ERIA Research Project Report 2021, No. 06b

Population Ageing in Thailand

Long-term Care Model: Review of Population Ageing Practices and Policies

Volume 2

Edited by

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Long-Term Care Model: Review of Population Ageing Practices and Policies

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ERIA Research Project Report FY2021 No. 06b

Published in June 2021

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Abbreviations and Acronyms

ABCD Centre	Ageing Business & Care Development Centre
BE	Buddhist Era
FAP	Family and Community Assessment Program
JICA	Japan International Cooperation Agency
n.d.	no date
SAO	sub-district (*tambon*) administrative organisation
VHV	village health volunteer
WHO	World Health Organization

Chapter 1

Introduction

Duangjai Lorthanavanich

1. Older People in Thailand

1.1. Population Ageing

Thailand is rapidly ageing. In 2017, 11.3 million or 17.1% of its 69 million people were 60 years old or more. Of older people that year, 16.5% had diabetes, 33.6% had hypertension, and 34.3% lived below the poverty line (Prasartkul et al., 2019; National Statistical Office of Thailand, 2018 [2561BE]).[1]

By 2020, more than 700,000 older people needed long-term care. By 2024, 2.78 million older people will be dependent and need long-term care: 60% will have low dependency, 30% moderate dependency, and 10% high dependency. (Srithamrongsawat et al., 2018 [2561BE]).

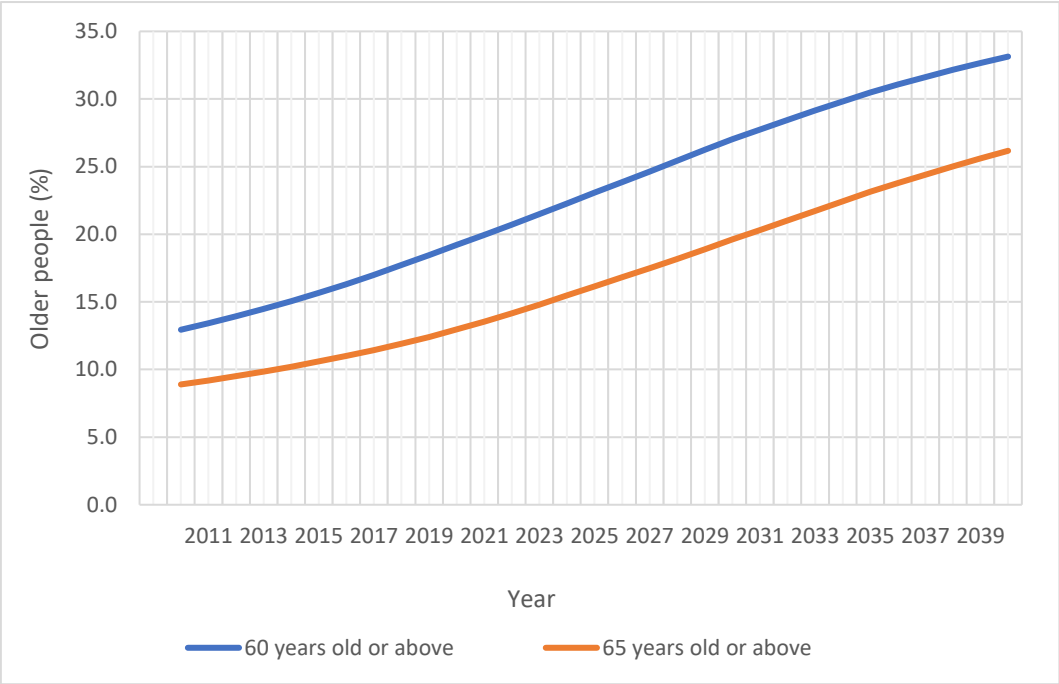
By 2040, more than 20 million people or 33% of the total population will be 60 years old or above.

Figure 1.1 shows the ageing trend in 2010–2040. The proportion of older people aged 60 and over and 65 and over will increase from 13% and 9% in 2010 to 32% and 25% in 2040 (Suwanrada, 2014).

In 16 provinces, people aged 60 or more were estimated to make up more than 20% of the total population in 2020. More people of productive age are expected to migrate from rural to urban areas, leaving their offspring behind to be cared for by their grandparents. Such skipped-generation households are particularly visible in the north and north-east (Srisuchart, Tangtipongkul, and Aroonruengsawat 2018 [2561 BE]).

[1] The references using the Buddhist Era (BE) are published in Thai.

Figure 1.1: Percentage of Older People in the Total Population of Thailand



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019).

1.2. Changing Families, Declining Capability to Care for Older People

Households are becoming smaller. In 1980, the average household had 5.2 people, but in 2017 only 3.2 (Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561BE]). People are marrying later and the birth rate has dropped. The total fertility rate in 2015 was 1.5, lower than the replacement fertility rate of 2.1. People's capacity to care for older people is declining and demand for elderly care is rising (Faculty of Nursing Chulalongkorn University, 2016 [2559 BE]).

Households comprising only older people rose from 22% in 2002 to 26% in 2011 to 32% in 2017. The trend is more remarkable in cities than in the countryside (Prasartkul et al., 2019).

The State of Thailand's Population 2015 (Peek, Im-em, Tangthanaseth, n.d.), published by the United Nations Population Fund and the Office of the National Economic and Social Development Board, shows household trends from 1987 to 2013. In this report, households are classified into four types: (1) nuclear families, (2) extended families, (3) one person, and (4) unrelated. Nuclear families are further classified into (1) husband and wife; (2) husband, wife, and children; and (3) single parent. Extended families are (1) three generation and (2) skipped generation. The 'husband, wife, and children' subtype was the most common in 1987 (54.1% of 11.3 million households), whilst in 2010, it was the 'three-generation' subtype (36.6% of 19.5 million households). 'Husband and wife' families increased remarkably from 5.6% of 11.3 million in 1987 to 16.2% of 19.5 million in 2013, and 'one-person' households from 6.1% in 1987 to 13.9% in 2013. The proportion of

'skipped-generation' households was low but steadily increasing, from 1% in 1987 to 2.1% in 2013.

In the past, women played a vital role in caring for older people in households, following traditional values and Buddhist teachings. Now, higher education and higher social status allow more and more women to enter the workforce, so they have less time to care for their older family members (Choowattanapakorn, 1999; Ingersoll-Dayton and Saengtienchai, 1999). In the past, if older people got sick, they were cared for by their children and grandchildren and other relatives, especially in rural areas where the whole village often consisted of neighbours and relatives (Sitthiwanthana et al., 2019 [2562 BE]).

1.3. Economy of Older People

1.3.1. Older People's Sources of Income

In 2015, 34.3% of older people lived below the poverty line (THB2,647/month). Their major source of income was support from children, which accounted for 37% in 2015, dropping from 52% in 2007. Older people's income from work rose from 29% in 2007 to 34.3% in 2015 (Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]).

1.3.2. Pension, Healthcare, and Public Support

Older people have not necessarily benefited from the pension system. Of 38 million people of working age, only 44.7% (17 million) are formally employed, with Social Security Fund membership and healthcare insurance, whilst 55.3% (21 million) are employed, without such welfare programmes.

One of the most common problems of people of working age is healthcare. Few employers provide healthcare insurance, and workers do not know their rights and do not receive proper treatment (National Statistical Office of Thailand, 2017 [2560 BE]; Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]).

The government provides welfare to older people, but the benefits depend on the category of beneficiary:

1) Retired government officer
    a) Lump sum from Government Pension Fund (about THB1 million)
    b) Monthly pension (about 70% of the average salary of the last 60 working months guaranteed) or lump sum
    c) Lump-sum payment equivalent to the salary of the last 30 working months in case of death before 60 years old (payable to parents, spouse, or children of the deceased)
    d) Civil Servant Medical Benefit Scheme, including spouse, parents, and children under 21 years old

2) Retired private formal sector employees and/or Social Security Fund members
    a) Government gives an allowance of THB600/month to those 60–70 years old, THB700/month to those over 70, THB800/month to those over 80, and THB1,000/month to those over 90. (Retired government officials are not

eligible for the allowance.)

b) Pension from the Social Security Fund of about THB3,000/month for those who have retired and worked and contributed to the Social Security Fund for 15 working years, and +1.5% incremental per 12 working months
c) Universal Coverage Scheme (or THB30 co-payment package combined with free medical check-ups, flu vaccination, and health promotion activities)
d) Provident fund (non-mandatory) and retirement compensation (10 months for 10 working years)

3) Retired informal workers (self-employed) and not members of the Social Security Fund
   a) Government gives an allowance of THB600/month to those 60–70 years old, THB700/month to those over 70, THB800/month to those over 80, and THB1,000/month to those over 90.
   b) Universal Coverage Scheme

Another safety net provided by the government is public welfare support. According to the Department of Older Persons, Ministry of Social Development and Human Security, older people living below the poverty line receive public welfare support and the government allowance for older people. Public welfare support is THB1,250–THB1,400/month to support housing expenses. Considering that average food expenditure is THB5,006/month and inflation increases by 3% per year, public welfare support is clearly not enough.

In 2019, the government allocated about THB72 billion for the older people's allowance, but only about THB419 million for public welfare support for older people living below the poverty line although as many as 4.6 million are eligible for public welfare support.

1.3.2. Employment of Older People

In 2015, 35% of people aged 60 years or older were still working, but the employment rate fell with age: 59% for those 60–64 years old, 46% for those 65–69 years old, 25% for those 70–74 years old, and 11% for those over 75 years old (Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]).

The average income was more than THB10,000/month in 2017. The average income per person increases with age, particularly for younger generations, but peaks at 55–60 years old (more than THB20,000/month) and declines at over 60 years old (Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]).

