COMMUNITY-BASED INTEGRATED APPROACH FOR

OLDER PERSONS' LONG-TERM CARE IN THAILAND

Project Members

Worawet Suwanrada
Wiraporn Pothisiri
Vipan Prachuabmoh
Siriwan Siriboon
Busarin Bangkaew
Chanettee Milintangul

College of Population Studies,
Chulalongkorn University

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Visid Prachuabmoh Building
Chulalongkorn University
Bangkok. 10330, Thailand
Tel: +66-2218-7340, +66-2218-7413
Fax: +66-2255-1469
e-mail: cpschula@chula.ac.th
URL = http://www.cps.chula.ac.th

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PREFACE

Thailand has a rapidly aging population, with the country currently ranked as the second most aged in Southeast Asia. In about two and a half decades, one in every three Thais will be 60 and above. The oldest of the old population (defined as those over 80), who are the most dependent and have the highest disability rate of any age group, is projected to increase even faster. By 2040, one in every five older people will be above 80 years old. With its economic and social development still ongoing, Thailand, unlike developed countries, is a nation "getting old before getting rich".

In Thailand, where the Buddhist principle of filial piety still prevails, most long-term care is provided informally at home by family members. However, with the demographic changes that have occurred, Thailand has started to face difficulties in providing care to its elderly citizens. As well, it is increasingly evident that there has been some shift towards formal care for a number of reasons. A decline in fertility rates and labor mobility has resulted in fewer family caregivers available to provide elder care. Advances in life expectancy means there has been a lengthening in the time spend in a condition of ill-health and disability at the later period of lives. Skilled care practitioners with additional expertise are required more and more because of the increasing complications of multiple chronic diseases. The inadequacy of the intermediate care system is found to exacerbate the need for long-term care as well.

To cope with these challenges, in 2009 the Thai government set up a working group to revise the country's second National Plan on Older Persons in Thailand (2002-2021). Based on the results from an earlier evaluation of this plan, the working group recommended, for the first time, the initiation of community-based integrated long-term elder care, where medical care would be provided, together with social care, at the recipient's home.

This project, "Community-based Integrated Approach for Older Persons' Long-term Care in Thailand", financially supported by The Toyota Foundation, was undertaken from December 1, 2013 to November 30, 2014. The project, which focused on communities where community-based integrated long-term elder care is available in four geographical regions of Thailand, has three objectives. Firstly, to propose 'best practices' for community-based integrated long-term care that appropriately address the needs of the older adults in the community and improves access to quality long-term care. Secondly, to draw up a set of guidelines and organizational models that show the alignment, connectivity and collaboration within and between the key actors involved in community-based integrated long-term elder care, such that the core essence of any recommendations can be replicated by any community

in Thailand. Thirdly, to provide lessons to be learnt from the best management practices so that communities, as well as related governmental entities, can understand the process of developing community-based integrated long-term care.

This report from the "Community-based Integrated Approach for Older Persons' Long-term Care in Thailand" project is comprised of five chapters. Chapter 1 is the introduction. In Chapter 2, why Thailand needs long-term care within the community is investigated. Chapter 3 provides an analysis and synthesis on the process of developing community-based integrated long-term elder care. Chapter 4 expresses some concerns, as well as proposes the direction for development of community-based integrated long-term elder care. The last chapter contains the conclusions that have been drawn from this project.

All project members strongly hope that this report will facilitate the arguments and debates on the development and improvement of the community-based integrated long-term elder care system in Thailand in the future. Naturally, any mistakes in this report are the responsibility of the project members.

Worawet Suwanrada, Wiraporn Pothisiri, Vipan Prachuabmoh,
Siriwan Siriboon, Busarin Bangkaew, Chanettee Milintangul

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CHAPTER

Introduction

1.1 Introduction

Thailand has a rapidly aging population, with the country currently ranked as the second most aged in Southeast Asia (Foundation of Thai Gerontology Research and Development Institute and College of Population Studies 2013). The number of older people in Thailand (defined as aged 60 and over) is projected to increase substantially from about 8.5 million in 2010 to about 22 million in 2040. In about two and a half decades, the share of older people is expected to reach 33.5 per cent of the total population, which means that one in every three Thais will be 60 and above. The oldest of the old population (defined as those over 80), who are the most dependent and have the highest disability rate of any age group, is projected to increase even faster, from about 1.1 million to 4.4 million during the same period. By 2040, one in every five older person will be above 80 years old (UN 2013).

In terms of economic development, Thailand is a good example of a nation "getting old before getting rich". Unlike developed countries, such as Japan, France and the US, Thailand has become an aging nation even while its economic and social development is still ongoing. This occurred in the year 2000 when the country's Gross Domestic Product per capita was only $2,206 (as compared with Japan which had a GDP of $12,499 when it transitioned into an aging society in 1967),[1] and a majority of the population was still predominantly rural (UN 2014) and largely engaged in the agricultural sector (FAO 2012).

Although life expectancy in Thailand has improved for both males and females, evidence suggests the depressing fact that people have survived only to suffer increasingly from advanced degenerative diseases, which has lengthened the duration spend in a condition of ill-health and disability at the later period of their lives. Recent research by Prachuabmoh and colleagues (2013) reveals that between 2002-2011, for Thailand's oldest-old people, the number of years of dependent living with functional limitation increased from 0.53 to 0.65 years for males and from 0.93 to 1.24 years for females. The research also observed that the ratio of active life expectancy to total life expectancy declined steadily with age. This information indicates that there has been a large increase in demand for long-term care services, which consequently poses a number of challenges and pressures on not only the family, but also communities and the country as a whole.

In Thailand, where the Buddhist principle of filial piety still prevails, it can be seen that most long-term care is provided informally at home by family members, especially adult daughters. However, it is increasingly evident that there has been

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1 Figures were calculated in current US dollars and obtained from the World Development Indicators Data Bank. 29 Oct 2014 <http://data.worldbank.org>.

some shift towards formal care (Suwanrada et al. 2010). This is because of a demographic transition resulting in a smaller number of children per family, together with the tendency of grown-up children to move to cities in search of job opportunities, as well as the increasing complications of multiple chronic diseases requiring the additional expertise of skilled practitioners. Nursing homes, day care centers and other forms of formal care have thus become significant sources of care for older people, especially those in higher socio-economic classes.

In addition, the current system of health care delivery is found to exacerbate the need for long-term care. At several government-run health facilities, it was found that seniors were often only provided with general practice services, usually with an inappropriate level of care for chronic diseases. Older people also tended to be discharged earlier than they were ready because beds were mostly reserved for acute care (Foundation of Thai Gerontology Research and Development Institute and College of Population Studies 2013). In this case, the elderly have tended to become an increased burden upon their families and the community.

Although the Thai government has made numerous efforts to improve the mechanisms and the quality of health care services provided to the older population, unequal access to services, insufficient quantity and quality of health resources (i.e., infrastructure, manpower and financing), and lack of coordination within and between health institutions in delivering care services still remains. In response to these problems, in 2009 the government set up a working group to revise the country's second National Plan on Older Persons (2002-2021). Based on the results from an earlier evaluation of this plan, the working group recommended, for the first time, the initiation of community-based integrated long-term elder care, where medical care would be provided, together with social care, at the recipient's home.[2]

The academic literature widely suggests that a promising approach to this issue is the integration of a unified concept of community-based elder care and long-term care, allowing for the provision of care to be driven and tailored by a community's health needs, beliefs and values (Plochg and Klazinga 2002; Huijbers 2011; Tsutsui 2014). However, this concept is relatively new in Thailand, as in many other developing countries, with the application limited mostly to rural areas. Therefore, it is not well known how communities define their long-term care, and how and to what extent community-level organizations should participate in providing long-term care. More importantly, it is unclear how community involvement fits with the existing health infrastructure, social services, and social capital. In addition to the process and function of long-term care, it is also very interesting to see the outcomes of success; for example, whether and to what extent community-based

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2 Japan International Cooperation Agency: http://www.jica.go.jp/project/thai/thailand/015/outline/index.html.

integrated long-term elder care reduces the family burden in providing informal care. All these issues warrant detailed examination and political attention.

1.2 Objectives and Expected Benefits

This project aims to propose 'best practices' for community-based integrated long-term care that appropriately address the care needs of the older adults in the community and improves access to quality long-term care. The project seeks to draw up a set of guidelines and organizational models that show the alignment, connectivity and collaboration within and between the key actors involved in community-based integrated long-term elder care, such that the core essence of any recommendations can be replicated by any community in Thailand. Moreover, the project intends to provide lessons to be learnt from the best management practices so that communities, as well as related governmental agencies, can understand the process of developing community-based integrated long-term care. As well, the challenges and problems that have been encountered by communities that have adopted best practices, and how those problems were analyzed and resolved, will be addressed.

As rapid population aging is currently occurring in a number of ASEAN countries, an increase in demand for long-term care and a shift from informal care towards formal care is undoubtedly occurring in other countries. Given that Thailand is one of the more advanced countries in terms of both population aging and economic and social development in the region, other countries will be able to learn and gain insight from Thailand's experience in developing community-based integrated long-term elder care. This will help them in designing appropriate long-term care systems for their own country.

1.3 Research Methods

This project employed various qualitative research techniques to obtain data from both primary and secondary sources and from several groups of people of interest, e.g., healthcare staff, older people and local authority staff. The following subsections describe in detail how primary and secondary data were collected.

1.3.1 Obtaining Secondary Data: Document Review

Documentary data can generally provide good official information of past occurrences. Documents were reviewed not only as a source of references, but as a key means for gathering secondary data. In order to address the targeted policy issue thoroughly, a wide range of materials from various sources were examined.

These materials include government documents, either published or unpublished, as well as care standards to guide and monitor the practice of long-term care. The investigation also included statistical reports, survey reports regarding long-term and community-based integrated care, and international agencies' reports, along with press clippings from newspapers. Literature on successes and barriers to implementation of community-based integrated care in other countries that share common culture underpinnings and family systems with Thailand, as well as Japan, the world's fastest aging society, were also consulted in order to derive evidence-based policy recommendations.

1.3.2 Obtaining Primary Data: In-depth Interviews and Focus-group Discussions

A series of in-depth interviews and focus-group discussions with staff and executives from various local agencies in communities where community-based integrated long-term care is available were conducted from November 2013-April 2014. In-depth interviews were utilized to elicit insights and perceptions from two groups of people involved in community long-term care systems: policy makers at local administrative offices and the directors of district and sub-district health promotion hospitals. Focus-group discussions were carried out to gather information from village health volunteers and older people at senior citizen centers.

All of the in-depth interviews and focus-group discussions were conducted by project members in accordance with established interview/discussion guidelines. This was to ensure that the discussions completely addressed all of the issues under investigation. To develop the interview/discussion guidelines for each group of key informants, the study adopted an issue-based questioning technique in order to maintain a consistent line of inquiry. The questions posed were predominantly open-ended and semi-structured since the intention was to gather a wide range of information that could be used to analyze how community-based integrated long-term care was conceived, developed and operated, and what contributing/hindering factors there were to the success of such care in individual localities.

1.3.2.1 Criteria and Method for Recruiting Communities

Based on a systematic review of the current state of community-based integrated long-term care in Thailand and personal discussions with government officers at the Ministry of Public Health, two criteria were established for recruiting the best-practice communities. Firstly, a best-practice community must have continuously provided effective care programs to older people in their own community. Secondly, the origin/inception of the care programs must have involved at least three key

actors: the elderly in the community, community-level health providers and local administrative units.

In addition, the project decided to employ an evidence-based approach by utilizing an existing list of 'best-practice' communities recently created by the Bureau of Health Promotion, Department of Health, Ministry of Public Health in 2012. The list includes communities for which their long-term elder care program has the following six elements:

1) Health and Activity of Daily Living (ADL) data available for the population aged 60+;
2) A senior citizen center that has passed evaluation by the Department of Health;
3) Volunteers to take care of older people in the community;
4) Home health care services provided by professional health personnel;
5) A preventive dental service in the community; and
6) A caring system for older people who are home-bounded or bedridden.

Out of the 17 'best-practices' communities listed, eight communities around the country were selected for primary data collection. The selection ensured that these communities were located in various regions so that differences in geography, culture, politics and other local setting factors could be captured.

1.3.2.2 Descriptions of the Interviews and Discussions

Details of the selected communities and primary data collection are presented in Table 1.1.

