

The market sets the standard

No universal long-term care insurance. Standards are produced by state licensing, voluntary accreditation that payers treat as compulsory, and liability. This is the closer analogue for Vietnam: a privately financed market that manufactures its own trust.

HOW A STANDARD GETS ENFORCED IN THE US



HOW IT WORKS IN VIETNAM TODAY



CRITERION	THE BENCHMARK STANDARD	ENFORCED BY	VIETNAM TODAY	GAP
Right to operate	A state licence is required to run a home care agency; requirements are set state by state.	State licensing authority	General business registration only; no home-care-specific licence regime.	Structural
Caregiver qualification	Set through state licensure rules and, for Medicare-certified agencies, federal Conditions of Participation.	State rules + CMS	No national occupational code or competency standard for care workers.	Structural
Screening & vetting	Screening obligations are written into state licensure conditions.	Condition of holding a licence	Left to each provider; no common minimum.	Structural
Assessment & care plan	A written plan of care is required of Medicare-certified home health agencies.	CMS Conditions of Participation	Not required; practice varies by provider.	Wide
Quality survey	Agencies are surveyed by the state, or by an accreditor with CMS deeming authority.	ACHC · CHAP · Joint Commission	No survey body and no published standard to survey against.	Structural
The payer as gatekeeper	Accreditation is voluntary federally, but payers check for it before admitting an agency to a network; 80%+ of Medicaid beneficiaries sit in managed-care plans.	Managed-care and hospital contracts	Families buy direct; no institutional purchaser applies a credential test.	Structural
Who pays	Medicaid for those who qualify, private pay, and private LTC insurance. There is no universal LTC scheme.	Mixed public and private	Out-of-pocket, with limited government budget and health insurance.	Wide
Redress	Liability cover, licence sanction, and litigation risk.	Regulator and the courts	The service contract between family and provider, where one exists.	Wide

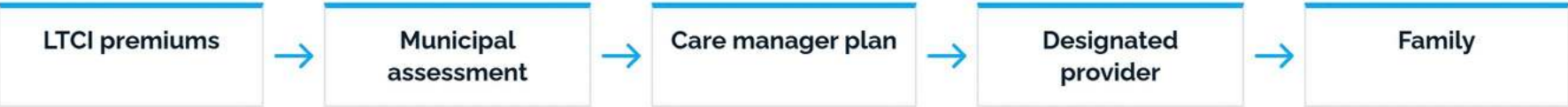


Sources. Home care agency licensure by state — Vitable Health (2026); Home care accreditation: ACHC vs CHAP vs Joint Commission — AveeCare (2026); ACHC home care accreditation; Long-term care in Viet Nam — ERIA (2021); Standardising the care economy workforce — Nhan Dan (Aug 2026). Gap ratings are a qualitative reading of the mechanism gap, not a score of individual operators.

The state sets the standard

One statutory system defines who is eligible, who assesses them, who plans their care, who is qualified to deliver it and what it costs. Consistency is high — but every part of it hangs on a compulsory insurance scheme Vietnam does not have.

HOW A STANDARD GETS ENFORCED IN JAPAN



HOW IT WORKS IN VIETNAM TODAY



CRITERION	THE BENCHMARK STANDARD	ENFORCED BY	VIETNAM TODAY	GAP
Entitlement & funding	Long-Term Care Insurance since 2000; compulsory for everyone aged 40 and over. FY2016 budget ¥9.6 trillion from premiums plus national, prefectural and municipal funds.	Statutory social insurance	No long-term care insurance. Households pay out of pocket.	Structural
Needs assessment	A municipal specialist committee assesses 74 items of daily living plus a physician's opinion, setting Preventative Support 1–2 or Care Levels 1–5; reassessed every two years.	Municipality, independent of the provider	No standard instrument. The provider that sells the care also defines the need.	Structural
Care planning	A care manager prepares the plan that unlocks services.	A defined, separate profession	No care-manager role exists; no independent planner.	Structural
Workforce qualification	A national certified care worker qualification with defined entry and progression routes.	National qualification framework	Occupational classification, code and competency standards not yet issued; a proposal is with the education ministry.	Structural
Services & pricing	Services and fees are defined inside the insurance system, so providers operate to its rules to be paid.	Payment flows through LTCI	Services and prices are unregulated and not comparable between providers.	Structural
Reach	Over 5 million people eligible (Apr 2016); 33.8m Category-1 insured at end-FY2015.	Universal entitlement by age	~4m older people had difficulty with daily activities (2015), rising to ~8m by 2039; only 36% of those needing help received it.	Structural
Who carries the load	Built explicitly as 'a system for society as a whole to support the long-term care of the elderly'.	Risk pooled across society	Family-based: 69.5% of older people lived with children (2011), down from 80% (1993).	Wide
Continuity of standard	One national system, so the standard does not change with the provider.	Single statutory framework	Standard is set provider by provider, so quality varies with whoever you hire.	Structural



Sources. Japan's Long-Term Care Insurance System — Japan Health Policy NOW; Qualifications framework for long-term care workers — ERIA (2021); Long-term care in Viet Nam — ERIA (2021); Standardising the care economy workforce — Nhan Dan (Aug 2026). Gap ratings are a qualitative reading of the mechanism gap, not a score of individual operators.