2. Long-term Care for Older People

2.1. Definition of Long-term Care

At the National Health Assembly in 2009, the Working Group on Recommendations for Long-term Care for Dependent Older People defined long-term care as comprehensive care covering the social, health, economic, and environmental well-being of older people

who suffer from chronic illness or are disabled or partially disabled and require full or partial assistance in their daily lives from medical staff members or family members. Long-term care also covers in-house care and care provided by the community or nursing homes (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

Most Thai researchers define long-term care as care only for dependent older people, but *World Report on Ageing and Health* defines it as 'the activities undertaken by others to ensure that people at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity' (World Health Organization, 2015).

2.2. Government Policies

In 2006, the National Strategy on Long-term Care and the Policy on Developing Long-term Care were approved by the National Health Security Office and the National Committee for the Elderly. The policies were designed to strengthen the capacity of households to care for older people so that they can continue living in a familiar environment with family members and neighbours. The principle has been adopted by sub-district long-term care policies developed by the Ministry of Public Health and/or other ministries involved in long-term care.

The 10th National Economic and Social Development Plan (2007–2011) emphasised valuing older people, strengthening their professional capacity, promoting self-care and health awareness , and fostering lifelong learning.

The 11th National Economic and Social Development Plan (2012–2016) emphasised developing a lifelong learning society, supporting social security, strengthening the potential of older people as the foundation of development, and promoting community activities to gain experience and knowledge to support older people.

The 12th National Economic and Social Development Plan (2017–2021) adheres to the 20-year National Strategy (2017–2036) and aims to create a dynamic and balanced ageing society where older people will be as physically, mentally, and economically self-reliant as possible so that healthcare system can be sustainable. The government is trying to improve the ecosystem of older people through programmes that make them more economically independent. These concepts were adopted by policies developed by ministries involved in issues of population ageing (Keeratipongpaiboon, 2018).

The evaluation report of the second (2002–2011) and the third (2012–2016) National Strategy for Older People suggests that implementation of policies on older people have not been effective. Many government agencies are working on older people's issues but lack coordination amongst themselves. Decentralisation and allocation of budget to local authorities have not been carried out effectively. Databases on older people are numerous but not synchronised nationally or locally, making it difficult to follow up and evaluate the work that has been done. All these shortcomings lead to ineffective implementation of the National Strategy for Older People.

2.3. Demand for Older People's Care

Chronic conditions such as diabetes mellitus or hypertension can cause critical events that result in functional loss and disability (Vu et al., 2020). Typical examples are cardiovascular diseases such as stroke or myocardial infarction. According to the results of the 2017 Survey of Older Persons in Thailand, the prevalence of diabetes and hypertension amongst older people in 2017 was about twice what it was in 2002 (Prasartkul et al., 2019).

Age is related to the deterioration of functional health. The same survey showed that only 18% of people aged 60–64 years had any functional limitations (e.g. lifting 5 kilograms, walking 200–300 meters, climbing 2 or 3 steps); difficulties in activities of daily living (e.g toilet, dressing, bathing, grooming); and instrumental activities of daily living (e.g taking public transport, counting change), whilst 80% of those 80 years old or above had functional limitations. The same trend can be seen amongst older people who reported the need for assistance. Of those 60–64 years old, only 3.9% reported that they needed assistance, whilst 25.5% of those 80 years old or more reported the need for assistance (Teerawichitchainan, Pothisiri, and Knodel, 2019).

Even though demand for long-term care for older people is growing, professional care workers are not common in Thailand. The 2017 survey found that assistance with daily living activities was provided to older people mainly by female family members such as daughters (40.4%) and spouses (31.9%) (Teerawichitchainan, Pothisiri, Knodel, 2019).

2.4. Cost of and Demand for Institutional Long-term Care

Long-term care for older people can greatly burden families economically because its length and seriousness are unpredictable. Every country is, therefore, encouraged to establish reliable long-term care systems to improve healthcare and the welfare system and prevent economic distress caused by the burden of long-term care (World Health Organization, 2003; Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

As the population of older people grows, the number of older people who need care, who need high-level care, and who have severe functional limitations also increases. Thailand is expected to have a growing number of older people eligible for institutional long-term care. According to a study that assumed 2% of those with severe dependency would be admitted into long-term care institutions, the cost of institutional long-term care would be THB0.9 billion in 2009r and THB2.8 billion in 2024. In case of a 25% admission rate of severely dependent people, the cost would be as much as THB34.6 billion (Srithamrongsawat et al., 2009).

The study's recommendations are the following:

1) Differentiate long-term care from acute care.
2) Develop the capacity of public residential homes to meet increasing demand for long-term care for older people.
3) Improve and enforce standards of care of long-term care institutions.

4) Strengthen home- and community-based long-term care services, considering the high cost of institutional long-term care services and most clients' preference to live at home.

3. Specialisation of Care Facilities and Capacity Building

Types of care that are most effective in promoting recovery from acute conditions, such as stroke, brain and/or spinal trauma, or perioperative conditions, vary depending on their phase. Healthcare systems are encouraged to clearly differentiate acute, intermediate, and long-term care to optimise resources and contribute to the maximum recovery of people who need care.

Intermediate care is vitally important to reduce the burden on long-term care resources. An effective referral system from major hospitals, which mainly provide acute care, to community hospitals is required to promote intermediate care. The Ministry of Public Health established a policy encouraging all community hospitals to provide intermediate care for patients with any of three acute conditions: stroke, brain trauma, and spinal trauma. The ministry aims for at least two beds for immediate care patients in each community hospital.

The ministry defines intermediate care as transitional, bridging the gap between acute and home- or community-based care. Intermediate care is for patients in stable medical condition but not sufficiently stable for the family or community to care for them. Intermediate care does not require up-to-date medical devices and equipment or doctors specialised in up-to-date acute care, but it does require a multidisciplinary approach. Such care can be safely provided at intermediate hospitals, which are between advanced hospitals and primary healthcare facilities. The cost of intermediate care can be covered by the universal health coverage scheme only for a designated period, which cannot be more than 6 weeks or 45 days.

In 2017, the Ministry of Public Health initiated a cooperation project with the Japan International Cooperation Agency (JICA) to establish a community care model for intermediate care.

Some communities have already established care systems in response to looming concerns about care for older people. Such activities are based on community solidarity and initiated by local hospitals or local authorities. Care for older people is considered the community's duty. Such systems are sparse so far and depend on the capability of the community leaders (Prasartkul et al., 2017), which is why Thailand needs a realistic strategy to cope with population ageing.

JICA surveyed 20 community hospitals and found that doctors, nurses, and patients did not recognise the necessity and effectiveness of intermediate care. They considered rehabilitation cumbersome. Many families did not have anybody to accompany the patient to rehabilitation regularly. The government is encouraged to promote cooperation between community and local hospitals and the Elderly Quality of Life Development and Career Promotion Centres, established by the Ministry of Social Development and Human Security and the Ministry of Interior and Senior Citizens Council of Thailand to provide

intermediate and long-term care efficiently at the district *(amphoe)* level. The Ministry of Social Development and Human Security is encouraged to promote caregiving training locally to raise awareness of the importance of intermediate care for older people who need community care in an integrated manner, from intermediate care to long-term care.

The JICA study found several acute-care hospitals that had strong leaders who initiated rehabilitation programmes in Surat Thani, Khon Kaen, and Nakorn Rachasima provinces. Hospitals in Chonburi developed a network connecting provincial acute-care hospitals; community hospitals; and geriatric hospitals under the Department of Medical Service, Ministry of Public Health. Another good practice reported by JICA was that of Nontaburi provincial public health office, which has fostered good relations with the provincial authority and developed an effective intermediate care system.

The human resources required to develop intermediate care are different from those needed for long-term care. Caregivers and care managers are crucial in long-term care, whilst physiotherapists and nurses have a key role in intermediate care.[2]

Long-term care not only provides medical treatment but also support for daily activities and modification of the living environment. Long-term care can be provided through cooperation amongst families, the community, healthcare staff members, and social workers. Community services for older people are still limited but integrated care is emerging in some places (Jaisin, 2018).

4. Recommendations for the Development of a Long-term Care Model

Thailand's long-term care system has the following problems (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]):

1) There is no standard for quality of care that older people receive. Care facilities in public hospitals could deliver quality care if the staff were trained to have compassion and treat older people as their own relatives. Donations through foundations affiliated with care facilities could help improve care.
2) Some older people are institutionalised at long-term care facilities although they do not have to be there. The government has the responsibility to prevent such cases. One option is to draft a law requiring adult children to take care of their own parents. Privately owned facilities should be registered, monitored, and evaluated.
3) Long-term care facilities may encounter (a) a lack of expertise and experience of staff members, (b) not enough staff members, and (c) a lack of an integrated database and information on long-term care facilities.

The authors suggested several policy approaches to improve long-term care. First, long-term care facilities should be registered and monitored by the Ministry of Social Development and Human Security and the Department of Medical Services, Ministry of Public Health. Second, the government should develop policies to encourage local authorities and the private sector to set up long-term care facilities and related services,

[2] From a by Akio Koide, chief advisor, JICA Thailand Office, at the Thailand Ageing Strategy Forum, 29 November 2018, hosted by the ABCD Centre, Thammasat Business School, Bangkok.

including rehabilitation and intermediate care. Third, clear rules and standards are required to improve the quality of long-term care facilities, as well as an assessment system of long-term care facilities. Assessment procedure should be a mutually agreed on by supervising and operating bodies. Last, community volunteers should be mobilised to care for older people.

5. Importance of Caregivers

Many long-term care models depend on charity or donations and are managed in compliance with religious principles.

We found that caregivers are vital at every level of care. Their quality is crucial to improve social and spiritual care. The public healthcare system has not focused on building caregivers' capacity. Most of the government budget for older people goes to monthly pensions, and more than half the district and sub-district healthcare budgets are spent on new medical equipment.

To improve the quality of life of older people, more experts should be deployed who have the skills to provide quality care to older people in communities, raise awareness of preventive care for older people, and train others to take care of older people. The budget and personnel of local authorities should be increased to improve long-term care services.

6. Objective and Method of the Study

Based on the background information on older people, this study asked two questions: (1) What are the long-term care models and best practices suited to the realities of Thailand? (2) What policies are needed to cope with population ageing so that people can enjoy healthy, happy, active, and productive lives as long as possible?