Table 1.1: Summary of Interviews and Discussions

Region	Selected Communities	Date of Visit/ Interview	Details of Key Informants
North	Tha Kwang Sub-district, Sarapee District, Chiang Mai	Nov 14, 2013	• Head of the Sub-district • Director of Tha Kwang Sub-district promotion hospital • 5 Village Health Volunteers • 5 Leaders of Senior Citizens
	Nongharn Sub-district, San Sai District, Chiang Mai	Nov 12, 2013	• Registered nurse at Paralysis Rehabilitation Center, Huey Kiang Temple • 2 Village Health Volunteers
Northeast	Tha Khon Yang Sub-district, Kantaravichai District, Mahasarakam	Mar 12, 2014	• Head of the Sub-district • Director of Tha Khon Yang Sub-district Promotion Hospital • 6 Village Health Volunteers • 6 Leaders of Senior Citizens
	Krachai Sub-district Administrative Organization, Pa Tew District, Yasothon	Mar 14, 2014	• Chief executive of the Sub-district Administrative Organization • Director of Pa Tew Sub-district Promotion Hospital • 6 Village Health Volunteers • 6 Leaders of Senior Citizens

Region	Selected Communities	Date of Visit/ Interview	Details of Key Informants
Central	Baan Chong Sub-district, Pa Nom Sarakam District, Chachoengsao	Apr 10, 2014	• Deputy Head of the Sub-district • Director of Baan Chong Sub-district Promoting Hospital • 6 Village Health Volunteers • 5 Leaders of Senior Citizens
	Samor Prue Sub-district Administrative Organization, Baan Lad District, Phetchaburi	Apr 28, 2014	• Chief executive of the Sub-district Administrative Organization • A registered nurse of Baan Lad Sub-district Promotion Hospital • 6 Village Health Volunteers • 5 Leaders of Senior Citizens
South	Baan Na Sub-district Administrative Organization, Ka Por District, Ranong	Apr 23, 2014	• Chief executive of the Sub-district Administrative Organization • Director of Baan Na Sub-district Promotion Hospital • 7 Village Health Volunteers • 6 Leaders of Senior Citizens
	Tha Kanon Sub-district, Kirirat Niyom District, Surat Thani	Apr 25, 2014	• Municipal Clerk • Director of Baan Na Sub-district Promotion Hospital • 6 Village Health Volunteers • 6 Leaders of Senior Citizens

1.4 Analytical Framework: 3-M + I

The project employed the well-known 3-M management framework to guide the analyses of the features of community-based integrated long-term elder care and the characteristics of communities where such care is available. As well, the 3-M framework was used to analyze the peripheral environment, including the political context, legal structure, financial systems, and health beliefs and value systems of the communities.

Based on the conceptual framework of 3-M – with the first M representing 'Man' – the project investigated how and to what extent the three community-based organizations –senior citizen centers, sub-district health promoting hospitals, and local administration offices – participated in long-term care. For the second M – representing 'Money' – the project explored possible sources of funding for long-term care, how long-term care has been financed, financial barriers, and how to promote the sustainability of the financial system. The third M – 'Management' – sought to understand how the above three organizations differ in organizational context, integration of culture and discipline, as well as how they cooperate and coordinate in the delivery of long-term care.

In addition to 3-M, management systems in the context of rapid globalization and advanced ICT need to include the additional component: 'I' – 'Information/Data Systems of the Community on Older Person Situations and their Needs'. This additional 'I' component is one of the most important tools for formulating a plan for appropriate long-term systems and programs, including monitoring and evaluating long-term operations, as well as revising or adjusting long-term programs and systems.

CHAPTER

Why Community-based Long-term Care is Needed

This chapter discusses the need for community-based long-term care in rapid aging societies, such as Thailand and Japan, starting with the needs and development of the community-based long-term care system in Thailand. Then, a brief discussion on the public long-term care insurance system in Japan is provided as an example for Thailand.

2.1 The Need for an Integrated Community-based Long-term Elder Care System in Thailand

As is well known, Thailand is rapidly becoming an aged society, quite similar to Japan. But the economic development and advancement of Thai society is still quite far behind Japan. The significant factors that have caused this aging situation include changes in demographics, particularly, a decrease in the fertility rate, which is now below the replacement rate. This is causing the proportion of older people to rise, especially those in the oldest group (80 years and above), who are the age group needing the most critical care and assistance, both health, economic and social. This trend, which is likely to increase very quickly, is combined with the fact that depending on one's children, as the elderly would have in the past, is become more difficult because those who are currently older had fewer children than in prior generations. In the past decade, the key issues related to the development of long-term elder care outside the family have attracted increased attention and interest. Integrated community-based care has become the alternative path for Thai society. There are four reasons why community-based care is needed: changes in the structure of families and the population; the government's vision on care for the elderly; weaknesses in the support system for elderly care for the middle class; and inequality in the accessibility to long-term care.

2.1.1 Changes in the Structure of Families and the Population and Long-term Elder Care

The latest population estimates for 2010-2040 by the National Economic and Social Development Board (NESDB) indicate that by 2028 the proportion of older people in Thailand will have increased to about one in four of the population, and by 2040, more than one in three of the total population will be considered elderly. Thai society, in the next 25 years, will have an aging structure similar to Japanese society today. Furthermore, from these population estimates, the number of mid-elderly (those aged 70-79) and the number of old-elderly (those 80 and above) will steadily increase as a proportion of the total population. This age segment of the population tends to have conditions making them more dependant than the young-elderly.

Accordingly, the need for elder care is likely to increase from the present. As noted above, the underlying factors for the changes in the age structure of the population are a decrease in the fertility rate and an increase in life expectancy. The increasing life expectancy of Thai people means that there is an increased likelihood that older people will become reliant on others for care. As well, the number of working age people and children who are the supply of caregivers is also gradual decreasing.

Furthermore, changes in households, which have gradually become smaller, and changes in the structure of households are push factors giving rise to an increased need for elder care. A study of Buathong and Suwanrada (2012), who used data from the Socio-economic Survey of the National Statistical Office from 1990 and 2009, examined the living arrangements of Thai households. They found that households that have at least one elderly person increased in number and proportion. As well, significant increases were found in the proportion of households with older people living alone, households with older people living together, households with skip generations and households with elderly staying with their children.

2.1.2 Vision of the Government with Respect to Elder Care

Government policies are another important factor that has pushed communities to put an emphasis on the duty to provide elder care. With respect to Thailand, there are clearly defined written policies stating that Thai society will use the family and community as the basis for elder care. According to the vision of the Second National Plan on Older Persons in Thailand (2002-2021):

"...The elderly are individuals who have value for society and their value should be promoted for as long as possible. But in case they fall into a condition where they must depend on others, families and communities must be first in providing support in order to allow older people to prosper and stay in the community. Government benefits should be in the form of a support system in order to provide for security to the elderly and stability of society..." (emphasis added).

2.1.3 Weaknesses in the Support System for Elder Care for the Middle Class

Knodel et al. (2013), using survey data of the elderly population in Thailand from 2011, examined the proportion of older people who received care in their daily living from caregivers and found that family members remain the primary caregivers. However, it was also found that there has been an increasing trend to hiring caregivers from outside the family to provide care for the older family member.

Knodel's research found that the highest proportion of caregivers is daughters (52 percent). Next are grandchildren, sons, son-in-law/daughter-in-law, spouse and siblings (37, 36, 35, 25 and 19 percent, respectively). With respect to people from outside the household, it was found that caregivers included companions or friends, housemaids/hired people and caregivers who were specifically retained to provide care (13, 6 and 5 percent, respectively). From these figures, it is possible to conclude the situation of elderly care today in Thailand is not that different from the vision of the government with respect to having the family be the primary unit or the first layer of the social safety net.

However, if the support system for providing elder care is examined closely, it can be seen that Thailand is still failing a portion of the system, namely the middle class (Suwanrada et al. 2009). In cases where the elderly person, who might be able to care for themselves on a certain level, is disadvantaged as a result of, for example, having been abandoned, having no caregiver, or being poor, they are able to access social welfare care in elder care centers (or nursing homes) that are under the responsibility of the Ministry of Social Development and Human Security. There are12 such sites that are under the supervision of the provincial administrative organizations. Another 11 sites are spread throughout the country. Services such as this are considered a part of the social welfare protection system and are in accordance with the government policy to use tax revenues to provide social services targeting a specific group of people.

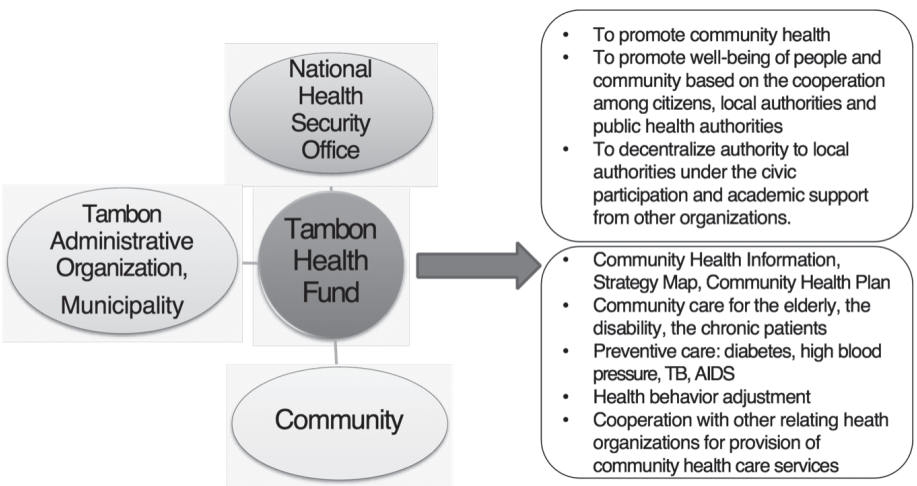
On the other hand, the elderly, or their families, who have significant means are able pay for private elderly care directly. Such private services include hired caregivers who provide home-based elderly care and/or placement of the older person in a privately run elder care facility. Two studies undertaken by Suwanrada et al. (2009) found that elder care services provided by the private sector are more expensive, no matter what type. This means that those in the middle class without a high income are not able to access these types of services. At the same time, they cannot access public social services because the amount of assets of the elderly person and their family is too high. As well, there is often concern about the quality of service in government run nursing homes. Under this current situation, where there is a lack of elder care support for the middle class, there is a particular need that should be addressed by setting up a system of elder care that will benefit those in the middle class who are not considered poor, but who do not have sufficient financial means to pay for private care services.

2.1.4 Accessibility of Long-term Care at the Local Level: Divided Development

At the local level, arrangements for elder care services have started to appear more and more, including arranging sources of funding, especially for volunteers who support elderly care in various ways. For example, the Project of Friends Helping Friends run by senior citizen centers, started in 2008, combines preventative care and health promotion for members in the community. As well, village health volunteers and elderly home care volunteers, started in 2003 in some localities, have now spread to every local administrative unit throughout the country. The operations of the village health volunteers are under the supervision of the Ministry of Public Health. The operations of the elderly home care volunteers were under the supervision of Ministry of Social Development and Human Security at the beginning, but have now been transferred to the local administrative units.

In addition, the Sub-district Health Fund, established in 2006, was expanded throughout the country in 2011. The Sub-district Health Fund arose from the cooperation between three entities: the National Health Security Office (NHSO), local governments (municipalities/sub-district administrative organizations) and communities, all of which jointly contribute funds. The activities funded under the auspicious of the Sub-district Health Fund include health promotion, prevention and well-being at the local level for community-based elder care.

Figure 2.1: The Initiation and Aims of the Sub-district Health Fund



However, examination of elder care on the local level using the assessment of the geriatric works conducting under the Second National Plan on Older Persons in Thailand (2002-2021), Round II, from the research efforts of Prachuabmoh et al. (2013, cited in Suwanrada and Tsuji 2014), indicates that only 60 percent of the sub-district administrative ± provide at least one activity related to elder care. Some organizations place an emphasis on health care, while others focus on social care. Accordingly, even though the locally basis elder care system shows development on one level, given the emergence of a wide variety of entities that have been recently set up, the system is still in the early stage of development and further in-depth research on integration of elder care occurring at the local level needs to be undertaken.

2.2 The Long-term Care System in Japan

Before the year 2000, long-term care in Japan, for the most part, was provided by family members. However, in some case, older people would be placed in the hospital, even if they were not ill or suffering from some debilitating condition. This was done because the elderly person could use their health insurance, which made the cost of such hospital care quite inexpensive, particularly as compared to placing them in a nursing facility. Placing older people with no special medical needs directly in the hospital in order to take advantage of the health insurance system created problems, such as a shortage of beds for patients with true medical needs, and was one of the reasons for the significant increase in health care costs to the government. In addition, admitting elderly people to the hospital, instead of placing them in a nursing home or elderly care facility, meant that the family could avoid criticism by their neighbors. This situation has been called "Social Hospitalization". Furthermore, sometimes care that is provided by the family results in problems and issues because the family does not necessarily have sufficient knowledge and understanding regarding proper elder care. As well, there are often limitations on the technical manner in providing care because the duty to look after the older family member mostly falls on the daughter-in-law in the family. All of this led to many problems with the system of family-based elder care.

