence at the system level is fragmented service delivery, weakened inter-sectoral coordination, and unverifiable care outcomes.

This gap identified in Vietnam is not an isolated phenomenon. A systematic review of low- and middle-income countries shows that community-based mental health care for the elderly can be effective in reducing depression, anxiety, and improving mental health, but the success of interventions depends heavily on the socio-cultural context and local adaptability (Giebel et al., 2022). At the same time, studies on interdisciplinary coordination in mental health care systems highlight that major obstacles often lie not in individual treatment techniques, but in the coordination, finance, and governance structures among the health, social, and community sectors (van Rensburg & Brooke-Sumner, 2023). This highlights a limitation of many existing studies: they are useful in describing services or interventions, but rarely delve into the governance structure and data architecture of the system. In this respect, the Vietnamese case has broader implications than just a national scope, as it illustrates a fairly typical difficulty faced by many ASEAN and LMIC countries in transitioning from a fragmented care model to a continuous, community-based, and data-driven model. This pattern is not unique to Vietnam but reflects a broader governance limitation in middle-income countries where health, social security, and administrative data systems are unevenly developed. Compared to more robust integrated systems, Vietnam lacks not only the technical infrastructure but also the mechanisms to link administrative data with decision-making. Therefore, international lessons can only be translated at the principle level; they are difficult to replicate verbatim.

International literature also shows that collaborative and coordinated approaches to care can improve outcomes at both the patient and provider levels in primary mental health care (Holmes & Chang, 2022). However, from the available literature, it can be asserted with relative certainty that there is data fragmentation and policy dispersion; conversely, the effectiveness of specific intervention models at the national level is still lacking sufficient evidence to draw conclusions. Therefore, Vietnam's problem does not stop at data. A greater weakness is that data has not yet been integrated into implementation coordination; consequently, services are difficult to operate continuously, and policy outcomes are difficult to verify. It can be argued that the current difficulties lie primarily in implementation rather than policy design. However, in this case, the fact that the mental health component for the elderly has not been sufficiently defined in the policy is part of the implementation failure. This interpretation also has limitations, because the relationship between data, policy, and services is not always linear; in reality, there are places where services are still deployed locally despite weak data infrastructure, or conversely, data exists but does not create significant changes in service delivery.

At the systemic level, population aging not only increases the demand for services but also forces the system to simultaneously adjust in terms of monitoring, resource creation, financing, and service delivery (Hajizadeh et al., 2025; Méndez-López et al., 2026). A unique characteristic of Vietnam is that the burden of care is still mainly absorbed within the family. Simply copying the logic of public services from countries with developed long-term care systems without considering this point will result in low operational efficiency. Therefore, data governance for older adults' mental health is not a technical addition at the edge of the system, but a necessary condition for a more stable care system to function in the context of aging. When data is not structured, interconnected,

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and accountable, the system will struggle to translate evidence into action. Furthermore, if the data does not encompass the psychological burden on caregivers within the family, the system will miss a crucial link in the support chain.

However, caution is needed when extrapolating these findings. The association between data fragmentation and service fragmentation identified in this study is primarily based on document analysis and benchmarking, and has not been tested with empirical data at the system level. Therefore, policy implications should be understood as a guideline for system design, rather than direct evidence of intervention effectiveness. In terms of scope, this paper does not aim to replace national epidemiological surveys or provide a new estimate at the national population level; its goal is to identify governance gaps based on existing evidence. This is also the main limitation of the study, and it opens the way for quantitative surveys and policy implementation research in the next phase. Beyond these limitations, this study also faces two increasingly important issues: the security of sensitive data and the digital divide in remote areas. Therefore, further research needs not only to expand the data but also to clarify the principles of data use and the application of AI in elderly care.