This study employed the following methods:

1) reviewing the academic literature published in 2008–2018 related to population ageing in Thailand, including various dimensions from health, social, environmental, and economic perspectives, and creating the Database of Ageing Research (http://aging.omeka.net) from the 1,424 results of subject and keywords searches (see Appendix);
2) analysing and integrating the results of the literature review to find
3) trends in government policies, private sector strategies, and practice models of healthcare and long-term care for older people; and
4) conducting focus group discussions with experts to develop policy recommendations from their ideas and the analyses of the literature review results.

The results of the study are discussed in accordance with the entities that provide care for older people. Chapter 2 discusses self-care, chapter 3 home- and community-based care, and chapter 4 institution-based care.

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Chapter 2

Self-care, Health Promotion, and Independent Life

Duangjai Lorthanavanich

This chapter focuses on self-care, health promotion, and independent life of older people. The key concept is active and healthy ageing. We would like to raise awareness of this concept so that older and younger people can enjoy physical, mental, and social well-being as the population ages.

1. Active Ageing

Active ageing is defined by the World Health Organization (WHO) as 'the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age' (WHO, 2002). This approach is applicable to countries that are ageing rapidly, such as Thailand, to promote older people's self-care and independent living. The concept of active ageing is mentioned in Article 12 of the Madrid International Plan of Action on Ageing, 2002: '[T]he empowerment of older persons and the promotion of their full participation are essential elements for active ageing' (United Nations, 2002).

The Foundation of Thai Gerontology Research and Development Institute recommended policies to promote active ageing in (1) the living environment, (2) living with dignity, and (3) health (Prasartkul et.al., 2017), adhering to the concept and rationale of the WHO for active ageing.

1) Living environment
    a) Living arrangements should be modified to enhance the quality of life of older people.
    b) Standards of living arrangements should be established to promote ageing in place.
    c) A system to support family members who take care of older people is required.
    d) Local administrative and community-based organisations are encouraged to participate in creating and monitoring a care-providing mechanism for older people.
2) Living with dignity
    a) Older people have the right to live in security and dignity.
    b) A monitoring system to detect changes in older people on time and accurately needs to be developed.
    c) An information system should be created to protect older people from potential threats.
    d) The role of older people's groups and clubs should be promoted and strengthened.

3) Health

a) A seamless transport system should be established to improve access to healthcare services.
b) Effective geriatric services outside the hospital, especially through home care and community-based care, are needed.
c) Increasing awareness of appropriate drug use of older people is encouraged to minimise drug side effects.
d) Enhancing health promotion and disease prevention is highly important, especially to prevent and control diabetes mellitus, hypertension, falls, and mental health issues.
e) Greater support for the following is required to promote physical and social activities: 1) a transport system for access to age-friendly places, including parks and green areas; 2) greater security for life and property; and 3) primary healthcare.
f) The community-based health service system for older people should be strengthened.
g) Physicians, nurses, and other health personnel are encouraged to be well versed in geriatric medicine, including rehabilitation.
h) Health should be promoted amongst the younger generations so that they can reduce the risks of noncommunicable diseases and enjoy longer, healthy lives.

2. Best Practices in Self-care and Health Promotion to Achieve Independent Living

This section shows several best-practice models suitable for Thailand, which focus on promoting older people's self-care, health, and physical and financial independence. According to the Survey of Older Persons in Thailand 2017, 11% of older people (60 years old and above) live alone and 21% of older people live only with their spouses. These proportions are increasing year by year (Prasartkul et.al., 2019). As population ageing advances, promoting self-care, health, and physical and financial independence will become more important as older people will be less likely to depend on the support of their families and relatives.

1) Public Space for All: Lumpini Public Park

Barrier-free Lumpini Park is in the heart of Bangkok. All visitors, including older people and people with disabilities, can engage in physical activities and attend public events. Ramps allow wheelchair users to move around easily. The main paths are lined with benches at intervals for park users to sit, relax, and chat. People can bring their own chairs and bicycles. The park's easy access and free-use policy gives residents a sense of participation in and ownership of the park (Thepwongsirirat, 2010 [2553 BE]).

The Lumpini model was developed by the Central Group of Companies as part of their corporate social responsibility in collaboration with the Ministry of Social Development and Human Security, the Bangkok Metropolitan Administration, and the Faculty of

Architecture of Chulalongkorn University. The non-profit Eleven Charities and the Lumpini Public Parks Office of the Bangkok Metropolitan Administration created a meditation space in the park.

Lumpini Park is a model of a public–private partnership, which is key to developing living arrangements that will ensure quality of life of older people.

2) Best-practice Model to Ensure Income Security and Employment of Older People

This section highlights the mechanisms for the private sector to collaborate with public services, educational institutions, or non-profit organisations as part of corporate social responsibility, particularly related to population ageing.

a) Thammasat model: Employment of older people in the community and community enterprises

The model facilitates intergenerational learning, reinforces wisdom, strengthens community enterprises, provides older people with jobs without a retirement age, and gives older people access to new knowledge so they can adapt to a fast-changing world.

As a model to develop sustainable community businesses, it is an important mechanism for developing community enterprises and the community economy based on a cooperation network amongst an educational institute (Thammasat University), non-profit organisation Community Partnership Association, the Government Savings Bank, and other public and private partner networks.

Thammasat Business School students are indispensable to the model. They are encouraged to spend one semester (more than 4 months) in rural and urban communities. The students learn from and share ideas with community members on how to improve their quality of life. The project provides an excellent opportunity for students to think about how to apply what they learn to real-life problems. It is a win-win relationship between the students and the receiving communities. The students can learn about the real rural life and earn school credits, whilst the communities benefit from the students' business ideas.[3]

The project's objective is to raise community members' standard of living. Community participants are mostly older people. They work with the students to create products and engage in income-generating activities, which keep them active, productive, and stress-free. Older people learn how to make use of up-to-date technology such as social media from the students. The programme is expected to produce synergy between students' knowledge and older people's wisdom, furthering innovation and productivity and opening markets. The programme has generated work and income for communities and solidarity between older people and students.

[3] For more details, see Udorn, Danthamrongkul, and Lorthanavanich (2018 [2561 BE]).

In Map Ta Phut district, Rayong Province, which has an industrial estate, the Government Savings Bank and the non-profit Community Partnership Association, founded by manufacturers in the district, are involved in the Thammasat model programmes. Monchai Raksujarit, manager of Community Partnership Association, said that the project generated a total income of THB25 million from community enterprises from 2015 to 2018.

A study on the income-generating potential of older people, targeting those who applied for loans from the Older Persons Fund in 2009, revealed that their potential could be optimised and projects' constraints overcome if older people added more value to their products. A way to add value is to connect to the modern marketing system using digital devices and social media (Soonthornchawakan, 2011 [2554 BE]). The Thammasat model is an example of how older people can overcome limits on income generation through community enterprises.

b) Jobs for older people in the public and private sectors

A report presented to the Department of Older Persons by the Thammasat University Research and Consultancy Institute and the Institute for Continuing Education and Human Resources recommended policies to promote the employment of older people: (1) reform employment laws and the social security policy, (2) restructure the employment system, and (3) foster cooperation in the labour market amongst the public and private sectors and non-profit or non-governmental organisations to create jobs for older people. These policies can be realised by allowing workers to move smoothly from formal employment to self-employment after retirement. Developing social enterprises is one of the most effective ways to expedite the employment of older people (Srisuchart, Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]).

Demographic change, particularly the decrease of the productive-age population, can constrain economic growth. The government should extend the retirement age as much as possible. Even those who are 60 years old or above should be encouraged to return to the workforce. Older workers should learn new skills and adapt to change. Re-skilling and reemployment of older people is estimated to mitigate the decline in economic growth by about 11%, whilst accepting 100,000 migrant workers per year is estimated to mitigate growth reduction by only 3.1%.

The private sector is key to creating jobs for older people. To establish a lifelong learning system to build the capacity of older people and younger generations, self-learning programmes should be developed. The government is encouraged to allot budget for them, whilst employers and workers are expected to contribute. The private sector should determine what human resources the future labour market needs and take the initiative in creating an age-friendly working environment (TDRI, 2019 [2562 BE]).

3) Re-learn and Re-skill: Schools for Older People

The 12th National Economic and Social Development Plan (2017–2021) states that the changing demographic structure is a challenge as well as an opportunity, and improving the care system and creating a suitable environment for an ageing society are part strengthening and realising the potential of human capital (NESDB, n.d.).

Re-skilling of older people, particularly improvement of their digital literacy, is crucial if they are to adapt in the era of digital transformation. Re-skilling will help achieve the national goal of building active and healthy ageing societies (Keeratipongpaiboon, 2018).

The Thai Health Promotion Foundation published a report on schools and clubs for older people and shows good practices in Thailand. Schools for older people can help them achieve digital literacy and connectedness, which are indispensable for living with dignity. The report describes several schools for older people and suggests a model for a school. Schools for older people were launched to develop their capabilities through systematic knowledge exchange. Those who completed the courses had high intellectual competency and financial literacy. The study suggests that curricula be at least 96 hours and consist of what older people need to know (50%), should know (30%), and want to know (20%).

This study recommends that schools for older people be developed locally and considered a key component of social welfare in accordance with the Older Persons Act 2546 BE (2003). The study recommends coordinating ministries' operations and building the capacity of school personnel so they can transfer knowledge appropriately (Yodpet, Pattanasri and Ssakdaporn, 2017 [2560 BE]).

As of 2017, more than 64,000 older people were attending 1,163 schools established by the Department of Older Persons. The students learn self-care, financial planning, law, and information technology, or take vocational training (Prasartkul et al., 2019).

2) Elderly Quality of Life Development and Career Promotion Centres

The Ministry of Social Development and Human Security started establishing the centres in districts and sub-districts in 2014. The centres provide older people with activities that improve their physical, mental, and social health. Cooperation between sub-district health promotion hospitals and the centres is encouraged because their collaboration makes providing intermediate care and long-term care more effective and efficient (Whangmahaporn, 2019).