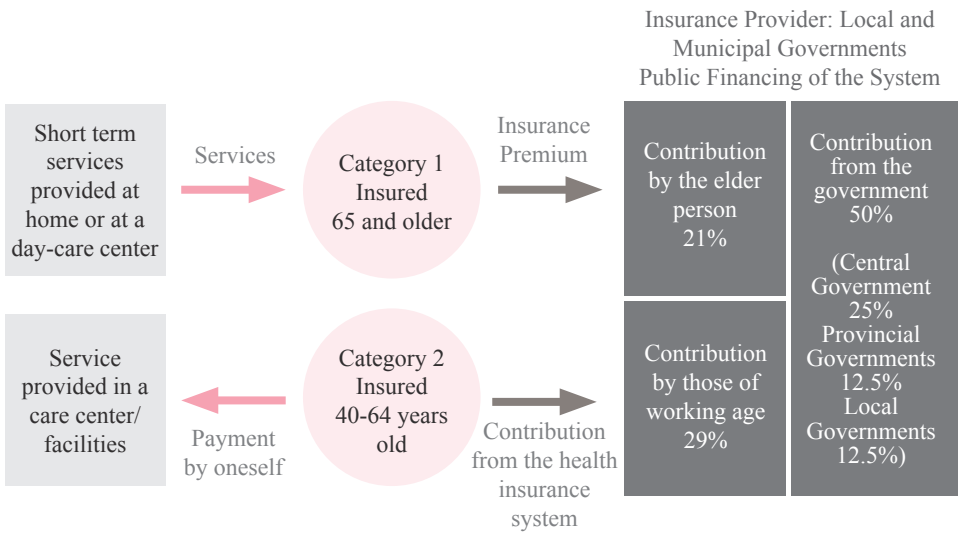
Therefore, in 2000, the Japanese government started a long-term elder care system under the social insurance scheme, the Long Term Care Insurance *(Kaigo Hoken Seido)*. There were four important reasons for taking this action: 1) to allow the system to support older people who need long-term care on a daily basis; 2) so that the social insurance system would have clearly defined and unambiguous benefits and financial responsibilities of the insured, which are also acceptable to the public; 3) in order to create a diversity of long-term care providers and allow the people who receive service the ability to choose their service provider freely; and 4) in

order to separate long-term elder care from the system of health insurance (Suwanrada et al. 2010).

2.2.1 The Overall Picture of the Long-term Health Care Insurance System in Japan

Figure 2.2 shows the overall picture of the long-term care insurance system in Japan. The important features of this system are that each local and municipal government *(Shijouson, Tokubetsu Ku)* is the insurer, with the insured being all those 40 years and older. Those 65 and older are defined as "Category 1 Insured" and those between 40-64 years old are defined as "Category 2 Insured". Data from the Welfare and Labor White Paper 2012 indicates that in 2012, there were 29.07 million Category 1 Insured and 42.63 million Category 2 Insured (Ministry of Health Welfare and Labor 2012).

Figure 2.2: The Overall Picture of the Long-term Health Care Insurance System in Japan



Source: Figure 5.1 in Suwanrada et al. (2010), with additional information from the Ministry of Health Welfare and Labor (2012).

Category 1 Insured pay their insurance premiums directly to the local government or can have the payment cut from their monthly pension. Today, about 90 percent of Category 1 Insured have their insurance premium cut from their pensions. As for Category 2 Insured, since they are still working, they pay their long-term care insurance premiums, together with their regular health insurance premiums, to the health insurance system in which they participate. Their long-term care insurance premiums are then transferred to the national entity *(Shakaihoken Shinryou Houshuu Shiharai Kikin)* and that governmental entity will apportion the insurance premium to the local government where the insured lives. In addition to the insurance premiums, which are a significant source of the funds for the long-term care insurance system, the other important source of funds is the contribution from the national government, the provincial governments and the local governments. Today, the proportion of the system funded by insurance premiums is about 50 percent of the total amount; Category 1 Insured contribute 21 percent and Category 2 Insured contribute 29 percent. The national government funds 25 percent, with the provincial and local governments funding 12.5 percent each of the total funding of the system (Ministry of Health Welfare and Labor 2012).

With respect to the collection of insurance premiums from the Category 1 Insured (the elderly), the insurance premium is set based on the insured's ability to pay or their economic status. Each local government will establish a base insurance premium, which is a fixed amount. The insurance premium that will be paid is adjusted according to the economic situation of the insured, which is subject to review based on the local tax burden of the insured, and for those who receive welfare benefits (impoverished families). If they have the ability to bear the tax burden, their contribution will increase accordingly or, if they already receive welfare benefits, the amount of contribution will be reduced.

In 2000, which was the first year of this new public long-term care insurance system, the local governments set the basic contribution by themselves according to the local situation. In 2000, the basic monthly contribution averaged around 2,000 yen. Today, this has increased to about 4,090 yen. Generally, for localities and municipal areas with large, dense populations, the people pay a lower insurance premium (Suwanrada et al. 2010).

Today, for Category 1 Insured, there are six levels of insurance premiums based on the insured's level of income. As can be seen in Table 2.1, 2.7 percent of Category 1 Insured pay insurance premiums at Level 1 (the lowest level). Level 2 covers about 17.0 percent, with 13.2 percent at Level 3, 30.2 percent at Level 4 (the basic insurance premium level), 21.1 percent at Level 5 and 15.8 percent at Level 6. As for Category 2 Insured, the contribution is increased according to the health insurance system in which the insured is a member. In the instance where they are a member of the national health insurance system, the contribution is split into two parts: the

fixed amount (with an amount equal to everyone else) and the amount based on their income. In the case of membership in other health insurance systems, the contribution is calculated based on a standard base income multiplied by the rate of contribution (Ministry of Health Welfare and Labor 2012).

Table 2.1: Level of Insurance Premium for Category 1 Insured

Level	Target Group	Level of Insurance Premium	Distribution of Insured
Level 1	• Those receiving welfare payments *(Seikatsu Hogo)*. • Those in households that do not pay local tax and receive elderly welfare pensions.	Base premium X 0.5	2.7%
Level 2	Those in households who do not pay local tax. (Combined income of the household together with pension not exceeding 800,000 yen per year.)	Base premium X 0.5	17.0%
Level 3	Those in households who do not pay local tax, but not included in Level 2.	Base premium X 0.75	13.2%
Level 4	Those who do not have to pay local tax.	Base premium X 1.0	30.2%
Level 5	Those who pay local tax not exceeding a set amount. (Income of the insured is not above 1.9 million yen per year.)	Base premium X 1.25	21.1%
Level 6	Those who pay local tax above a set amount. (Income of the insured is above 1.9 million yet per year.)	Base premium X 1.5	15.8%

Source: Suwanrada et al. (2010), as adjusted with data from the Ministry of Health Welfare and Labor (2012).

2.2.2 Receiving Care under the Long-term Care Insurance System in Japan

With respect to those who are in need of dependent care, the physical and mental conditions of the insured must be evaluated before they can receive service. This includes a review of their files, as well as examination by a doctor and consideration by a committee. When they go for service, a care plan *(Kaigo Sabisu Keikaku)* will be created before care is begun.

Those who are in need of care are subject to evaluation and assignment to one of three groups: 1) those who do not need any extra support or assistance; 2) those who are in need of some level of care and support *(You Shi-en Sha)*, who are further assigned to one of two sub-groups; and 3) those who are in need of immediate attention and care *(You Kaigo Sha)*, who are further assigned to one of five sub-groups. In 2011, there were 29,069,219 Category 1 Insured, of whom 5,075,610 had been assessed and approved for assistance and care, or about 17.5 percent of the Category 1 Insured. As for the elderly assessed and approved for assistance and care under Group 2, 13.1 percent of the total Category I Insured were assigned to Level 1 and 13.2 percent to Level 2. As for Group 3, 17.9 percent were assigned to Level 1, 17.7 percent were assigned to Level 2, 13.8 percent were assigned to Level 3, 12.6 percent were assigned to Level 4 and 11.7 percent were assigned to Level 5. Of those who had been assessed and obtained approval to receive care, 82.3 percent received some type of care, 73.3 percent of which received care at home, 6.5 percent received community care, and 20.2 percent received institutional care.

A Care Manager will be assigned to help formulate a plan of care appropriate to the needs of the insured person based on the results of the assessment. The type and level of benefits they can receive will be assigned according to the assessment of their needs. The results of the assessment of their level of needs for care will also determine the form and manner in which the elderly person will be able to receive care from the long-term care insurance system, the amount to be received and the amount of monthly benefits. The care that can be received from the long-term care insurance system can cover home-care *(Zaitaku Sabisu)*, institutionalized care and participation in preventive care programs.

Home-care covers: home visits; assistance with bathing; rehabilitation services; rehabilitation at an elderly day care facility; advice regarding health and hygiene from a doctor; overnight or temporary care at an elderly care center (day care or short-term stay); and borrowing or assistance in arranging for the purchase of various equipment and/or renovation of their home in order to make their residence more elder friendly. With respect to the level of benefits under the long-term care

system available for those with care and assistance needs, such as those who receive home-care services *(Zaitaku Sabisu)*, there is a ceiling of service that they can receive, as detailed in Table 2.2. Each 'unit' has a value of between 10-11.26 yen, depending on the local area. Any amount above this will be the responsibility of the insured. Care services can be obtained from any of a variety of care centers.

Table 2.2: Level of Need With Respect to the Condition of Older People

Level of Need	Condition of the Older Person	Ceiling of Service Available
Elderly who are in need of some level of care and support, Level 1.	Able to go to the toilet/eat food by themselves, but need assistance in some of their daily living.	4,970 units per month
Elderly who are in need of some level of care and support, Level 2.	Need assistance and are ill or injured.	10,400 units per month
Elderly who are in need of immediate attention and care, Level 1 (general care).	Need assistance with daily and instrumental activities / reduced cognitive skills.	16,580 units per month
Elderly who are in need of immediate attention and care, Level 2 (limited care).	Need assistance with daily and instrumental activities / impaired mobility / reduced cognitive skills.	19,480 units per month
Elder who are in need of immediate attention and care, Level 3 (moderate care).	Need assistance with daily and instrumental activities / impaired mobility / have irregular bowel movements / suffer from diminished cognitive skills.	26,750 units per month

Level of Need	Condition of the Older Person	Ceiling of Service Available
Elderly who are in need of immediate attention and care, Level 4 (intensive care).	Need assistance with daily and instrumental activities / limited or no mobility / nearly unable to move their bowels / impaired cognitive skills.	30,600 units per month
Elderly who are in need of immediate attention and care, Level 5 (critical care).	Need assistance with daily and instrumental activities / no mobility / nearly unable to move their bowels or eat on their own / impaired cognitive skills.	35,830 units per month

Source: Suwanrada et.al. (2010), as adjusted with information from the Ministry of Health Welfare and Labor (2012).

With respect to receiving care in a care facility, those receiving such services are responsible for 10 percent of the expense, other than the cost of accommodations and food, which they must pay by themselves in full. In cases where the 10 percent payment is very large, assistance will be provided according to their financial situation as determined by the local tax that the insured has paid and whether they receive income assistance (low income households), similar to how insurance premiums are calculated

In the case of those who do not pass the assessment that they are in need of assistance or care, a category of service called the **"Area-based Support Program"** under the long-term care insurance system in Japan has been established. This program organizes preventative care activities of various kinds to help elderly people who are at risk of falling into a state of needing long-term care in the future. The Area-based Support Program is managed by the local governments. The program has three parts: **1) The Long-term and Preventive Care Program,** a program set up by the local governments, is comprised of health related activities, transportation services to care centers, home-based long-term preventive care, distribution of information about preventative care, and support of preventative care of other types; **2) The Management of the Long-term Care Insurance System Support Program** covers advice and advocacy for the elderly, and manages the overall system for sustainability of the long-term care system; and **3) Volunteer Programs** provided by local governments.

2.2.3 Types of Care

Based on data from the Ministry of Health Welfare and Labor (2012), Japan has many types of care for the elderly, including home-based care, institutional care, and community-based care, as set forth in Figure 2.3. At the same time, there are other services, with the primary objective being preventive care.

Figure 2.3: General Picture of Care Services Under the Long-term Care Insurance System in Japan

HOME-BASED CARE
- Home Visit
- Home Visit for Bathing Support
- Home Visit for Nursing
- Home Visit for Rehabilitation
- Home Visit for Recuperation Advises
- Day Care Services in Facilities
- Short Stay Care in Facilities
- Short Stay Care in Facilities for Recuperation
- Care in Special Facilities
- Lending Services of Welfare/Care Equipment
- Special Welfare/Care Equipment' Sale Services

COMMUNITY-BASED CARE
- Regular Patrol Services
- At-any-time Home Visit
- At-any-time Home Visit for Care/ Nursing
- Night-time Home Visit
- Day Care Facilities for Dementia Patients
- Small-multifunctional Home Care Services
- Group Home for Dementia Patients
- Care in Community-based Elderly Welfare Facilities
- Care in Community-based Elderly Welfare/Care Facilities

INSTITUTIONAL CARE
- Institutional Care in Elderly Welfare Facilities
- Institutional Care in Elderly Care Facilities
- Institutional Care in Medical Facilities for Recuperation

OTHER TYPES OF CARE
- Subsidization on Home Renovation Expenses

PREVENTIVE CARE
- Preventive Care Services
- Community-based Preventive Care Services

Source: Ministry of Health Welfare and Labor (2012)

Other than these various types of long-term care for the elderly, many entities have been set up to provide care under the long-term care insurance system. Such entities include local governments, social welfare corporations, medical clinic corporations, foundations and incorporated associations, cooperatives, non-governmental organizations, and special non-profit corporations (NPO). The "Survey of Service Facilities and Care Service Providing Establishments in 2013" undertaken by the Ministry of Health Labor and Welfare found the distribution of service facilities and care giving establishments, as set forth in Table 2.3. This survey indicates that generally service facilities and care giving establishments are for-profit establishments, other than some types, for example, short stay care facilities, which are typically social welfare corporations or service facilities, such as day care facilities for dementia patients. As well, care prevention support business operators, for the most part, are social welfare corporations. In addition, local governments have established various services, but these are not a large proportion, other than those that are primarily care prevention support business operators. Specified non-profit corporations (NPOs) have the responsibility to provide community-based services.