7. RESEARCH CONTRIBUTIONS

From the above analyses, three main contributions of the article can be drawn. First, the article shifts the focus of analysis from clinical burden to the capacity of the public system in using data to identify, stratify, and intervene early in mental health risks in the elderly. Second, the article identifies a conceptualized type of disruption as data-service coupling failure, thereby showing that data fragmentation is not only a technical problem but is also directly linked to service fragmentation and interdisciplinary coordination. Third, based on a comparison between international standards and the domestic situation, the article proposes an integrated data-governance-service model that can be used as a reference framework for research and governance reforms in the context of rapid aging.

8. POLICY IMPLICATIONS

In the short term, policy priorities should focus on establishing a core set of indicators for mental health in the elderly and integrating them into the state management data system. The minimum set of indicators should include signs of depression, anxiety, level of loneliness or social isolation, early cognitive decline, living alone, economic dependence, caregiver burden, and access to services. At the technocratic level, a shared data layer between the health and labor/social sectors could be designed, initially at the minimum data field level to synchronize identification, policy entitlement, screening status, and referral information. However, the feasibility of implementing these proposals depends directly on the digital capacity of the primary care level and the willingness to share data between agencies.

In the medium term, mental health in the elderly needs to be integrated as a specific component in the implementation of public health care policies and policies for the elderly. This does not require a parallel system, but rather clearer goals, indicators, and processes for screening, early intervention, and continuous support at the primary care level. This component also needs to be designed according to target groups: the elderly with pensions, those receiving social welfare, single-parent groups, rural groups with limited access to services, and those who are still able to use digital platforms independently cannot be addressed by the same intervention model. Financially, the payment mechanism needs to shift towards integrating mental health screening indicators into the basic health service package for the elderly at commune/ward health stations, thereby allowing health insurance and local budgets to jointly support screening, monitoring, and case management activities in the community instead of only funding treatment when the disorder is already clear.

In the long term, community public services need to be developed according to risk stratification and a clearer inter-sectoral coordination logic. Commune/ward levels can be responsible for periodic screening and initial data recording; provincial levels should maintain the role of professional organization, coordinating counseling, social support, and referral; Specialized clinics will receive cases with clear disorders or high risk. After the district-level local government ceases operations on July 1, 2025, according to Law No. 72/2025/QH15, the local coordination design needs to adhere to a two-tier structure of provincial and commune levels, instead of continuing to rely on the previous three-tier administrative assumption. To reduce institutional conflicts, a responsible data sharing mechanism is needed, ideally in the form of joint regulations or unified guidelines between health management agencies and social security agencies, clearly defining the lead unit, exploitation principles, and accountability of each entity.

Digital transformation in this field remains a necessary direction, but it cannot be separated from the overarching principle. If mental health services are developed digitally without user support, user-friendly interfaces, and accompanying mechanisms, digital policies could increase access inequality, especially among the most vulnerable elderly population. Experience in Ho Chi Minh City shows that while older adults have a certain level of digital literacy, their ability to translate this literacy into access to high-quality digital services remains limited. Therefore, digital infrastructure must be integrated with service design and user support. Within this framework, families can participate as a support channel for recording initial information about psychological changes, daily

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routines, and risk factors in older adults, using simple and user-friendly digital tools. This solution both compensates for the shortage of grassroots personnel and supports earlier detection.

9. CONCLUSION

This study shows that Vietnam's central bottleneck lies not in the complete lack of evidence on the mental health of the elderly, but in the fact that the existing evidence has not been transformed into a data structure and coordinated effectively to guide policies and services. Theoretically, the paper proposes understanding this issue as a form of data-service coupling failure in public administration. In terms of policy, it suggests that meaningful reform should not begin with expanding slogans, but with standardizing indicators, clearly defining policy components, and redesigning the inter-sectoral coordination chain. In terms of research, the propositions proposed in the paper can serve as a basis for further empirical testing in Vietnam and other middle-income countries. If the mental health of the elderly is not placed within the same data structure, policies, and services, the system will continue to be reactive, fragmented, and costly.

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