3) Social Enterprise Model Providing Home Care and Health Promotion Services

Buddy HomeCare was established in 2012 by the non-profit and non-governmental Foundation for Older Persons' Development, established in 1999 in Chiang Mai. Buddy HomeCare is a social enterprise with three missions: (a) train disadvantaged youths to care for older people; (b) provide older people with cost-effective and high-quality home care; and (c) develop a network of volunteer-based care services for disadvantaged older

people, charging affordable fees, and eventually empower them to live independently and support others in sustainable manner (Foundation For Older Persons' Development, n.d.).

As a social enterprise, Buddy HomeCare receives basic knowledge-sharing, financial, and technical support from, amongst others, the Thai Health Promotion Foundation, the Thai Social Enterprise Office, and the Faculty of Nursing of Chiang Mai University. Buddy HomeCare partners with HelpAge International, Mae Fah Luang Foundation, Thai Health Promotion Foundation, Social Enterprise Thailand, Foundation for Social Entrepreneurs, Maharaj Nakorn Chiang Mai Hospital, Opendream Co., Ltd etc.

With Chiang Mai University, the Foundation for Older Persons' Development organises care work training programmes for disadvantaged youths from hill tribes. The university and foundation train volunteer home helpers in Chiang Mai as part of the joint initiative of the Association of Southeast Asian Nations (ASEAN) and the Republic of Korea to promote home care. Buddy HomeCare has trained 65 hill tribe youths as caregivers, fully sponsored, and provides volunteer-based home help services to 600 disadvantaged older people.

Buddy HomeCare has developed a mobile app into which clients, care workers, family caregivers, and volunteers can input data on daily health check-ups, such as blood pressure. If conditions requiring medical treatment are detected, the app sends alerts to nurses and other support team members. The app allows everyone involved in care to access clients' care plans (Asia Health and Wellbeing Initiative, 2020).

Buddy HomeCare therefore benefits both hill tribe youths and older people in Chiang Mai.[4]

3. Recommendations

3.1. Policy Recommendations

1) Encourage the government and stakeholders to support modification of living arrangements of older people so they can live independently and perform daily chores by themselves. Modify transport and public spaces to make them age-friendly and promote outdoor activities of older people.
2) Provide older people with regular health check-ups, access to exercise spaces near their homes, places for social interaction, safe food, and access to assistance for daily life.
3) Create jobs for older people, without a retirement age. The Thammasat model is a good way to integrate university students' knowledge, such as information technology, and older people's experience and wisdom. The model has promoted community enterprises and can create jobs, including for older people.

[4] The information in this section is from an interview with Sawang Kaewkantha, founder of Buddy HomeCare, conducted by a study member in March 2019.

4) Encourage the government and stakeholders to provide older people, regardless of their age, with easier access to knowledge and training on new technologies so they can adapt to the fast-changing world, particularly digitalisation. Schools for older people may cover a wide range of topics, such as information technology, investing, volunteering, and a healthy lifestyle.

3.2. Practice Recommendations

1) Locate primary healthcare facilities near older people's homes.
2) Develop a seamless healthcare and long-term care system to improve access to them.
3) Provide more day-care centres and home-care services so that older people can age in place with assistance in activities of daily living.

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Chapter 3

Home- and Community-based Care: Household, Community, Local, and Network Long-term Care for Older People

Nalinee Tantuvanit

This chapter reviews the practice of long-term care in Thailand, mainly based on articles or reports published in Thai in the last 10 years. Long-term care was defined by the National Health Assembly in 2009 as all dimensions of care, including social, health, economic, and environmental aspects, for people who have difficulties due to chronic disease or disability and are partially or totally dependent on others for daily living activities (Asian Development Bank, 2020). We found cases throughout Thailand that have achieved notable success in long-term care. They can be classified according to scale of practice and target of activities: household, community, local, and network.

1. Household Long-term Care

A large number of studies have focused on the roles of members of older people's households in long-term care because of traditional values such as filial piety and gratitude to older people. The number of senior citizens is drastically increasing, whilst the number of family members living in the same household is decreasing (Srisuchart., Tangtipongkul, and Aroonruengsawat, 2018 [2561 BE]). Due to low agricultural productivity, low prices of agricultural products, and high demand for labour in industry, many young family members migrate to towns for work.

According to the National Health Security Office, the average household had six members in 1960 and only three in 2010 (Sawatphol et al., 2017 [2560 BE]). A survey by HelpAge International, Thailand showed that a number of members of older people's households worked away from home and sent money back. During 2007–2011, 50% of households consisting of only older people received about THB10,000 annually as financial support from family members working elsewhere, 28% received THB30,000, whilst 10% received as much as THB50,000 a year. Some family members provided hardware such as adjustable beds, air mattresses, walking aids, wheelchairs, handrails, and/or funds for house repairs (Knodel et al., 2015). Many households, especially in rural areas, had financial troubles.

Most older people (aged over 60) in poor rural communities are relatively independent and able to perform activities of daily living and social functions, but 15% live alone and have to depend on others for housework assistance and social support, and another 5% have chronic diseases (Panyathorn, Worrawitkrangkun, and Pinyo, 2016 [2559 BE]; Panyathorn, 2014 [2557 BE]). They not only need housework assistance but also daily

routine health support. Health support includes physical hygiene, provision of healthy food, transport to hospitals, and health follow-up; 6% of older people are bedridden and completely rely on others (Srithamrongsawat, 2009 [2552 BE]; Sindhvananda, 2009 [2552 BE]).

Due to the advancement of communication technology, family members who live elsewhere can contact their parents and grandparents frequently through mobile phones, video calls, social media such as Facebook, and LINE. Although they do not live together, they are virtual co-residents. Money transfer is convenient and fast. Such technology-aided care is an indispensable component of household long-term care.

Limitations of Household Caregiving

A study of household care shows that most caregivers are daughters aged 30–49, with little education. About 60% of caregivers have physical problems. On average, they must care for their parents for 20 years consecutively. Almost half (47.5%) work and care for their parents concurrently. They can hold only part-time jobs. They have low incomes and scarce opportunities to join the labour market due to their limited education and skills. More importantly, they suffer from depression because of caring for their parents over a long period. The more older people in their households, the more severe the caregivers' depression (Sawatphol et al., 2017 [2560 BE]).

The National Health Security Office defines and classifies dependent older people into four (National Health Security Office, 2016 [2559 BE]): those who

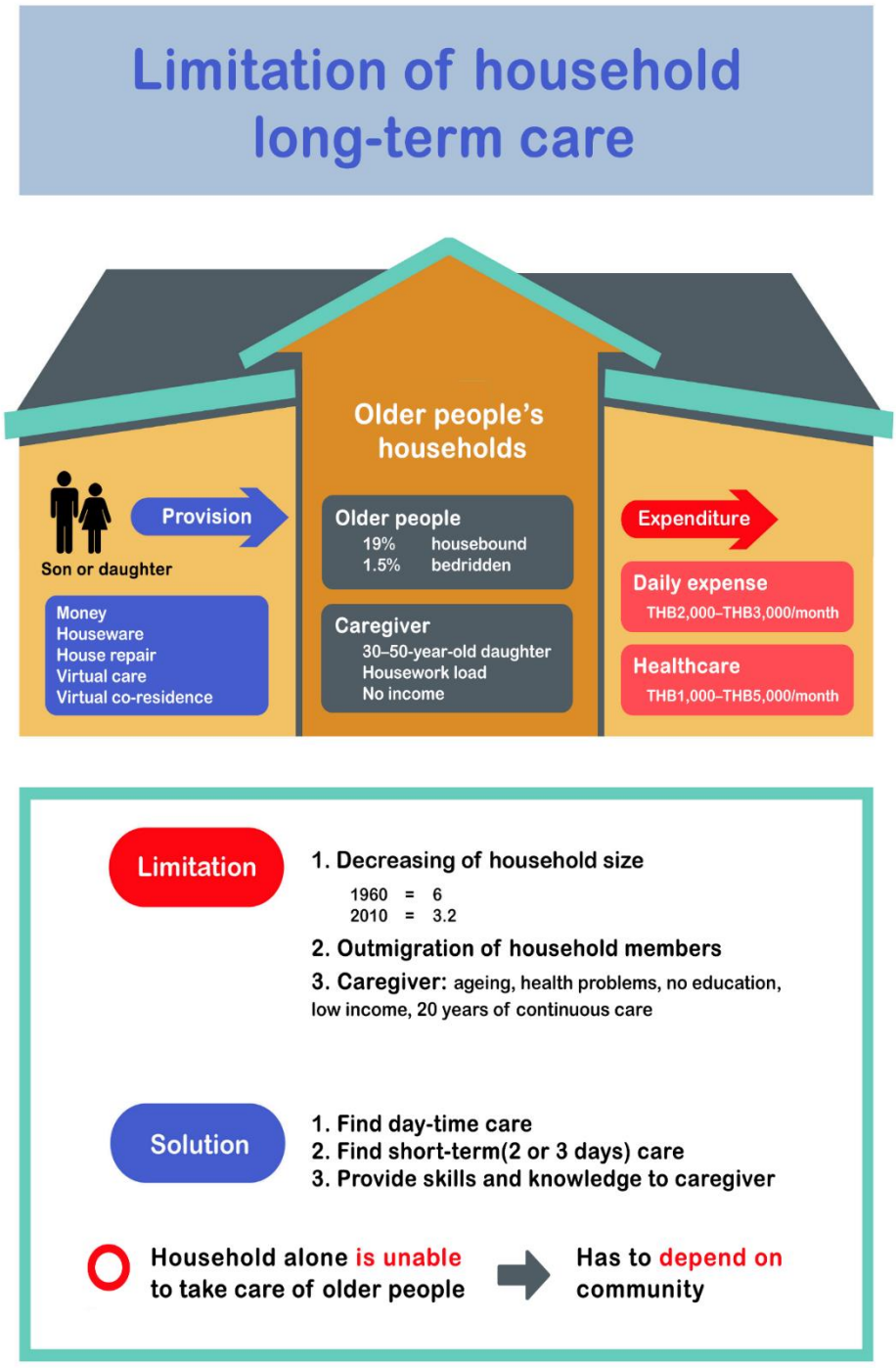
1. have no symptoms of brain disorders and can move by themselves but have difficulties eating and/or toileting,
2. have activities of daily living limitations as described in the first category and have brain disorder symptoms,
3. cannot move by themselves and might have difficulties in eating and/or toileting or have serious illnesses, and
4. have activities of daily living limitations as described in the third category and have critical or life-threatening illnesses.