Table 2.3: Services and Care Service Providing Establishments in 2013

Type of Organization / Type of Service	Total	Local	Japan Red Cross/ Social Insurance Affiliate	Social welfare corporation	Medical corporation	Foundation/ Incorporated Association	Cooperative	For Profit Corporation	Special Non Profit Corporation (NPO)	Others
HOME-BASED CARE										
(Home Visit Type)										
Home Visit	100.0	0.4	-	20.0	6.1	1.2	2.7	64.0	5.3	0.4
Home Visit for Bathing Support	100.0	0.5	-	37.3	1.9	0.8	0.5	58.3	0.6	0.0
Visiting Nurse Station	100.0	2.9	2.5	8.0	34.7	11.3	3.1	35.3	1.8	0.4
(Outpatient Type)										
Day Care	100.0	0.8	-	29.0	6.6	0.7	1.6	56.3	4.6	0.4
Day Care for Rehabilitation	100.0	3.1	1.4	9.3	76.5	2.9	-	0.0	-	6.8

Type of Organization / Type of Service	Total	Local	Japan Red Cross/ Social Insurance Affiliate	Social welfare corporation	Medical corporation	Foundation/ Incorporated Association	Cooperative	For Profit Corporation	Special Non Profit Corporation (NPO)	Others
(Other Types)										
Short Stay Care Facilities	100.0	2.8	-	81.7	3.8	0.1	0.4	10.6	0.5	0.1
Short Stay (Recuperation)	100.0	4.1	1.7	11.6	76.9	2.9	-	-	-	2.8
Special Facilities for Care	100.0	1.0	-	24.1	4.9	0.6	0.3	67.9	0.5	0.7
Care Equipments Lending	100.0	0.1	-	2.4	1.3	0.3	1.9	93.0	0.6	0.4
Special Care Equipments Sales	100.0	0.0	-	1.5	0.9	0.2	1.8	94.6	0.6	0.3
COMMUNITY-BASED CARE										
Regular Patrol Services	100.0	-	-	28.1	14.9	2.6	2.2	49.6	2.6	-
Night-time Home Visit	100.0	0.7	-	28.1	12.9	2.9	0.7	51.8	2.9	-
Day Care Facilities for Dementia Patients	100.0	0.5	-	46.7	12.1	1.0	1.5	31.7	6.3	0.2

Type of Organization / Type of Service	Total	Local	Japan Red Cross/ Social Insurance Affiliate	Social welfare corporation	Medical corporation	Foundation/ Incorporated Association	Cooperative	For Profit Corporation	Special Non Profit Corporation (NPO)	Others
Small-multifunctional Home Care Services	100.0	0.1	-	31.2	13.1	0.8	1.7	45.8	7.0	0.4
Group Home for Dementia Patients	100.0	0.1	-	23.8	17.3	0.4	0.5	53.1	4.7	0.2
Community-based Elderly Care Facilities	100.0	-	-	31.1	13.9	0.8	0.4	51.3	2.5	-
Complex-Type Services	100.0	-	-	9.7	32.3	4.8	1.6	43.5	8.1	-
Community-based Elderly Welfare Facilities	100.0	8.8	-	91.2	-	-	-	-	-	-
Care prevention support business operators	100.0	29.0	-	51.9	12.4	3.6	0.9	1.6	0.5	0.1
Home Care Support Office	100.0	1.0	-	25.9	16.5	2.6	2.6	47.3	3.4	0.5

Source: "Survey of Service Facilities and Care Services Providing Establishments in 2013" *(Kaigo Sabisu Shisetsu – Jigyousho Chousa)*, Ministry of Health Welfare and Labor (2013), Japan.

CHAPTER

The Process of Developing Community-based Integrated Long-term Care

This chapter presents results derived from information regarding the best practices for community-based integrated long-term care from eight prototype communities in seven provinces of several regions in Thailand: 1) Sarapee District, Chiang Mai, 2) San Sai District, Chiang Mai, 3) Kantaravichai District, Mahasarakam, 4) Pa Tew District, Yasothon, 5) Pa Nom Sarakam District, Chachoengsao, 6) Baan Lad District, Phetchaburi, 7) Ka Por District, Ranong and 8) Kirirat Niyom District, Surat Thani. The project identified the processes and factors comprising the best practices for community-based integrated long-term care covering two essential areas:

1. An awareness of the need to arrange for long-term care for the elderly within the community; and
2. The factors needed to arrange for long-term elder care in the community

3.1 An Awareness of the Need to Arrange for Long-term Care for the Elderly within the Community

From the eight best-practice prototype areas studied, it was found that success in providing community-based integrated long-term elder care started from community members who have a mutual awareness of the need to providing care for older people. Such awareness is comprised of many factors, including demographic, economic, health, and social and cultural.

3.1.1 Demographic Factors

In every area studied, the project found that community members are fully aware that the number and proportion of older people is increasing. Data from some areas indicates that the proportion of the elderly population is as high as 19% of the total population. In addition, currently there is a trend for older community members to live longer, thus the number of elderly will only increase in the future, likely resulting in an increase in elderly who are bedridden. Furthermore, people are generally having fewer children; therefore, there are going to be fewer family members to take care of older members in the future. Finally, the government has continuing limitations on both the amount of budget that can be allocated and personnel that can be assigned for care of the elderly. Therefore, a network of community volunteers needs to become more involved.

3.1.2 Economic Factors

Many older people in the community are disadvantaged and poor. Furthermore, there are many people now engaged in the non-agricultural sector of the economy

which means that many family members work away from the house during the day or are employed far away from home. Therefore, the community needs to help take care of the elderly, both in terms of daily living and healthcare.

3.1.3 Health Factors

Many elderly people with chronic health problems, including those who are depended, disabled or bedridden, have limited access to healthcare and medical treatment. Even though there may be medical care in the form of home visits from hospital personnel after the elderly has been discharged from the hospital, the number of professional caregivers is quite limited and they often have to rotate to other areas. Therefore, health authorities and local public health volunteers need to help take care of patients and provide advice and information to relatives or casual caregivers. Older people with chronic diseases need continuous and close special care, in addition to their general healthcare needs, and it should not be left to their children or relatives to take care of them "according to their means".

3.1.4 Social and Culture Factors

At both the micro level, the local community, and at the macro level, national policy and regulations, community awareness regarding the need to arrange for long-term care for the elderly can be raised. At the local community level, family and kinship systems are a sort of socialization training, similar to an 'internal control' that cultivates the young to respect, listen to, help and show gratitude toward older people. In this regard, there are many pronouns in the Thai language that refer to relatives in the family, such as grandfather, grandmother, uncle, aunt, brother and sister, which are also used by Thai people to refer to non-relatives. This indicates that other people, who do not necessarily have blood lineage, are considered a sort of family relation. Therefore, in rural Thai society, people tend to help others because they tend to consider other people as their own family.

There is also an 'external control' mechanism in the form of social sanctions on people who neglect others or do not help people in distress, especially the elderly or people who are suffering or are poor. Accordingly, there are many ways help is provided to older people by community members, including donation of equipment, such as wheelchairs, beds, walking sticks, and walkers. When such items are no longer needed, or an older person has passed away, family members will donate them to others, resulting in a rotation of the equipment for the elderly who have health problems, which also helps reduce expenses.

In addition, lifestyle and local culture also plays a key role in creating values and guidelines for supporting and caring for the elderly. This can be seen through many

traditions, such as paying respect and showing appreciation to older people during the Songkran festival, the Thai traditional New Year. In addition, the *Suep Chata* ritual practiced in the northern part of Thailand is a religious ceremony held for the elderly to have a long life and be healthy. As well, there is the *Tan Tot* tradition, which is a way to help take care of the poor and the disadvantaged, who are mostly older people. The community gathers to consider the people who should be given some assistance. They will then bring food and necessary items to such person's home, but the recipient will not feel ashamed as they do not ask for such things. Therefore, the *Tan Tot* tradition is the basis for creating a sense of charitableness among the people in the community and leads to such activities as Project of Friends Helping Friends, which senior citizens centers have established as a support mechanism among the elderly.

At the macro level, taking care of the elderly is considered to be one of norms of society based on three important factors: reciprocity, equality and social responsibility (Schulz 1990). The national government has clearly established the role and responsibility of families and communities in providing care of older people in Second National Plan on the Elderly in Thailand (2002-2021) (Revision 1 of 2009). This includes the requirement that the Ministry of Social Development and Human Security be responsible for the welfare and support of elderly people, including promulgating regulations and legal provisions requiring that the local administrative units, both in the city and in the rural areas, such as municipalities and sub-district administration organizations, be responsible for taking care of the older people in their area, particularly with respect to the promotion of quality of life (Laothammathat 2000).

3.2 The Factors Needed to Arrange for Long-term Elderly Care in the Community

The project used the well-known management concept of 3-M to analyze the features of community-based integrated long-term care, as well as the characteristics of the localities where community-based integrated long-term care is currently available, including the peripheral environment, the political contexts, legal structures and financial systems. Based on the conceptual framework of 3-M, with the first 'M' representing 'Man,' the project investigated how and to what extent the three community-based entities – senior citizen centers, sub-district health-promoting hospitals, and sub-district administration organizations – participate in long-term elder care. For the second 'M', which represents 'Money,' the project explored the possible sources of funding for long-term care, how long-term care is financed, and any financial barriers. For the last 'M', 'Management,' the collaborative structure

among the three community-based entities was reviewed. As well, relevant mandatory regulations were investigated.

3.2.1 Man

Man is the first factor that impacts the success of the community-based integrated long-term elder care. Direct stakeholders in providing care for the elderly at the community level include three entities: senior citizen centers, sub-district health-promoting hospitals and sub-district administration organizations. The origin and significant roles of each entity is as follows:

1. Senior citizen centers, which are currently well known, are gathering places for the elderly to develop themselves and the community in the form of a social network at the local level. The centers belong to the elderly, are run by the elderly and are for the benefit of the elderly with regulations, physical locations and separate funds. The activities of the centers are mainly arranged according to the demands and interests of the members. The first senior citizen centers were established in Thailand on December 20, 1962 (formerly called a senior citizen assembly) by Neuroscience Research Foundation Under Royal Patronage of H.M. The King, Nervous System, Phaya Thai Hospital and were based on the concept of Professor Doctor Prasop Ratanakorn (Daranee 1997; Utawichai 1996). However, their operation was quite limited. Senior citizen centers started to be more widespread in 1982 when the Ministry of Interior ordered provincial governors to establish senior citizen centers at the regional level (Malinee Wongsit and Siriwan Siriboon, 1994). In 2008, according to the Thailand Council of Senior Citizens, there were 19,475 senior citizen centers, although, in fact, there is likely more centers as many have been unofficially established and are under the support or supervision of other organizations (Councils of the Elderly of Thailand 2008).

Senior citizen centers operate under the Project of Friends Helping Friends. The older people in the community, who are still capable and strong, will arrange home visits to help take care of those elderly who are in need because of their economic, social and health condition. A rotation is set up for providing care, especially for those who live near each other. The activities cover both checking physical health, such as measuring blood pressure, and reviewing health conditions, such as food, diet and exercise, along with monitoring mental health by talking and being a companion. As for recreation, the centers organize music, folk art, handcrafts, planting, traveling, etc., as well as income generating activities, such as basketry and handcrafts for sales. The centers will also help to arrange the home environment to be more elder friendly, such as organizing their bedroom to be bright, with good ventilation, installing handrails in the bathroom, change squat toilets to sitting toilets, or adjusting stair railings and slopes. Senior citizen centers will arrange to have representatives in each village coordinate or make referrals when the elderly

in the community has a problem or needs help through the village health volunteers, the personnel of the sub-district health promotion hospitals and the personnel of the sub-district administration organizations.

In addition, the study found that in many areas, senior citizen centers collect data on the elderly that is used to resolve problems, as well as to initiate activities to help others. Activities concerning physical and mental health will be handled with the sub-district health promotion hospitals, with the elderly as the essential participant in formulating and setting up activities and the sub-district health promotion hospitals acting as consultants. Some areas have volunteer projects to take care of older people near the end of their lives to help make them proud of themselves and feel a sense of worth. In other areas, senior citizen centers have set up funds to support their members when they experience problems.

The operations of the senior citizen centers focus on building networks for long-term care comprised of various authorities and volunteer groups, such as village health volunteers, the elderly home care volunteers, sub-district health promotion hospitals and sub-district administration organizations.

2. Sub-district health promotion hospitals are government authorities at the primary care unit level under the control of the Department of Health, Ministry of Public Health. Their key role is to prevent disease, as well as promote and restore health. These hospitals are considered government health authorities that provide health services closest to the community. In addition to having government officers who are responsible for the hospital operations, the Ministry of Public Health also arranges for village health volunteers, who are community members trained by the sub-district health promotion hospitals, to provide primary, first-stage health care to the people in the community and, in cases where a situation is beyond the capability of the village health volunteer, to refer the elderly person to the hospital.