Nobody is setting the standard — so the provider is

The US shows what a **market** can enforce. Japan shows what a **state** can enforce. Vietnam has neither layer yet, which is why quality varies provider by provider rather than because operators are careless.

01 · THE THREE LAYERS OF A CARE STANDARD

	UNITED STATES	JAPAN	VIETNAM
Funding layer Who pays for care, and at what scale	PARTIAL Medicaid, private pay and private LTC insurance; no universal scheme	PRESENT Compulsory LTC insurance for everyone aged 40+	ABSENT Households pay out of pocket
Rules layer Who is qualified, how need is assessed, what a service must contain	PRESENT State licence rules and, for certified agencies, federal conditions	PRESENT National qualification, municipal assessment, care-manager plan	ABSENT No occupational code or competency standard yet issued
Enforcement layer Who checks, and what happens when a provider falls short	PRESENT State survey, accreditor survey, and payers who check the credential	PRESENT Providers operate inside the payment system to be paid	ABSENT No survey body; recourse is the private contract, where one exists

02 · WHAT ACTUALLY TRANSFERS

Borrow from the US first

Accreditation is voluntary in law and compulsory in practice, because payers refuse to contract without it. That mechanism needs no legislation — only a buyer with enough volume to insist. In Vietnam that buyer is a corporate or an insurer, not a family.

Japan is the destination, not the route

Its assessment, care-manager role and qualification framework all hang off a compulsory insurance scheme. Copy the instruments without the funder and they become paperwork nobody pays for.

The uncomfortable conclusion

Most of Vietnam's gap is structural, not operator failure. But nothing in the NOW column requires anyone's permission — which means the excuse only covers part of the distance.

03 · THE ROADMAP TO THE BENCHMARK

NOW Operators, acting alone 0–12 MONTHS	NEXT The industry, together 1–3 YEARS	LATER Policy 3–5+ YEARS
Publish a competency standard and certify against it Adopt an existing framework rather than inventing one. The GRACE programme standardised 206 trainees and trained 29 master trainers on Australian-standard methods in its first year. CLOSES: Workforce qualification	Stand up an accreditation body and a published standard A third party that surveys providers against a written standard, the role ACHC, CHAP and the Joint Commission play in the US. CLOSES: Quality survey	A licensing regime specific to home care Entry rules for operating a home care business, distinct from general business registration. CLOSES: Right to operate
Screen every caregiver, and keep the file Background and identity checks held per caregiver, producible on request for the person assigned. CLOSES: Screening & vetting	Get the occupational code issued Back the proposal already with the education ministry for a national occupational classification, code and competency standard. CLOSES: Workforce qualification	A national assessment instrument and care levels One standard way of deciding how much care a person needs, as Japan does with its 74-item assessment. CLOSES: Needs assessment
Assess before you sell, and write the plan down A home assessment and a written care plan before service starts, reviewed on a stated cycle. CLOSES: Assessment & care plan	Separate assessment from selling An independent assessor or care-manager role, so the party defining the need is not the party billing for it. CLOSES: Care planning	A funder: co-payment scheme or LTC insurance pilot Without a pooled payer, care stays a discretionary household purchase and coverage stops at what families can afford. CLOSES: Entitlement & funding
Put the promises in the contract Replacement time, supervisor ratio, 24/7 escalation route, liability cover and a complaints process — written, not implied. CLOSES: Redress	Make insurers and employers the gatekeeper Corporate and insurance purchasers demand accreditation before they buy. This is the step that makes the standard bite. CLOSES: The payer as gatekeeper	

Each action tagged with the gap it closes on Sheets 1 and 2



Sources. Home care accreditation and payer requirements — AveeCare (2026), ACHC; home care licensure by state — Vitable Health (2026); Japan's Long-Term Care Insurance System — Japan Health Policy NOW; qualifications framework for long-term care workers — ERIA (2021); Older persons and long-term care in Viet Nam — ERIA (2021); standardising the care economy workforce — Nhan Dan (Aug 2026). Timings are the author's judgement of feasibility, not a published plan.