Several studies point out that household or family care can work for dependent older people who fall into category 1 but not for dependent older people in other categories (Panyathorn, 2014 [2557 BE]; Chumnanborirak et al., 2012 [2555 BE]; Jitramontree, Thongcharean, and Thayansin, 2009 [2552 BE]).

Poor households have limited capacity to provide long-term care for older people because they usually cannot afford to employ a paid caregiver. They need support from community members and local administrative offices (see the next section.)

Figure 3.1 shows the limitations of household long-term care.

Figure 3.1: Limitations of Household Long-term Care



Source: Author's compilation.

2. Community Long-term Care

The concept of community has been expanded in response to the complexities of modernity, and includes the village community and the virtual one (Rambo, 2017). In a traditional village community, members are related to one another, live in the same location, and share socio-cultural values. In a virtual or constructed community, members share similar ideas and are willing to work together. Although they have different backgrounds and live in different locations, virtual community members contact each other through the internet. They may or may not interact face-to-face. This type of community is voluntary.

2.1. Village Communities

Most households are unable to provide household or family care for their older members and need community support. Four main actors play important roles in community caregiving: village health volunteers, community organisations and funds, community institutions, and neighbours. Each performs different roles (Jundaeng, 2018 [2561 BE]; Kraichan et al., 2014 [2557 BE]; Koktatong, Manoch, and Seubnuch, 2013 [2556 BE]).

2.1.1. Village Health Volunteers

Thailand adopted the Declaration of Alma-Ata, September 1978, which expressed the need for urgent action by all governments and stakeholders to promote Health of All in 1980, and has developed its primary healthcare system (The Isaan Record, 2015). An important programme was the introduction of village health volunteers (VHVs) to improve access to healthcare services in poor rural communities. Village leaders select 7–10 adults per village to be trained by local sub-district hospitals. Each volunteer is expected to work with 7–12 households in every community. VHVs provide basic care and health check-ups and support older people with impaired ability to perform activities of daily living such as bathing or feeding. VHVs monitor the general conditions of households assigned to them (Kowitt et al., 2015). VHVs are expected to report emergency cases and coordinate with government public health institutions. The number of VHVs is increasing every year. In 2018, there were about 1.1 million (Jewjinda and Chalermnirundorn, 2018).

A study that assessed the effect of pilot projects introducing the VHV system in 24 sub-districts in four regions found that although the programme started in 2003, implementation began in early 2007, when local authorities were allocated funds from the central government so that VHVs could receive frequent training and regular financial support. The study showed that good community, household, and family caregivers were mostly low-income adults from small families, with VHW experience (Whangmahaporn, 2017 [2560 BE]).

Best Practices of Village Health Volunteers in Poor Rural Communities

We identified the following activities as best practices of VHVs. We selected one model from each region. Each model has components of practices of VHVs beyond their routine work.

a. Health map: A model from eight villages of Pua district, Nan Province, in the rural north. With support from sub-district hospitals, the volunteers develop a health map of the older people (Thanakwang, Rattanawitoon, and Tanurat, 2011 [2554 BE]). VHVs record details of the health older people and plot their status on household maps of the VHVs' service areas using symbols to denote 'self-reliant', 'in a risky situation', 'dependent', and 'having chronic or life-threatening conditions'. The maps allow local hospitals to plan their home visits and provide better, timely, and immediate healthcare service to older people (Sisot, 2009 [2552 BE]).
b. Reviving traditional rites: A model from Pang Nga province, in the rural south. To encourage older people to exercise daily, VHVs and community organisations modify a traditional dance, the *menora* by slowing it down so that older people can perform it (Koolnaphadol and Hanjone, 2015 [2558 BE]).
   Dancing is not only an exercise routine but also a way to preserve the region's cultural heritage.
c. Friends Helping Friends: A model from Si Somdet district, Roi Et province, in the rural north-east. The VHVs launched a campaign for relatives and neighbours, Friends Helping Friends (Sawatphol et al., 2017 [2560 BE]). Neighbours, mostly relatives, take turns visiting older people, especially those with limited mobility. Project members help household and family caregivers, who are usually daughters of the people who need care, with household chores.
d. Older people's group: A model from Pothi Prachak sub-district, Singh Buri province, in the rural central region. VHVs, together with community leaders, the local hospital, and the older people's group, organise courses to train younger people to care for older people. Coordinating with village leaders, VHVs set up transport services to take older people to hospitals (Srithamrongsawat et al., 2009 [2552 BE]).

The best practices show that the conditions that enable the community to deliver care to older people are strong leadership, strong community ties, and ability to cooperate with outside organisations, especially health institutions.

2.1.2. Community Organisations and Funds

A strong community organisation is the most important factor for the success of care for older people. We found several community organisations and funds that have developed care services for older people, in rural and urban areas.

Best Practices of Community Organisations and Funds

a. **Community welfare funds for older people.** We found best-practice models of community funds in the rural south that are key to older people's welfare (Yodpet, 2009 [2552 BE]). In Pakpoon, Nakhon Si Thammarat province, energetic community volunteers, including older people, are key to cooperation with health organisations and professionals. With a THB20 membership application fee and THB1 daily savings, an adult aged 60 or over is eligible to receive a lump-sum payment of THB200 after membership of 3 years, THB400 after 6, THB1,000 after 12, THB1,600 after 21, and THB2,200 after 30. In case of hospitalisation (not exceeding 10 days per year and not exceeding 3 days per stay), members and their caregivers are eligible to receive THB100 daily. Ta Kham, Songkhla province, which is similar to Pakpoon, has several sub-district health funds and community welfare funds (Srithamrongsawat and Bundhamcharoen, 2010 [2553 BE]).

b. **Village groups.** Several village groups for older people had been established but had not been active until 2007. The government launched the Health for All programme in 2007 and allocated budget for healthcare to sub-district administrative organisations (SAOs). Then village groups were revitalised and some clubs provided care for older people. Following the example of rural northern communities (Pa Wo sub-district, Tak province; Pa Sak sub-district, Lamphun province; Jae Hom community, Lampang province; and Nonglom sub-district, Phayao province), members of village groups for older people participate in various activities such as exercising and paying respects to older people during the Thai New Year (Songkran) festival. Some communities organise 'mutual visit' campaigns to encourage members to visit older people once or twice a month, particularly those with mobility difficulties (Wongwilairat et al., 2013 [2556 BE]).

c. **Revival of Buddhist teachings of gratitude and the five precepts.** This practice was reported in eight sub-districts of Si Somdet district, Roi Et province, in the rural north-east. Community organisations there initiated monthly visit programmes to households with older people to show gratitude, kindness, and empathy (Sawatphol et al., 2017 [2560 BE]). Visitors ask older people about their happiness, suffering, and health, and bring them food, household necessities, and medicine. Other communities set up welfare funds by obtaining money from members, SAOs, and the Ministry of Social Development and Human Security. Each member pays a THB50 membership application fee, saves THB1 daily, and saves THB50 annually. Funeral funds provide a THB2,100 allowance for funerals and additional allowances, which may not be used for alcoholic drinks or gambling. Abstaining from alcohol is the most important precept and underlies the other precepts against taking life, stealing, engaging in sexual misconduct, and lying.

d. **City-based community practices.** We found three noteworthy practices community care for older people in urban areas.

   Blocks 4, 5, and 6 of Klong Toey community in Bangkok, (Jitramontree, Thongcharean, and Thayansin, 2009 [2552 BE]) cover 3.36 hectares, surrounded by high-rises. This community provides emergency transport; patients are carried on

a stretcher out of buildings. Since 1998, the community has received financial assistance from different sources. For example, with a donation from Father Joseph H. Maier, an American priest, the community built a multi-purpose building. With support from the Social Investment Fund,[5] the community built a healthcare centre. The Red Cross College of Nursing assigns students to the community for field learning and training, and sends therapists and 25 volunteers to work on health registration three times a week. The community set up a *thanakarn uppakorn* (healthcare equipment bank) from which people in need, including older people, can borrow walking sticks, wheelchairs, hospital beds, oxygen tank, amongst others, temporarily or for lifelong use.

Samsib Kanya Pattana, a poor community in Nakorn Ratchasima province, established a health centre in the house of the VHV head. In 1998, community organisations received initial funds from the Social Investment Fund to develop a community shop, which employs older people from the community.

A group of older people and VHVs in Samakkhi community, Maha Sarakham province, established a multilateral cooperation system amongst Maharat Hospital, the nursing college, and the community health centre on home healthcare. Older people receive regular health check-ups from trainee nurses. Those who need emergency medical treatment are transferred to the local hospital (Kraichan et al., 2014 [2557 BE]).

2.1.3. Community Institutions

Every community has three important public institutions: a community committee, a temple, and a school. Most community committee members hold official positions such as village head, village head assistant, and leader of a community organisation. The committee has 2–10 elected members. The committee head is the village head. The committee is expected to carry out programmes to benefit community members, plan and implement development programmes, and supervise other community organisations and/or funds. The term of committee members is 4 years. The committee, monks, and schoolteachers are expected to work together on village development projects. The temple and Buddhism are the centre of village life. The following describes a model of how a temple cares for older people.