One of the key roles of the sub-district health promotion hospitals regarding providing care for the elderly is to create a database of elderly people. Coordinating and working closely with professional nurses, physical therapists and occupational therapists at the community hospitals using Activity Daily Living (ADL), the elderly are classified into three groups, color coded as green, yellow and red. Green stands for those in the Active Ageing Group, who are older people who can go anywhere by themselves, as well as help themselves and others. Yellow is the Self Reliant Group, who are those who can help themselves, but are not ready to help others. Red is for the Disabled Group, who are those who needs special care, as many of them are disabled or bedridden.

In addition to creating a database and classifying the elderly for care providing purposes, sub-district health promotion hospitals also arrange for elderly home

visits to follow up on patients who have just been discharged from the hospital or the elderly who have serious health problems, such as those who have pressure ulcers. By arranging home visit teams, in which a village health volunteer will join, the sub-district health promotion hospital personnel will give advice to the relatives of the patients. They will also provide advice and knowledge to the village health volunteer so that they can take care of the patients under supervision of the sub-district health promotion hospital. Having village health volunteers assist in these activities helps to reduce the need for medical personnel and allows for the patients to receive continuous and attentive care. In the case where the patient's symptoms are beyond the capability of the village health volunteer, there is a communication and refer system to the sub-district health promotion, district or provincial hospital, as necessary.

In practice, the health service units in the local community, such as the sub-district health promotion hospitals, are not the only organizations who provide healthcare to the elderly. The authorities and organizations that empower the operation of the sub-district health promotion hospitals are the community hospitals and the village health volunteers.

Community hospitals are health service units under supervision of the Department of Medical Services, Ministry of Public Health, whose significant role is to provide medical treatment. District hospital personnel include doctors, professional nurses, physical therapists, dietitians, pharmacists and occupational therapists, all of whom are highly competent in providing medical care. This study found that in the best practices prototype areas, personnel of the community hospitals and sub-district health promotion hospitals typically coordinate their services, establish clear responsibilities and forward work to each other systematically. Since community hospitals are primarily responsible for medical treatment, they support sub-district health promotion hospitals with respect to personnel and equipment. This includes arranging for professional nurses to participate in home visits, providing support personnel who are specialists, such as physical and occupational therapists, and supplying equipment to be used for taking care of patients.

Village health volunteers are members of the community who have a service mind to provide healthcare to members of the community in every age group. The village health volunteers work under the supervision of the sub-district health promotion hospitals. The village health volunteer program was started in 1977 and is considered to be a significant mechanism in carrying out activities regarding disease prevention, health promotion and recovery of community member of all ages. Therefore, as rural society has a higher percentage of elderly members, village health volunteers play a key role in providing healthcare for the elderly in the community.

Village health volunteers play an important role in taking care of the physical, mental and spiritual health of the elderly, using a holistic approach. With respect to physical health, village health volunteers have been trained to perform primary supervision and screening of patients by being able to measure blood pressure and take blood for tests. They also give advice to the elderly and their relatives on the use of medicines, diet, exercise and primary physical therapy, including coordinating and referring patients to sub-district health promotion hospitals when anomalies are found.

A significant role of village health volunteers is performing home visits, either by themselves or together with a multidisciplinary team from the district hospital operating under a work plan or care program established together with the sub-district health promotion hospital and the community hospital. The operations of the village health volunteers are separated into zones according to the residential areas of the village health volunteers. Since they are also community members, they can follow up and watch the condition of the patients closely.

In addition to taking care of physical health, village health volunteers also take care of the mental health of both patients and their relatives. Given that the condition of most patients with chronic diseases is not always stable, relatives sometimes get discouraged, which leads to worry and stress and less attention being paid to the care of the older person. Village health volunteers can provide knowledge and encourage family caregivers at the same time, especially concerning those elderly who are disabled or bedridden.

For older people who are still in good health, but just want to stay at home or are not inclined to participate in activities/social contacts in the village, village health volunteers will talk and try to persuade them to join the community activities to help prevent depression. As well, village health volunteers have an important mission in going on home visits in order to assess the condition of the older person's home, and can arranged for services such as house cleaning or rearranging the bedroom to have sufficient ventilation.

The activities of village health volunteers are not limited to health work. Village health volunteers also provide information and help the elderly obtain medical services, such as applying for a disability card for medical treatment, requesting medical equipment, such as wheelchairs, walkers, walking sticks, and beds, from the sub-district health promotion hospitals, community hospitals or sub-district administration organizations.

3. Sub-district administration organizations: Even though Thailand has been governed under a system of democracy since 1932, management of the country is still quite centralized. Most care and support for the elderly in local areas is under the responsibility of the central and provincial governments. The 1997 Constitution

of the Kingdom of Thailand clearly indicated the importance of local administration decentralization, which has had an impacted on the structure, role and mission of local government administration regarding care and support for the elderly. The operating guidelines for local administration regarding the elderly follows the policies and strategies set forth in the Elderly Act of 2546 (2003), and the National Elderly Plan No.1 (1982-2001) and No. 2 (2002-2021) (Foundation of Thai Gerontology Research and Development Institute 2008).

The role of local administrative organizations regarding the elderly officially started in 1993 when the government established a fund to promote the welfare of older people in the community with a monthly allowance of 200 baht (Siripanich 1999). The law establishing the plan and steps for decentralization to local administration passed the Parliament in 1999 and was announced in the Royal Gazette on November 17, 1999. Section 30 of this statute prescribed the transfer of public services to local areas. This was a significant change that allowed communities to play a clear role in supporting the elderly. Local administrative units established four welfare plans for the elderly: 1) a health services plan; 2) a plan for promotion of living together and strengthening of the elderly organizations; 3) an elderly and disabled occupation and income promotion plan; and 4) a plan arranging for volunteers to take care of the elderly and the disabled (Foundation of Thai Gerontology Research and Development Institute 2008).

The Second National Plan on Older Persons (2002-2021) mandated that one of the missions of the local administrative units is to arrange for elderly services in the community comprising: 1) multi-purpose centers for older people; 2) day-care centers for the elderly; 3) elderly home visits; 4) healthcare services at the homes of older people; 5) transportation service for the elderly in the community; 6) systemization of the promotion of elderly care; 7) elderly care volunteers; 8) training for caregivers or volunteers; and 9) authorities/third parties to train caregivers and volunteers for elderly care inside the village (Prachuabmoh et al. 2008).

This study found that in the eight best practices prototype communities the local administrative units play a significant role in providing budgets to support activities promoting senior citizen center operations, as well as providing funds for medical equipment and physical therapy for the sub-district health promotion hospitals. In addition, transportation is provided for the elderly to get medical treatment, along with promotion of social welfare benefits relating to payment of medical bills, which is essential to the health of older people. Moreover, personnel from the Division of Public Health are encouraged to arrange home visits together with teams from the sub-district health promotion hospitals and community hospitals. Home visits often result in changes to the home environment to be more suitable for an elderly lifestyle, including providing funds to buy equipment to make their life more comfortable and to prevent accidents and falls.

In addition, many local administrative units support social activities in the form of recreation, travel and traditional and religious events for both the mental and spiritual development of the elderly in all three groups. Local administrative units also pay attention to the development of the quality of life of older people with respect to their financial situation through the monthly allowance for living expenses and encourage savings. As well, support and promotion of vocational training, work promotion, and marketing, including making arrangements for many types of income generated activities for the elderly, is provided.

Another significant role of the local administrative units, especially the sub-district administrative organizations, is arranging for volunteers to take care of the elderly in the community. Started in 2003-2004, the project for the elderly home care volunteers, a separate program from the village health volunteers, was piloted in four regions, two provinces in each region, totaling eight provinces: Chiangmai, Phitsanulok, Phetchaburi, Suphanburi, Khon Kaen, Roi Et, Songkhla and Surat Thani. This program, set up in one sub-district of each province, with an initial target of 40 volunteers in each area, has been carried out continuously since then. In 2006, the operation was expanded until all provinces were covered. 95 sub-districts participating in the project, with 5,000 volunteers providing care to 30,340 elderly people (The Elderly Promotion and Protection Bureau 2008). By resolution dated November 5, 2004 of the Promotion and Coordination of Grievances Committee No.1/2005, it was decided to extend the program all over the country (Phanthumnawin et al. 2006). On April 10, 2007, the Cabinet issued a resolution regarding protection of the condition of the elderly by implementing the operations of the elderly home care volunteers project, mandating that local administration units should be the main organizations to carry out this project, together with the national government, the private sector and people in the local area, with the Ministry of Social Development and Human Security providing technical support. By 2013, the elderly homecare volunteers project covered every district in the country, with 7,602 local administration units arranging elderly homecare volunteers in their areas. 51,854 volunteers now provide services to a total of 787,957 elderly people (Ministry of Social Development and Human Security 2014).

The role and responsibility of the elderly care volunteers relates primarily to social welfare and elderly rights covering 20 activities: 1) making home visits; 2) overseeing diets; 3) taking care of medicines; 4) helping with exercise; 5) transporting to the doctor; 6) bringing the doctor for treatment at home; 7) taking the elderly to join events in the community; 8) arranging for relaxation outside the house; 9) helping to join in religious activities; 10) assistance in adjusting living conditions inside the home to be more suitable; 11) forming groups of elderly to conduct activities; 12) providing information to the elderly and their families; 13) advising the elderly when they have a problem; 14) providing knowledge concerning

accessing their rights; 15) providing information concerning services that are beneficial to the elderly; 16) coordinating with authorities that provide help to the elderly; 17) collecting data; 18) following up on problems encountered; 19) helping to take care of errands or do them on their behalf; and 20) conducting activities that are beneficial to the elderly. A performance evaluation of the elderly home care volunteers in the community, conducted by College of Population Studies, Chulalongkorn University, found that even though the elderly home care volunteer program just started, the volunteers have been able to provide social welfare benefits to the elderly at a satisfactory level (Suwanrada et al. 2014).

Although the three main entities – the senior citizen centers, sub-district health promotion hospitals and sub-district administrative organizations – are the main organizations that play a key role in the success of community-based integrated long-term care, in practice, other organizations and social networks of the community also play key roles in helping empower these main entities. These organizations are:

1. Community leaders: Both village headmen and heads of the sub-districts join in promoting community-based integrated long-term care by undertaking important activities in communication and public relations. This includes building networks with other government organizations to request support, including resources, personnel, financial support, academic knowledge and technical expertise in promoting long-term elder care in the community.

2. Buddhist monasteries: Although it sometimes seems as if religious institutions work reactively on long-term care, rather than proactively, Buddhist monasteries do provided some level of support for many elderly care activities. This includes giving advice on activities for the elderly and providing buildings and places to conduct events, as well as arranging traditional ceremonies and rituals. These activities help to promote the mental and spiritual health of the elderly so that they can realize they are venerable people who are still precious for society and the family. In addition, in some areas, Buddhist monks play a role in home visits and spiritual health in the period of end of life care, helping older people pass away calmly, as well as providing support to their relatives.

3. Schools: Many schools arrange for students and the elderly to conduct communal activities, such as handcrafts, basketry, weaving, making brooms and massage. This helps children become aware of the value of older people and to realize that it is necessary to provide care to the elderly. Some schools arrange for training for elderly care young volunteers and family activities to let children get close and learn how to take care of older people.

4. The provincial offices of the Ministry of Social Development and Human Security are government authorities at the provincial level with the mission to arrange for social welfare and protect the rights of the elderly. These offices are responsible for allocating funds and arranging activities to promote social welfare, provide medical equipment to the disabled and arrange activities to promote occupational training and income enhancement for older people, including providing funds to local administration units for training volunteers to take care of the elderly.

3.2.2 Money

Money is the second factor affecting the success of community-based integrated long-term elder care. This project found that in the eight best practices prototype areas most sources of funds used to arrange activities for the elderly come from the central government budget by way of public health services authorities – the community and sub-district health promotion hospitals. As well, provincial authorities responsible for social welfare and rights protection, such as the provincial office of the Social Development and Human Security Local Administration, along with local administration units in the rural community that receive funds through the sub-district administrative organizations, also provide funding.

However, the study also found that another significant source of funds are local health funds or the Sub-district Health Fund, which are funds established under the National Health Security Act BE 2545 (2002) that take care of the health of people in the community. The Sub-district Health Fund was first established in 2006 under the support of the National Health Security Office. The objective of these funds is so that the elderly can access effective medical and public health services according to their rights and benefits as set by the National Health Security Committee. By operating in the form of fund raising, with labor provided by villagers and brainstorming for health promotion activities, illness and risk of illness can be reduced.[1]

There is a basic concept that health is not just treatment of illnesses and is not only the responsibility of the doctors or nurses, but that there are social factors that are important to health – the social determinants of health. The National Health Security Office provides funds for disease prevention and health promotion to change the behavior of people, such as promoting exercise, safe diets, and health risk reduction through social activities in which the community is the responsible party by which public activities are conducted.[2]

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1 *29 May 2009 <http://cmumk.nmkcenter.net/pages/kongtun.html>.*

2 *29 May 2009 <http://www.matichon.co.th/matichon/ view_news.php?newsid=01act03060552>.*

In practice, funds obtained from the Sub-district Health Fund, or the National Health Security Office, are generally used for problem solving. Funds obtained from sub-district administrative organizations are part of the annual government budget. Such funds can only be used for the main mission of the operations of the sub-district health promotion hospitals, as set forth in the working and budget plan of the sub-district administrative organizations which have arranged activities concerning elder care.