Maeka Temple, Payao Province

On the initiative of the abbot of Maeka temple, a school for older people was established in 2014 to help them stay active and age gracefully (Jundaeng, 2018 [2561 BE]). The 14 volunteer teachers are monks, retired teachers from community schools, and health personnel from the sub-district hospital. The students must be over 55 years old. The school has three levels and each level has three courses: Buddhism and way of living (good

[5] The Social Investment Fund was under the Social Investment Project, initiated by the government with a World Bank loan. The project started in 1997. The fund emphasised social capital formation to help poor communities affected by the socio-economic crisis. Community development projects received THB450,000–THB11,250,000 each.

health and good spirit), academic subjects (English and math), and vocational training. Each course takes 20–24 days. To move on to the upper level, the students must pass exams. The number of students has increased every year. In 2017, the school had 120 students.

2.1.4. Neighbours

Villages used to have a high level of solidarity based on kinship ties. Such solidarity has started to decline due to modernisation. However, most studies done in the past 10 years show that ties are still strong in many villages. The villagers consider each other relatives. They help each other out with farm work, childcare, and care for older people. Neighbours and relatives are expected to help take care of older people. (Cooperation between VHVs and neighbours is discussed in 2.1.1.)

2.1.5. Strengths and Limitations of the Village Community as Caregiver

Village life is going through a great transformation in agricultural technology, social systems, cultural values, people's aspirations, and villagers' sense of identity (Rambo, 2017). The traditional subsistence economy has been replaced by a capitalist market-oriented one. Villagers migrate to find jobs in cities and abroad. The migrants send money back to their families in the villages. The number of skipped-generation households – those with children and only their grandparents – is increasing. Rural people are becoming more integrated into national, regional, and global socio-economic systems. Community organisations depend more on government financial support and less on people living in the same communities. It is thus a challenge for communities to continue caring for older people.

2.2. Virtual Community

The rapid social transformation has affected people's livelihoods and communities. Life has become more hectic, confusing, and complicated, isolating people more than ever. However, modernity does have positive effects. It has transformed people's relationships. People working far from home can easily communicate with older family members using information and communication technology, creating a sense of virtual co-residence and virtual care. Not only voice and video calling but also fund transfer has been drastically simplified. Packages can be delivered anywhere in the country in a day. People create new relationships in a rapidly changing society.

The virtual community provides several types of caring. Community members offer spiritual support to older people who are dying, such as those in the terminal stage of cancer. To those who require full or partial assistance in their daily lives, the virtual community can provide social and economic support. Providing respite to family caregivers is important. Caregivers post their requests through Facebook or LINE to community members who can help.

Several virtual community best practices follow.

Compassionate Community

The idea of mobilising community support for palliative care emerged from Kerala, India. Non-governmental organisations set up an outpatient clinic and home care services in 1993. Recognising that coverage was limited and that volunteers were important, Dr.Suresh Kumar established Neighbourhood Networks Palliative Care, which empowers local communities to care for the chronically ill and the dying (Sitthiwanthana et al., 2019 [2562 BE]; Kumar and Palmed, 2007; Paleri and Numpeli, 2005). These efforts gave rise to the Institute of Palliative Medicine, established in Kozhikode, Kerala (Institute of Palliative Medicine, n.d.).

In the later 2000s, a system of community-based palliative care similar to Kerala's – *chumchon karuna* or compassionate community – was formed in Thailand (Sitthiwantana et al., 2019 [2562 BE]}.

Dr. Rojanasak Thongkhamcharoen of Mae Sot hospital, Tak province, a key person in community-based palliative care, shared his experience in initiating the project (Sitthiwantana et al., 2019 [2562 BE]). Having cared for housebound and bedridden patients, he found problems ranging from lack of caregivers to lack of necessary appliances. He looked for allies in Buddhist and Muslim networks, retired officials, student trainees, and local leaders. After extensive consultation, they asked hospitals to train volunteers and community members in healthcare and palliative care. Monks provided training in how to give spiritual support to patients.

This compassionate community was established as a village-based cooperation system but has been expanded to involve the people from different backgrounds – families and friends of patients, religious people, health personnel, and good Samaritans who have no association with the beneficiaries or no professional background. The compassionate community accepts people from other places such as Bangkok, Chiang Mai, Khon Kaen, and Ubonratchatani. Community members share experiences and ideas and learn from each other using email or social media (Facebook or LINE). Those who need support can post their requests on social media. Members respond in several ways, including paying short or long visits, being asubstitute caregiver .

Art Therapy for Underprivileged Cancer Patients

The non-profit ART for CANCER was founded by Ireal Traisarnsri, a breast cancer patient, in 2011 to provide art therapy for underprivileged cancer patients at three government hospitals: Siriraj hospital, Ramathibodi hospital, and the National Cancer Institute in Bangkok. She started working with Sirinthip Khattiyakarn, a survivor of advanced malignant lymphoma. They expanded their activities and established a social enterprise in 2018 (ART for CANCER, n.d.). They organise campaigns for donations to underprivileged cancer patients. Activity participants contact each other through online networks and occasionally meet face-to-face.

The I-see-U Community

The I-see-U community was launched by Arunchai Nitisupornrat and Phra Khanchit Akinchano, abbot of Weerawongsaram Temple, Chaiyaphum province, in 2014 (Thai Happiness Team, 2016 [2559 BE]). The community offers Buddhist teachings with healthcare and palliative care in a series of courses. Each course has about 40 participants. An online chatroom was set up for participants to share activities with patients in various hospitals. Six hospitals work with the group in various activities.

Last Happiness

The Muangnamdam (the old name of Kalasin province) volunteer group in Kalasin province conducts Sook Sud Tai (Last Happiness) in the community (Srisuwan, n.d.). The activity raises awareness amongst volunteers that give spiritual support to dying patients. After training, groups of volunteers routinely visit terminally ill patients. In 2016, the Kalasin municipal authorities sponsored the Last Happiness project using the municipal healthcare fund.

Pray for Love

Buddhachinnaraj hospital, Phisanulok province, with financial support from Chonlapratarn hospital, pioneered in palliative care combined with Buddhist teachings and developed Pray for Love (Sitthiwantana et al., 2019 [2562 BE]). The idea of spiritual support embraces other religious beliefs, too. Members are those who are losing or have lost their loved ones. They may not have known each other before joining but are willing to support those in similar circumstances. Notified by a grieving family on the webform, members set the time and place to share grief and gratitude with people with life-threatening illnesses and/or their families and/or relatives. Pray for Love has been active since 2010.

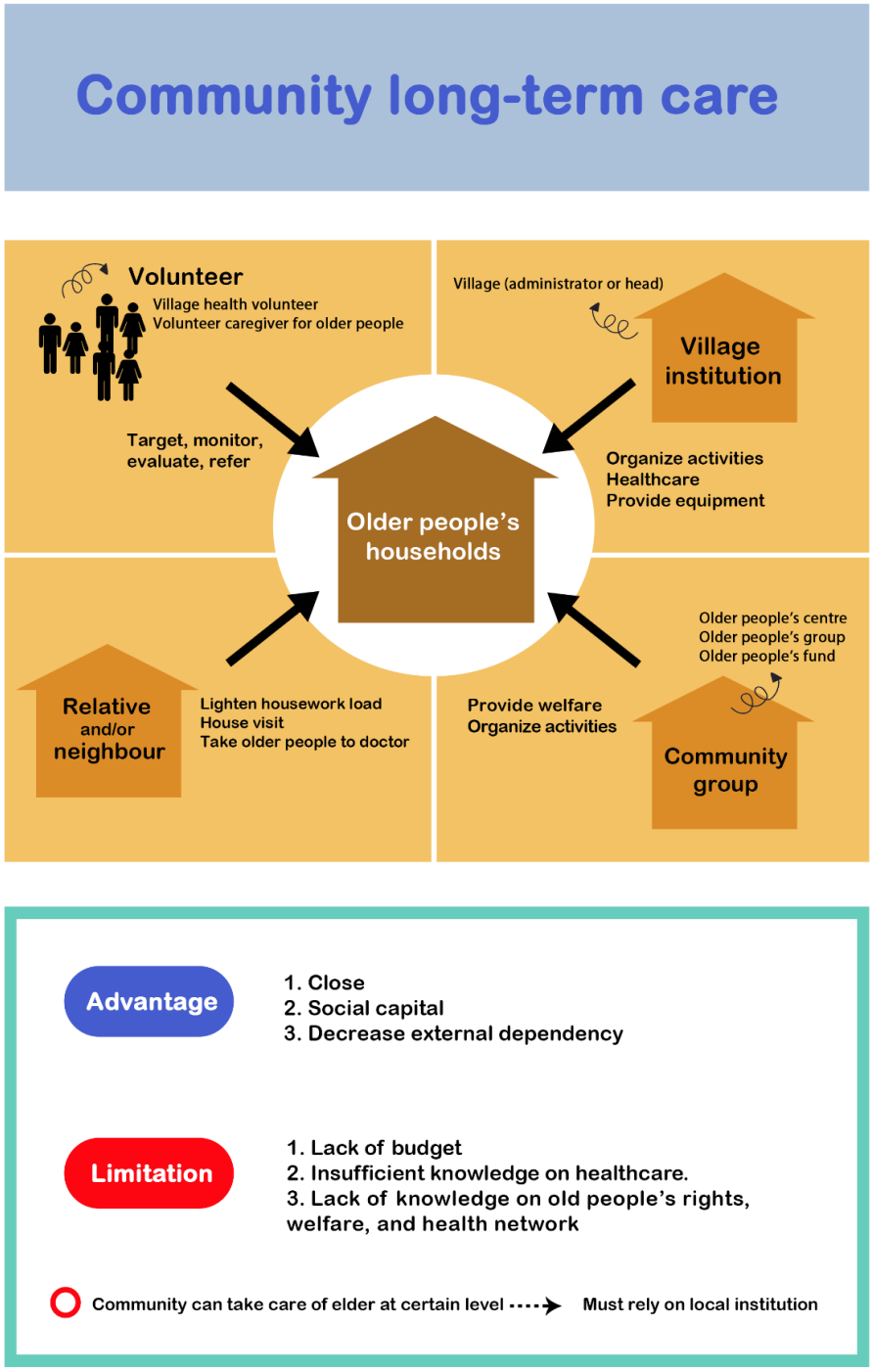
The forOldy Shop

The forOldy Shop was founded by Oranuch Lerdkulladilok, a retired government official from the Department of Community Development, Ministry of Interior. Her responsibility was to support people living in Bangkok slums. In 2010, with financial support from Help Without Frontiers Foundation, she set up Rann Khun-ta Khun-yai (grandpa-grandma shop). Through the information board on its website, the shop asks for donations of equipment for older people, such as wheelchairs, hospital beds, and oxygen tanks. The shop then lends them to those in need at cheap rates daily or monthly. The shop is run by older people. They help record equipment rentals, collect rental fees, and see to the needs and health of older people in the community. The shop set up the Kong Toon Un-jai (Be at Ease Fund) to provide funeral assistance with the motto ‘Graceful old age, comfortable sickness, and peaceful departure’. Members of the fund pay THB20 twice a month. The project now covers nine areas in Bangkok: three communities in Sathorn district, two in Sai Mai, one in Kanna Yao, and three in Dusit.