In some areas, although the budget set by the sub-district administrative organization is for a period of three years, every year there will be a meeting to adjust the spending and budget plan to be in line with their mission. As well, every year there will be a performance appraisal to follow up on how the budget was expended, and the local community can propose projects to request funding if they want to conduct certain activities.

For example, village health volunteers can request support from the Sub-district Health Fund to set up projects for the elderly who enjoy socializing, like to stay at home or are bedridden. Older people who enjoy socializing often arrange recreational activities, such as singing, dancing, exercising, health promotion activities, worship activities, and sightseeing.

As for those elderly who like to stay at home, there can be home visits or income generating activities, such as weaving, which can be done at home. Weaving activities as arranged by senior citizen centers allow the elderly to have friends, perform some work and earn extra income.

As for bedridden older people, there can be a home visit team, as well as village health volunteer visits, to provide care according to their capability. If the situation is beyond their capability, the team will coordinate with the sub-district health promoting hospitals to take care of the elderly person.

3.2.3 Management

Management is the last factor needed for the success of community-based integrated long-term elder care. This project found that management in the best practice prototype areas differs according to the social and cultural context of the community. For example, in the northeast, management and practices used in the operation of community-based integrated long-term care is under a process called “Mong Soh Sor So”, for which each word has a meaning:

Mong means place, the area to conduct activities, which is usually the information center of the village where people gather.

Soh means to observe, analyze and collect data.

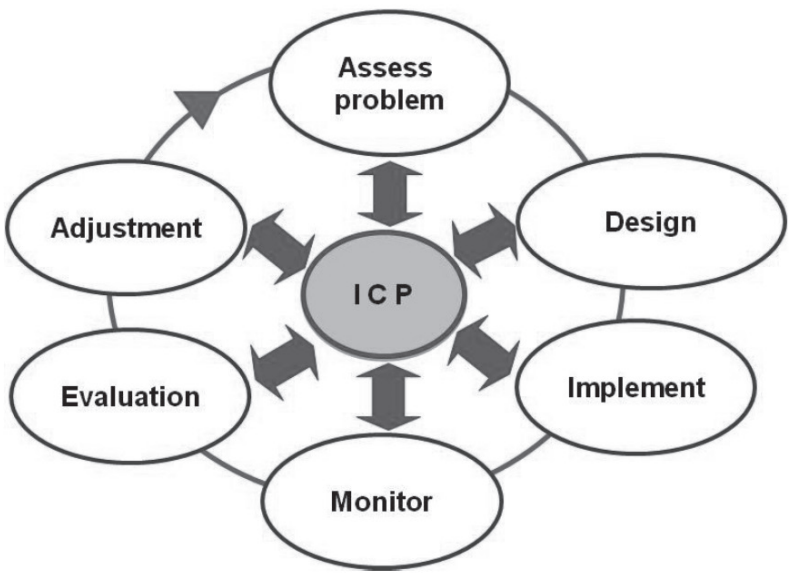
Sor means checking data received to see that it is clear and valid.
So means meeting, formation of a community.

Overall, *Mong Soh Sor So* means a work process starting from determining the problem and participating in thinking, conducting, sharing ideas, designing, separating work, and performing. There will be regular meetings to follow up and evaluate work performance so that participants can perform better, learn and develop. Following Mong Soh Sor So makes problem solving fast and timely.

The *"So Re"* process is similar to a forum or a platform that allows people in the community to exchange and share what they have done. So Re, therefore, is similar to a stage for promoting capabilities that are the most natural. So Re is similar to everyday life, since in addition to obtaining answers for one's own problems, one will also learn about matters carried out by others.

This project found that although management in each area is different, every successful best practice prototype area has the same pattern of management, that is, Adaptive Management as shown in Figure 3.1.

Figure 3.1: Adaptive Management Adopted by the Communities Studied



The findings from this project provide a critical review of factors that help determine successful development of community-based integrated long-term elder care. It has been suggested that Adaptive Management be adopted to foster on-going community-based integrated long-term care because this is a learning-based process to improve management decisions. Adaptive Management focuses on learning and adapting through participation by all stakeholders. In order to set up community-based integrated long-term elder care, full cooperation is required among the three parties: the governmental units, both at the national and local levels, the non-governmental sector and the public. The adaptive approach involves the whole process, starting from assessing or formulating the problems, designing the ways to solve the problem, working on implementing, analyzing, monitoring, evaluating and adjusting the management.

Adaptive Management mechanisms help in the process of capacity building and cultivating ownership in the local community. Operating mechanisms with respect to communication of the project at all levels, whether central communication, a linkage between the center and local areas and communication inside the area, can be summarized as follows:

1. Meetings at all levels are changed from a format of 'perception' to 'learning' in order to build capacity.

2. Practices for participation in the meetings and communication are changed from 'cooperation' to 'participation and ownership'.

3. The outcome of meetings in terms of accountability, reliability and validity of work performance is monitored and evaluated with kindness and goodwill leading to value added and empowerment that can be perceived at all levels.

The gathering of field data clearly shows that the significant factors of success in using Adaptive Management arise out of three significant elements: Information, Cooperation and Participation or ICP.

'I' means 'IEC' – Information, Education and Communication – which creates mutual learning and leads to awareness building and alertness to the problems of the older people in the area and local community. In particular, the creation of an elderly database, the analysis of the data and classification of the severity level of dependence or disability of the elderly is important. The gathering and sharing of data leads to thinking and working together to solve problems and meeting the needs of the elderly, which is truly in line with their demands and problems.

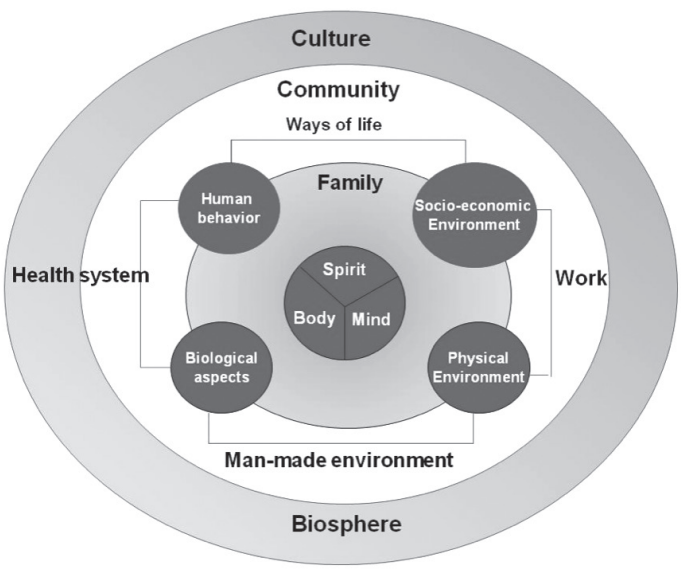
'C' means 'Cooperation', which is working together to 'complement' each other. The meeting of many parties concerned with elderly care gives rise to the developing of partnerships and networks for cooperation, and results in helping one another, sharing ideas and learning both in the local area and across the region.

'P' means 'Participation', which extends results from the cooperation level to join in thinking, planning, conducting activities, following up, evaluating, being responsible and receiving benefits from the actions undertaken, so that many areas are able to develop to be "best practice" areas. Such a process leads to growth, progress and mutual development – growing together.

In considering the role and function of Adaptive Management, the significant words that best reflect this management technique are ***"Learning together, going together*** and ***growing together"***, all of which are in accordance with the speeches of His Majesty King Bhumibol Adulyadej who said, "Understand, Reach and Develop".

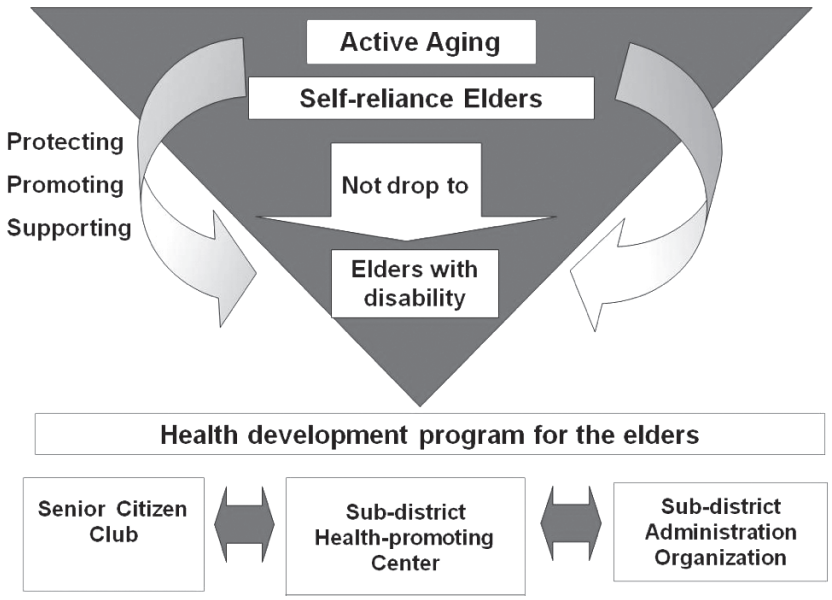
One of the interesting issues of long-term care in Thai society is that elderly activities and care do not just focus or pay attention to the elderly who are bedridden or disabled. This project found that people in Thai society have a holistic approach concerning elderly long-term care that can be seen by how they pay attention to more than just the health aspects of care. The organizations at the community level involved in elderly care, including senior citizen centers, sub-district health promotion hospitals and sub-district administrative organizations, not only provide care to the elderly regarding health, but also pay attention to the overall well-being of the elderly. Happiness at the end of life for an older person has the same pattern as for people of other ages, that is, living without serious health problem, both physical and mental. Moreover, the elderly should be able to live with spirit, perceiving that they are valuable and that society cares for them. Therefore, spiritual health is one of the important components that Thai society pays attention to. In addition, long-term elderly care also covers financial matters, social issues and being in a friendly environment. This conceptual framework is shown in Figure 3.2.

Figure 3.2: Conceptual Framework of Community Based Integrated Long-term Elder Care in Thailand



The community classifies older people according to their health, economic and social conditions by separating them into the three groups, Active Ageing, Self Reliant and Disabled. Responsibilities are allocated to organizations directly concerned with providing care for the elderly in line with their condition and needs so that the healthy elderly will not fall into a condition of poor health. This is illustrated in Figure 3.3.

Figure 3.3: Community-based Integrated long-term care



However, organizations providing care to the elderly do not work independently. They form cooperative networks with other organizations and groups of people, both inside and outside the community, all arranged in the public sphere so that direct stakeholders can meet and participate in thinking, designing and working. Accordingly, there is follow up, supervision, and performance evaluations, including adjustment of methods and approaches to be the most beneficial in taking care of the elderly. This process is in line with the Adaptive Management approach, or a similarly named process according to the context of the area, culture and community lifestyle, such as *"Mong Soh Sor So"* or *"So Re"*. This study found that when organizations involved with the elderly care had a chance to meet and share ideas, this led to capacity building and ownership, resulting in sustainable development of community-based integrated long-term elder care in the local communities.

CHAPTER

Development Direction for Community-Based Integrated Long-term Elder Care

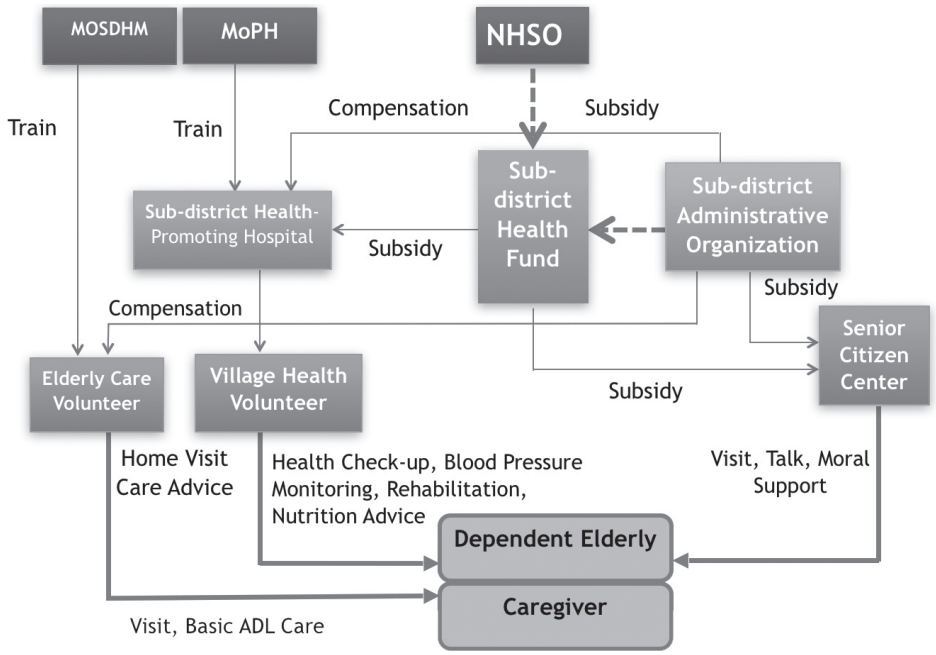
This chapter aims to propose a development direction for community-based long-term elder care, starting with synthesizing the existing system of community-based integrated long-term elder care in Thailand. Then, a discussion is provided regarding the concerns about such a system. These concerns include the condition and changing nature of Thai society; the needs of older people; a definition of long-term care; the importance of the role of key actors in providing long-term care (Man); sources of funding for long-term care (Money); systems for managing long-term care (Management); and development of ICP: Information – Cooperation – Participation.[1] The last part of this chapter provides suggestions on a development direction for a community-based long-term elder care system in Thailand.