From the study on village long-term care, we found that some communities, particularly impoverished ones, had difficulty collaborating with outside networks. The virtual community, it is hoped, will transcend such limitations.

Figure 3.2 describes community long-term care.

Figure 3.2: Community Long-term Care



Source: Author's compilation.

3. Local Long-term Care

This section lays out the local model. In this report, 'local' refers to SAOs, sub-district hospitals and health centres, and district and provincial hospitals.

The SAO[6] is the smallest of the local administrative organisations and closest to the local people. In 1999, the responsibility of developing local healthcare systems and managing district hospitals was transferred from the national government to local administrative organisations. The local healthcare budget was allocated directly to local government. Since then, local elder care has taken off (Whangmahaporn, 2017 [2560 BE]). Direct budget from the national government enables SAOs to provide healthcare, including for older people, flexibly and effectively. Several policies have been implemented.

The other three local entities are the sub-district, district, and provincial hospitals, which are all governmental organisations. Besides medical services, the hospitals provide care for older people and mobile home healthcare. The home healthcare team is composed of doctors, nurses, physical therapists, and social workers.

We found two best-practice models from many studies.

Joint Management Model of Long-term Care by SAOs and Local Hospitals

This model can be effective if the community has a hospital. We found six cases of this model, in Me Prik district, Chiangrai province, in the rural north; Pakpoon sub-district, Nakorn Si thammarat province, in the rural south; Khao Suan Kwang district, Khon Kaen province, in the rural north-east; Baan Kruad district, Burirum province, in the rural north-east; Baan Paew district, Samud SaKorn province, in the rural central region; and Chalay and Na Suan districts, Kanchanaburi province, in the rural central region. The hospitals have special units to care for older people and offer long-term care. However, district and provincial hospitals generally do not have enough trained doctors to work in communities. The SAOs coordinate with VHVs to support local hospitals' mobile home healthcare units. The VHVs conduct routine health check-ups and regularly report to local hospitals and refer patients to larger hospitals if necessary (Srithamrongsawat and Budhamcharoen, 2009 [2552 BE]). The findings from the model cases suggest that, to facilitate local hospitals' provision of good care for older people, local hospitals' home healthcare units should be administratively independent, receive direct financial support, and be equipped with personnel trained to work in community.

[6] The tambon (sub-district) councils were first established in 1956. They were part of the direct administrative system of the national government and consisted of representatives from each village in the sub-district, village heads, the sub-district head, teachers, and five others. The Tambon Administrative Authority Act 1994 and the Constitution of 1997 drastically changed the sub-district administrative system. The councils were converted into SAOs, which were not directly associated with but were supervised by the government. SAOs still receive their budgets from the central government. The budget depends on the SAO's size and tax income. Most SAO members are elected from each village in the sub-district.

Joint Management Model of Long-term Care by SAOs and Community Committees

We found several successful models of joint management between SAOs and community committees, in Pasak sub-district, Lumphun province, in the rural north; Pa Wo sub-district, Tak province, in the rural north; Pak Poon sub-district, Nakorn Si Thammarat province, in the rural south; Baan Kruad district, Burirum province, in the rural north-east; Ta Mai and Jorake Puak precincts in Kanchana Buri (in the rural central region). They started developing community long-term care systems and then coordinating with local hospitals.

All the cases started with the establishment of seniors clubs in the early 2000s. They hold regular recreational activities; follow the advice of VHVs based on the results of health check-ups; and provide transport to hospitals for those who need it, with priority given to older people. The clubs receive financial support from community committees.

According to a study by Suthisukon et al. (2014 [2557 BE]), SAOs in the rural central region adopted the '4M' business management principles to care for older people: (1) manpower: home visits by VHVs, SAO members; (2) money: allocation of budget from sub-district hospitals to SAOs and communities; (3) material: distribution of basic healthcare equipment (pressure gauges, feeding tubes, thermometers, glucose meters, amongst others) to communities; and (4) method: setting up Friends Helping Friends projects, training volunteers, providing healthcare services, and offering 24-hour transport to older people.

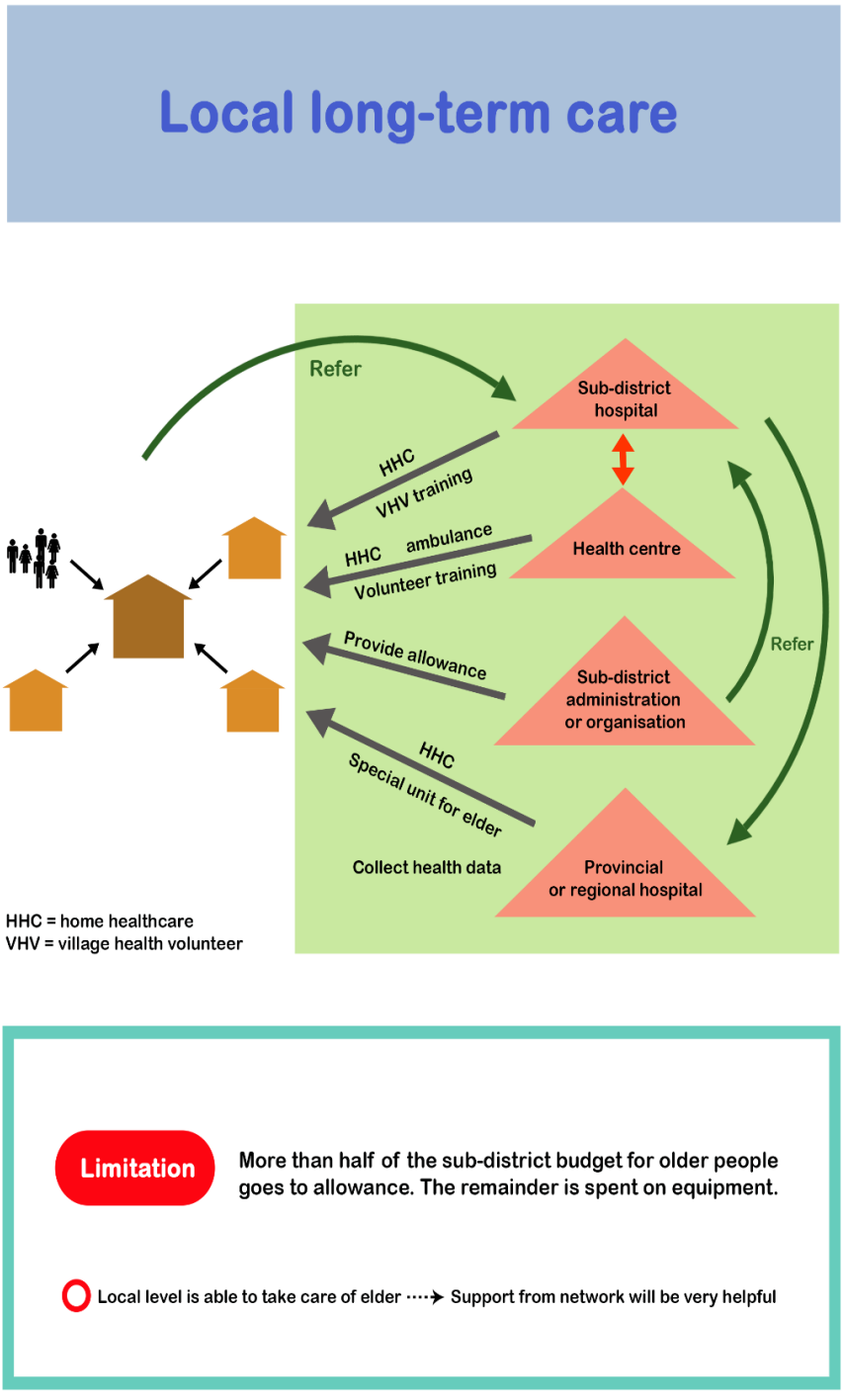
SAOs receive financial and technical support from sub-district hospitals, and SAOs help communities set up small day-care centres in community temples.

Limitations of Local Administrative Organisations

Although some local administrative organisations provide best-practice models for long-term care, many others do not have such resources. Sudsomboon et al. (2016 [2559 BE]) found that most SAOs were not concerned about population ageing although they knew that the number of older adults had been increasing year by year and would have a great impact in the future. Most SAOs mainly just provided allowances for older people, with some SAOs spending more than half, in some cases more than 90%, of the budget for older people on direct allowances (Yodpet, 2009 [2552 BE]).

SAOs have too many responsibilities assigned to them by different government departments, other than population ageing issues. Such excessive burden on SAOs may have resulted in the insufficient development of local long-term care systems.

Figure 3.3: Local Best Practice



Source: Author's compilation.

4. Network Best-practice Model

Household, community, and local care for older people each have strengths and limitations. Creating networks of stakeholders would enable them to collaborate, strengthening each other.