4.1 Synthesis of the Community-based Integrated Long-term Elder Care System: Evidence from the Best Practices Prototype Communities

According to the primary data collected in the eight selected best practices prototype communities, a synthesis of existing community-based integrated long-term care systems is set forth in Figure 4.1.

1 These concerns are the seven issues of most concern raised at two brainstorming sessions for the "Community-Based Integrated Long-term Elder Care Project". The first was held on Thursday, 11 September 2014 at the Tawanna Hotel and the second was held on 30 October 2014 at the Dusit Thani Hotel, both in Bangkok.

Figure 4.1: Synthesis of Existing Community-based Integrated Long-term Care Systems in Thailand



There are four main distinguishing features of the community-based long term elder care system in Thailand:

1. Coordination Within the Community: Although the relevant governmental entities are fragmented at the national level among various departments within the Ministry of Public Health, the Ministry of Social Development and the Human Security, National Health Security Office, coordination and cooperation exists among the related stakeholders – sub-district administrative organizations, sub-district health promoting hospitals and senior citizen centers – at the community level. Such coordination and cooperation supports the implementation of community-based integrated long-term elder care. However, each community has its own context such that there is no specific ready-made answer as to who is the core leader of the system.
2. Care Service Providers: There are three providers or actors at the community level: senior citizen centers, the elderly care volunteers, and the village health volunteers under the supervision of the sub-

district health-promoting hospitals. In some areas, Buddhist monks also play an important role.

3. Elderly Care Services: Each of these core providers offers different services. Senior citizen centers generally facilitate home visits in order to provide moral support and to give advice on fundamental daily-living issues. Elderly care volunteers provide basic care to support activities of daily living and knowledge and information on the basic rights of older people. Village health volunteers provide additional health and preventive care to the elderly. Their services are, for example, regular home visits, health check-ups, measuring blood pressure, rehabilitation using Thai traditional massage, nutrition advice, and care advice to the family.
4. Source of Funds for Elderly Care Services: To provide the care services mentioned above, various channels have been established through which care providers can attain resources. Senior citizens centers can receive subsidies from the sub-district administrative organizations and/or sub-district health fund on a project basis. Elderly care volunteers can obtain financial support from the sub-district administrative organizations. Village health volunteers and sub-district health promoting hospitals provide care services to the elderly in the community as a part of their employment responsibilities, which is covered by the national budget thorough the Ministry of Public Health. Additional projects can be funded through the sub-district health fund and/or a subsidy from the sub-district administrative organizations. Currently, the National Health Security Office (NHSO) and the sub-district administrative organizations are the main financial contributors to the sub-district health fund. In some communities, community members also contribute to this fund.

4.2 Concerns Regarding the Community-based Integrated Long-term Elder Care System in Thailand

Although, there is a fairly clear picture of the community-based integrated long-term elder care system at the local level, there are still some concerns. Below are the seven issues of most concern that have been identified as a result of our investigation and two brainstorming sessions held with geriatric experts.

4.2.1 The Condition and Changing Nature of Thai Society

With respect to community-based integrated long-term care for older people, the most important word is 'care'. This word has two meanings: 'attentive assistance' and 'watchful treatment'. Treatment is generally the responsibility of doctors and nurses, while assistance is the responsibility of the community. In the past, elder care was mainly provided on a local basis given the close-knit nature of society. This was particularly evident in rural areas and helped to create a bonding element that strengthened communities through a sense of generosity and helpfulness from the time one was born until they passed away.

However, today, society has become more complex, with many people finding it difficult to advance and some even struggling just to survive. In order to work and earn a living, many family members have moved to urban areas, which has caused a change in the relationship between various generations in the immediate family. Younger children are often left alone to be cared for by older family members while their parents are away working in another location. In addition, modern information technology has had an influence on the daily lives of those in rural society as it seems people have become addicted to their mobile phone and social media, becoming less attentive to others around them, which has weakened communal bonds. This means that ways to restore the strength and vitality of traditional communities need to be explored.

4.2.2 The Needs of Older People

The needs of older people to enhance their quality of life can be broken down into three factors:

1. The need for older people to have good health, both mental and physical.
2. The opportunity to live with their own children and grandchildren, and to have someone care for them, particularly when they are ill.
3. To ability to have stability and security in their lives, including:
    a) Stable and secure living arrangements, for example, living with immediate family members and residing in a well-built house with appropriate facilities.
    b) Having a steady and reliable source of income.
    c) Feeling safe and secure from danger.
    d) Participating in social and community events of particular interest such that the older person feels a sense of worth and contribution.
    e) Equal and fair accessibility to government services.
    f) The chance to die calmly and in peace.

4.2.3 A Definition of Long-term Care

4.2.3.1 The meaning and definition of long-term care as used in research as compared with general use

Long-term care has different meanings in the context of different kinds of research. Therefore, a clear definition or meaning of 'long-term elder care' needs to be established, both on a general basis and as used in research efforts, so that there is a clear understanding and thoughts and ideas can be compared. The word 'long-term care' is generally used by researchers to mean the ability to help oneself in terms of Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). However, since this project is concerned with community-based integrated long-term care, the concept as used in research reports or publications needs to take into account generational factors and other dimensions relating to the integrated, community-based element, and not just be limited to the ADL or IADL aspects.

4.2.3.2 Every older person needs long-term care

There is often a misunderstanding among researchers of who among older people should receive long-term care. This may arise from the fact that older people are typically separated into three groups: 'young old'; 'very old'; and 'old old', and researchers tend to focus only on those in the 'old old' group. However, long-term care should start from when one reaches the age of being an elder citizen and last until one passes away, not just when an older person becomes ill or is near death.

4.2.4 The importance of the role of the key actors in providing long-term care (Man)

As for the people who should be involved with or are responsible for long-term elder care, there are several issues and recommendations that need to be considered.

1. Given that the average number of children in the family has been decreasing, the number of family members available to look after their elders has also been decreasing. As well, there is a rising proportion of older persons, especially in the over 80 category, resulting in an increase of bedridden older people who need constant care and attention.
2. In addition to their health related duties, sub-district health promotion hospitals should take on the primary responsibility in

coordinating or integrating all the actors providing long-term elder care in the community, and not assume that the non-health related participants will take care of these matters.

3. Private institutions need to play an enhanced role in providing care to older people. For example, private companies could provide funding for elder care as part of their CSR role, which would be another way of furthering their business.
4. Buddhist monasteries or "wats" are organizations that are very well developed and integrated in the Thai social structure. Many monasteries have significant means and resources, as well as adequate funds, and ought to play a role in promoting and developing programs for older people. In this regard, there is the potential for monasteries to provide some aspect of long-term elder care, such as establishing service centers to provide assistance to older people at the monasteries.
5. Senior citizen and community centers are places where older people can gather and engage in various activities "of older people", "by older people" and "for older people". Accordingly, every village and community should have a center where older people can meet and participate in group recreation.
6. Long-term elder care should be organized to involve others in the local community, for example, motorcycle taxis drivers. Motorcycle drivers could assist the older people when they need to buy food for daily consumption or to make merit by giving alms to the monks in the morning, as well as by helping to calling a taxi to provide transportation to the doctor.
7. Capacity enhancement for people to provide care for the elderly should be undertaken through a variety of projects. For example, the Long-Term Care Service Development of the Frail Elderly and other Vulnerable People (LTOP) is a program for training people to be care mangers in order to oversee the systems of long-term care. This project, if implement on a wider basis, could result in the creation of additional employment opportunities and careers in the communities.
8. Long-term care necessarily has many organizations, each with various duties and responsibilities that need to coordinate their efforts. For example, the Provincial Health Office is responsible for establishing general guidance with respect to elder care and providing technical support and human resources; the District

Health Office is responsible for overseeing and following up on the work of the sub-district health promotion hospitals, including activities relating to elders; community hospitals are responsible for providing technical support and personnel, and sending interdisciplinary teams made up of doctors, nurses and physiotherapists to homes to care for bedridden patients; and sub-district health promotion hospitals are responsible for supporting and enhancing the overall physical and mental health and well-being of the older population. Other than this, local administrative units are responsible for providing support funding, staffing and vehicles and in coordinating public relations and communications to foster community awareness.

4.2.5 Sources of Funding for Long-term Care (Money)

The following are factors that need to be considered with regard to the sources of funding to support long-term elder care:

1. The government should specifically designate funds to support long-term projects for the care of older people, and not rely upon local governing units – local municipalities and sub-district administration organizations – to fund such projects. This is because funding provided to the local governing units is usually only on a one-year basis. Therefore, only single, short-term projects are typically funded and once the money has been used up, the projects are terminated.
2. The government should allocate a portion of lottery proceeds to support efforts relating to the older population. This will serve to return some benefit to the people, particularly those who are poor or in need. For example, this could be accomplished by setting up a foundation or charitable organization, similar to the Thai Health Foundation.
3. The government should promulgate legislation mandating the use of proceeds from excise taxes be clearly designated to fund activities for older people. This would create a sense that the allocation of government tax proceeds has a real direct benefit for the people, particularly those in most need, including older people.

4. Some funds should also come directly from the local people in order to help strengthen the bonds in the community. For example, a fund could be established whereby everyone contributes two baht per day as a way to promote savings. These funds could be used for defined purposes, with perhaps some specifically designated for funeral services to be tapped when someone passes away. This will similarly lead the way to help the community realize the usefulness of establishing a "fund for long-term community care" that will foster development. For example, training village health volunteers and elderly home care volunteers or employing Care Mangers to set up long-term care systems can have a long-lasting impact on the community.

4.2.6 Systems for Managing Long-Term Care (Management)

There are a number of suggestions regarding administration and management of long-term care programs, as follows:

1. In the past, the government has not had clear policies regarding the older members of the population. Policy statements change with each subsequent government. Therefore, it is recommended that a statement be included directly in the Constitution regarding the promotion of the welfare of older citizens and long-term elder care. If this were to be done, then even if there were a change of government, the policy and programs regarding the elderly could not be changed or abandoned.
2. Long-term care systems should utilize the capabilities of the community. Thai society has great potential and communities have significant capacity. However, since long-term elder care cannot just rely upon family members, systems need to be established in order to provide personnel and organizations for the community. For example, sub-district health promotion hospitals, volunteers and senior citizen centers can all share in the responsibility and duties in caring for the elderly.
3. Volunteer systems should be set up that can be integrated with the health and social aspects of long-term care. In the past, the operations of public health volunteers and elderly home care volunteers were not always coordinated since public health

volunteers emphasized the health aspects of long-term care and elderly home care volunteers would only focus on the social aspects.

4. Funding is critical to ensure that an appropriate level of service is provided. Accordingly, it is imperative that any existing limited funding be managed more efficiently.
5. In the past, each actor involved in long-term elder care, including the Ministry of Social Development and Human Security, sub-district health promotion hospitals, local municipal organizations, or sub-district administrative organizations, would focus only on their own area of responsibility. Accordingly, with regard to funding, each actor could share some effort to provide funds so that each makes a contribution. This could also help reduce complications and misunderstandings.
6. Older persons are often unable to exercise their rights and obtain access to government services. Even though there are rules and regulations, or even laws in place, in practice, these are not always followed. For example, hospitals often have signs that say those over 70 do not need to queue for services. However, in reality, older people typically have to wait because there are not enough doctors and nurses. This also applies to providing free services and entry fees for older citizens, which in practice, does not always happen. Accordingly, means should be found to be able to enforce these rules and regulations.
7. Adaptive Management is a form of management that allows for improvement and change so that organizations can respond and adapt to issues and problems. This is a mechanism or process that can help fulfill the goal of providing long-term care because communities have a wide variety of shifting social duties and responsibilities. If communities were to have a designated central place where people could gather to discuss issues, there would perhaps be a better chance to understand necessary changes or solutions. Since each party has their own specialty, a link could be established between those who have different expertise, instead of each working on their own. Coming together to discuss and share ideas and methods to be introduced to the management of the community can help identify issues that are most critical so that appropriate efforts can be taken with respect to the care of older people. After this has been successfully implemented, then monitoring and evaluation must also take place so that necessary

adjustments can be made. This is an important mechanism to ensure that all parties are integrated and work in cooperation with each other.

4.2.7 Development of ICP: Information – Cooperation – Participation

4.2.7.1 I - Information, Education, Communication

1. In some areas, information is difficult to obtain, particularly in large cities. For example, Bangkok is an area where reaching older people is not easy, which makes it very difficult to compile complete and necessary data on the older population.
2. Registration of older citizens is a very important issue in the evaluation and assignment of the elderly to various groups. This allows each group to receive an appropriate level of services or special attention, and allows for assessment of the level of family support and technical assistance needed in the community.
3. To ensure that the data is useful, it is important that the source be considered because information about the older population has a tendency to change frequently. Accordingly, the best and most reliable source of data about older people is likely to be the sub-district health promotion hospitals. This is because the hospitals have the closest connection with the elderly and generally know their current condition, including those who have passed away or are bedridden. Therefore, sub-district health promotion hospitals should be given support to establish information systems that can reliably and timely track older people in the community.
4. There are many organizations that gather information on older people, for example, local administrative units and senior citizen centers. However, the information is not always accurate and useful because it is not reviewed for completeness and timeliness. Information should be gathered and verified every year, or two at the most, because the data about older people can change quickly, especially with respect to their level of needs or whether they have passed away. Accordingly, the importance of gathering timely and accurate information should be impressed upon the local communities. They should be given the tools to be able to review and analyze the information to be able to access the

condition of older people. They should also have the ability to use the data in their operations and activities in order to provide the best and most appropriate services and assistance needed by older people and the community.

5. Those in the family or local community that care for older people often do not have full knowledge of how to provide long-term elder care. Accordingly, there should be promotion of knowledge regarding the care of older people because many local cultural traditions that have been handed down from generation to generation are not appropriate for the care of elderly people, particularly related to food and nutrition. One way to overcome this is to have educational institutions help. For example, the universities in the Rajabhat system in each province could assume some responsibility for this activity. Alternatively, smaller educational institutions, such as vocational colleges, could provide some assistance and knowledge to caregivers so that they will understand what to do in providing long-term elder care.
6. Elderly care volunteers need enhancement of their skills. This project has found that village health volunteers and elderly home care volunteers do not have sufficient training to service the elderly population. Therefore, they need support in improving their skills so that they can improve their services. However, if these volunteer organizations do not have such ability, then someone who has been properly trained should be sent to assist them with providing long-term care. Sometimes their operations are not well organized, resulting in the volunteers being unable to respond as they should or to carry out their duties efficiently. Therefore, there should be some information gathered to find out which areas of village health volunteers and elderly home care volunteers operations are lacking, and why, in order to find ways to help develop and improve their personnel.
7. Family members seem to have a general lack of knowledge regarding caring for older people, and should be given some training and knowledge in order to be prepared and ready to provide adequate care. This would also help them recognize symptoms and conditions so as to be able to respond accurately to the needs of elderly family members.
8. Technology should be applied when possible to help improve the care provided to the older population at the community and

municipal levels. For example, a system for providing reminders to take medication or for managing emergency situations should be considered. If an older person is in a situation where they live alone, they should have ready access to some modern channel of communication whereby they can easily contact someone for assistance.

4.2.7.2 C – Cooperation, Collaboration, Assistance

Senior citizen centers where older people can gather and engage in various activities should be more widespread. These centers are sites where essential services can be provided and where the elderly can relax and enjoy themselves. In fact, these days there are many senior citizen centers, but they are typically only in large municipal areas. Accordingly, some means should be found to build such centers throughout the country, in each province and local area.

4.3 Development Direction for Community-Based Integrated Long-term Elder Care in Thailand

Based on the existing community-based integrated long-term elder care system and the concerns that have been previously raised in this report, this final section sets forth some suggestions for further development direction of community-based integrated long-term elder care.

4.3.1 Expanding the Definition of Long-term Elder Care for More Diversified Services

As mentioned in Sections 4.1.1 and 4.2.2, the needs of older people to enhance their quality of life are broader than simply physical and health care. As previously mentioned, the word ‘care’ has two meanings: ‘attentive assistance’ and ‘watchful treatment’. Treatment is generally the responsibility of doctors and nurses, while assistance is the responsibility of the community. In addition, as clarified in Chapter 2 in the case of the Public Long-term Care Insurance System in Japan, preventive care should also be included as a part of a long-term care system, in addition to traditional home based, community-based, or institutional care. Preventive care includes various types of social activities aimed at older people so they do not fall into a state of dependency. In order to design a long-term care system for the future, the definition of long-term care for the elderly should be expanded. In this regard,

non-health professional personnel, such as local authorities, care volunteers, senior citizens, community members in general, and existing social organization, should participate in providing community-based integrated long-term care through more social-oriented services. As clarified in Figure 2.2 in Chapter 2, diversification of long-term elder care services currently exists regarding home-based, community-based and institutional care. If the definition of long-term care can be expanded, some services do not necessarily need to be provided by health professional personnel. Such services might include home visits, visits for basic ADL support, regular patrol services, at-any-time home visits and night-time home visits. In addition, Buddhist monasteries can be involved in this area by playing an important role in promoting and developing programs for older people.

4.3.2 Increase Financial Contributions to the Sub-district Health Fund from Other Sources

Under the current system, the source of funds for running community-based integrated long-term elder care comes mainly from the national government budget through annual budget appropriations to sub-district health-promoting and district hospital, and the contribution from National Health Security Office to the Sub-district Health Fund, along with the budgets of local authorities for specific care-related projects and for contribution to the Sub-district Health Fund. In order to maintain sustainable services and to improve services for older people, additional financial contributions, especially to the Sub-district Health Fund, are necessary. One possible source of funds is a co-contribution from provincial administrative organizations. Currently, some provincial administrative organizations have to manage public elder care homes, which have been transferred from the Ministry of Social Development and Human Security (MOSDHS) as a part of decentralization. In addition, some other public elder care homes currently run by the MOSDHS will be transferred in the future.

There are several reasons underlying this proposal. Firstly, to support development of lower tier local authorities (i.e., municipalities and sub-district administrative organizations) which is a mandatory function of provincial administrative organizations as determined in the Provincial Administrative Organization Act B.E. 2540 (1997). Secondly, supporting community care for the elderly will indirectly decrease the financial burden of taking care of the elderly in the senior citizen homes managed by the provincial administrative organizations in the future.

In addition to the financial contribution from the provincial administrative organizations, sub-district administrative organizations or municipalities that are directly in charge of managing the Sub-district Health Fund should call for co-

contributions from community members, both those of working age and elderly people. Moreover, Buddhist monasteries should be included as a part of the community long-term care system because many monasteries have significant existing resources and funds.

4.3.3 Establishing New Mechanism or a "Committee for Community Long-term Care for the Elderly" to Enhance Coordination and Cooperation at the Local Level

Long-term care necessarily involves many entities, each with various duties and responsibilities that need to coordinate their efforts. As clarified in Section 3, the current system of community-based integrated long-term elder care is based on coordination among senior citizen centers, sub-district health-promoting hospitals and sub-district administrative organizations. Unfortunately, each community has its own context such that there is no specific ready-made answer on which entity should take the lead role in the system. In order to maintain sustainable long-term elder care services, additional mechanisms need to be established in order to maintain or to strengthen this kind of coordination and cooperation among the often fragmented organizations, for example, a Committee for Community (Sub-district) Long-term Elder Care. Although there may be fragmentation at the upper level, a committee such as this can help to blend all stakeholders together at the community level. In order to tackle the diversified and changing needs of older people, the Adaptive Management technique that allows flexibly for improvement and change should be adopted as one of the basic principles of such a committee.

4.3.4 Human Resource Development in the Area of Long-term Care for Older People at the Community Level

At the community level, those involved in family and community care often do not have adequate knowledge, which creates issues of providing quality care. Simultaneously, communities often lack an adequate labor force in this area – a quantity problem. Thus, human resources development in long-term care is one of the most important challenges in maintaining community-based integrated elder care. The community should provide regular training programs for people involved in long-term care, such as family members, members of senior citizen centers, community care volunteers, officials of local authorities or other community members, in order to enhance their knowledge and capacity with respect to elder care. In order to do so, higher educational institutions, such as the Rajabhat Universities and vocational colleges, should be involved in providing such knowledge to the community as a part of the social responsibilities of such educational institutions.

CHAPTER

Conclusions

Thailand is facing a rapidly aging population. In about two and a half decades, one in every three Thais will be 60 and above. The oldest of the old population (defined as those over 80), who are the most dependent and have the highest disability rate of any age group, is projected to increase even faster. By 2040, one in every five older persons will be above 80 years old. With its economic and social development still ongoing, Thailand, unlike developed countries, is a nation "getting old before getting rich".

Providing care for the elderly has become one of the most focused issues under the context of population ageing. In Thailand, where the Buddhist principle of filial piety still prevails, most long-term care is provided informally at home by family members. However, given the current demographic changes, Thai families have started to face difficulties in elder care issues. There is increasing evidence that shows some shift towards formal care for many reasons. A decline in fertility rates and increased labor mobility has resulted in fewer family caregivers to provide care to the elderly. Advances in life expectancy means a lengthening in the time spend in a condition of ill-health and disability at the later period of life. Skilled care practitioners are more and more being required because of the increasing complications of multiple chronic diseases. Inadequacy of the intermediate care system has been found to exacerbate the need for long-term care as well. To cope with these challenges, in 2009 the government of Thailand set up a working group to revise the country's second National Plan on Older Persons (2002-2021). Based on the results from an earlier evaluation of this plan, the working group recommended, for the first time, the initiation of community-based integrated long-term care, where medical care would be provided, together with social care, at the recipient's home.

Based on our investigation in eight communities in seven provinces – Chiang Mai, Mahasarakam, Yasothon, Chachoengsao, Phetchaburi, Ranong and Surat Thani – where community-based integrated long-term elder care is available, we have confirmed the fact that demographic, economic, health and social and cultural factors have raised the awareness of the need to arrange for long-term care for the elderly within the community. In addition, we found four main features of the community-based long-term care system.

The first feature is **"Within Community Coordination"**. Although the relevant governmental entities are fragmented at the national level among various departments within the Ministry of Public Health, the Ministry of Social Development and Human Security, and the National Health Security Office, coordination and cooperation exists among related stakeholders – sub-district administrative organizations, sub-district health promoting hospitals and senior citizen centers – at the community level. This kind of coordination supports the implementation of community-based integrated long-term elder care. However,

each community has its own context such that there is no specific, ready-made answer as to who should be the core leader of the system.

The second main feature is the existence of various **"Care Service Providers".** Generally, there are three main providers at the community level: senior citizen centers, elderly care volunteers, and village health volunteers, under supervision of sub-district health-promoting hospitals.

The third main feature is **"Elderly Care Services"** provided at the community level. Each of the core providers mentioned above offers different care services. Senior citizen centers generally facilitate home visit in order to provide moral support and to give advice on fundamental daily-living issues. Elderly care volunteers provide basic care to support activities of daily living and knowledge and information on the basic rights of older people. Village health volunteers provide additional health and preventive care to the elderly. Their services cover, for example, regular home visits, health check-ups, measuring blood pressure, rehabilitation using Thai traditional massage, nutrition advice, and advice to family caregivers.

The last feature is **"Source of Funds for Elderly Care Services".** To provide the care services mentioned above, various channels have been established through which care providers can attain resources. These sources include the national budget through line ministries, subsidies from sub-district administrative organizations and the Sub-district Health Fund. Currently, the National Health Security Office (NHSO) and sub-district administrative organization are the main financial contributors to the Sub-district Health Fund.

In addition to these four features, we found that the best practices areas applied Adaptive Management to the operations of the long-term care system. Involving full cooperation of all stakeholders, Adaptive Management is a learning-based process to improve management decisions. This method of management helps in the process of capacity building and cultivating ownership in the local community. Not only **Man** and **Money**, but **Management** – management that is adaptive or in another words **"Learning together, Going together and Growing together"** – also plays an important role in sustaining on-going a community-based integrated long-term elder care system. In successfully using Adaptive Management in community-based long-term care, **Information, Cooperation and Participation**, or **ICP**, are three significant elements.

Based on the evidence found in the current community-based integrated long-term care systems, along with various concerns on the progression of this system, we propose the development direction as follows.

1. **The definition of long-term elderly care** should be expanded to cover more diversified services, including both attentive assistance and watchful treatment. This will allow non-health professional personnel to be able to participate in the arena of long-term care along side health professionals. In addition, a more holistic approach or care for the overall well-being of the elderly can be focused upon, rather than just on bedridden or disabled older persons.
2. There should be **more financial contribution from other sources** to strengthening the Sub-district Health Fund. For example, financial assistance could be provided by provincial administrative organizations, members of the community, or Buddhist monasteries.
3. In order to avoid the problem of lack of leadership, and to enhance **coordination and cooperation among various stakeholders** at the local level, new mechanisms should be established, such as a "Committee for Community Long-term Care for Older People".
4. Because of an expected shortage of caregivers in the future, **human resources development** in the area of long-term care for older people at the community level should be undertaken.

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