We classified network best-practice models into three categories, according to patterns of coordination amongst stakeholders: doctor-led local networks, local hospital networks, and health information networks.

4.1. Doctor-led Local Network

Lamsonthi District, Lop Buri Province

The success of the doctor-led local network in Lamsonthi was said to be the result of the family-doctor model implemented by the Public Health Foundation.

In 2006, Dr. Santi Larpbenjakul, director of the Lamsonthi hospital, found several old dependent patients living in their households without proper care. He then set up a care team by coordinating with the SAO (Khonthai Foundation.Org, 2018). After 5 years, the network expanded to the other six sub-districts.

The team includes health professionals from district and sub-district hospitals, community leaders, and volunteers. Its main task is to ensure housebound patients' health and social well-being. The medical professionals – doctors, nurses, physical therapists, psychologists, and pharmacists from local hospitals – offer services at patients' homes. Volunteers help patients in routine activities such as bathing, feeding, haircuts, nail clipping, and adjustment to the residential environment.

The volunteer caregivers receive a monthly allowance of THB5,000–THB5,500 from SAOs to take care of bedridden patients (Matichon Online, 2016). Each sub-district has three or four volunteers. In 2016, six sub-districts had a total of 30 volunteers.

The community funds played a key role in care for older people. In 2016, 160 community funds provided financial support to older people throughout Thailand. In Lomsonthi, a community fund was piloted and gained support from government and non-governmental organisations (National Health Commission Office, 2017 [2560 BE]; Srithamrongsawat et al., 2018 [2561 BE]). In 2016, THB10 million was donated to build the Geriatric Care Centre (Sinuraibhan et al., 2016 [2559 BE]). The centre, equipped with 20 beds and two-bedroom suites, focuses on patients who have had strokes and brain and spinal injuries. The centre offers respite care to relieve home caregivers. The centre plans to launch its own social enterprises to become financially independent.

4.2. Local Hospital Network

The best-practice models of care-providing systems for older people are often found in communities around district hospitals. Such communities have the advantage of proximity to hospitals in developing long-term care systems. In this section, we present three cases as best-practice models of collaboration between local communities and hospitals to provide care to older people.

Baan Paew District and Baan Paew Hospital Network

Baan Paew hospital, next door to the Baan Paew district office in Samut Sakorn province, was set up in 1965 with 10 beds. It later became a district hospital, with 30 beds. After the 1997 economic crisis, the Ministry of Public Health reformed government health facilities by allocating budget to sub-district hospitals to encourage their financial independence. Privatisation of sub-district hospitals was promoted if they had the potential to be sustained as private hospitals (Matichon Weekly, 2017 [2560 BE]).

In 1998, the Health Systems Research Institute surveyed potential sub-district hospitals for pilot projects, including Baan Paew hospital, which had strong support from the community, many members of which were willing to join the hospital executive committee. In 2000, the cabinet passed a decree for Baan Paew hospital to be the first public organisation under the Ministry of Public Health.

With an active executive committee, Baan Paew hospital has been steadily growing over the years. The hospital started with about 150 personnel and 600 outpatients per day, but it had been expanded to about 1,200 personnel and 3,000 outpatients per day by 2015. The hospital has a variety of specialists who offer holistic healthcare services and transfer know-how to nearby communities, with which the hospital has always worked closely.

Mae Saruay Hospital, Mae Sot Hospital, and Religious Organisations

Mae Saruay district hospital, in Mae Prik sub-district, Chiangrai province, has played a key role in care for older people since 1993 by providing home healthcare. A multidisciplinary team regularly visits nursing homes.

In Tak province, the Catholic Centre and Pa Wo community work closely with Mae Sot district hospital. They have a multidisciplinary team to provide medical care and social support to older people. The team visits households on the first Friday of every month (Wongwilairat et al., 2013 [2566 BE]). Medical personnel from Mae Sot district hospital are team leaders responsible for medical care, whilst the Catholic Centre helps organise church members, especially retired nursing assistants, and other experienced caregivers, to participate in home healthcare. VHVs in Pa Wo guide the team to older people's households. The home healthcare services include basic physical examinations, health advice, and referral to higher medical facilities if necessary, amongst others.

Maharaj Hospital and Village Health Volunteers in Samsib Kanya Pattana Community

Maharaj provincial hospital in Nakhon Ratchasima province organises VHVs in Samsib Kanya Pattana community, Muang district to develop family health units (*vetchapatibut kropkrua*). The units provide primary care, especially for older people (Jitramontree, Thongcharean, and Thayansin et al., 2009 [2552 BE]). In case older people need higher-level medical treatment, Maharaj hospital accepts referrals. The VHVs perform routine health check-ups of people just discharged from hospital and forward the results to the patients' doctors to decide whether further treatment and medical intervention are needed.

The cases suggest that the success of health networks is owed to close cooperation amongst stakeholders, such as VHVs, community authorities, and local hospitals, amongst others.

4.3. Health Information Network

This section shows two best-practice models that improved healthcare and long-term care services using community-based health information systems.

Walailak Univesity and Family and Community Assessment Program Health Data System

Walailak University gave scholarships to nursing students from Pakpoon SAO, Muang district, Nakhon Si Thammarat province (Yodpet, 2009 [2552 BE]). In 2004, Dr. Urai Jaraeprapa from the Faculty of Nursing, and the team from Tasala hospital developed the Family and Community Assessment Program (FAP) information system to facilitate self-management in community health. Pakpoon SAO was responsible for collecting data. The FAP database covered community assessment, household situations, and villagers' health information. The team then analysed the information to evaluate the health and well-being of each participant in pilot projects in 12 villages. Dr. Urai's team trained SAO officials to collect data and advised them on data processing.

With the success of FAP, Pakpoon SAO received further funding from the Thai Health Promotion Foundation to expand the FAP model to 60 sub-districts in 2007.

The Case of Mae Tha Hospital and Continuity of Care Health Data System

In 2016, Mae Tha district hospital in Lampang province created the Continuity of Care programme to link health data between Mae Tha district and Lampang province (Wicha et al., 2018 [2561 BE]). The health data system facilitates communication between patients and physicians involved in ongoing healthcare management. The data are uploaded into the system from Mae Tha district hospital to Lampang provincial hospital. The provincial hospital staff members can detect immediate and long-term patient needs through the system. Physicians then add preliminary diagnoses into the database and send them back to Mae Tha district hospital. The intensity of required care based on collected data is plotted on a map of households. Households with people who have chronic illnesses, have disabilities that require full or partial assistance in their daily lives, and need intensive care are marked with a red symbol, indicating urgent need for care. In case the database detects patients suffering from multiple chronic conditions, an interdisciplinary team visits the patients within a couple of weeks and then plans frequent home visits. The interdisciplinary team is composed of not only physicians but also physical therapists, social workers, and psychologists. Households marked with a yellow symbol – indicating less serious cases – are visited every 2–4 weeks. After home visits, the team updates the status of participants in the Continuity of Care health data system.

5. Summary

Long-term care covers the system of not only medical care but also socio-economic and environmental aspects of lives of people who suffer from illnesses and need assistance in their daily activities. Such people need comprehensive care (Sasat et al., 2009 [2552 BE]). From this review of long-term care practices based on Thai-language publications in the last 10 years, we find that long-term care focuses more on the healthcare system than on other aspects of care.

Long-term care is offered at the household, community, local, and network levels. With certain limitations, household members have the capacity to care for older people who are still self-reliant even if they have some difficulty in mobility. In rural households, family caregivers are mainly daughters in their 30s or 40s who have low education levels and incomes. Agricultural households cannot afford to employ professional skilled care workers, but strong community support can lighten the burden of care.

Two types of community can contribute to long-term care: village and virtual. The main actors in village communities are VHVs, community organisations or funds, community institutions, and neighbours or relatives. VHVs and community organisations or funds play key roles in providing long-term care for older people. Some strong community organisations provide financial support to older people. Some village temples and schools have set up schools to train older people in self-care and for jobs. The revival of Buddhist beliefs targets not only older people but also young villagers. Village life is going through a great transformation from subsistence agriculture to a market-oriented economy, so strong networks outside villages, such as public support, will be more important to further develop village long-term care systems.

Since information and communication technology have become widespread, the once small virtual communities have expanded. Members are retired officers, religious group members, local leaders, and those with direct experience in caring for older people. Members are socially and spiritually linked through online networks and occasionally meet face-to-face and care for older people in person. They share ideas and experiences, raise funds, develop training programmes for caregivers, and provide substitute caregiving to relieve family caregivers. Virtual communities provide several types of care. Members may help older people in the final stage of life, such as those suffering from advanced cancer, by offering spiritual support. To those who need assistance in daily life, members may provide social and economic support so that clients may live in dignity. Most of these activities occur only in Bangkok.

Local care for older people is offered by four public organisations: SAOs, sub-district hospitals, district hospitals, and provincial hospitals. Close and full cooperation amongst communities; SAOs; and sub-district, district, and provincial hospitals is the most important factor for success.

Local long-term care is provided through doctor-led, local hospital, and health information networks. If long-term care systems are developed separately and only at one level, they will be limited. Networking is the key to establish long-term care systems that can provide good care for everyone who needs it.

Table 3.1 shows the main actors at each level of care, the practice models, and their strengths and limitations.

Table 3.1 : Long-term Care in Thailand

Levels of Practice	Main Actors	Practice Models	Advantages	Limitations
1. Household	Daughter	Support for daily activities, housework	Close, intimate	Unskilled, low income, health problems, stress
2. Community 2.1. Village	Village health volunteer (VHV)	- Health map - Revival of traditional rites - Friends Helping Friends - Older people's clubs	- Receives regular training - Has voluntary work experience - Has coordination skills - Brings together health and administrative personnel	- Small number of trained VHVs - VHVs have their own household chores.
	Community group or fund	- Elderly welfare - Home visits - Encouragement of Buddhist teachings - City-based practice	- Less external dependency - Close to older people and can react quickly	Not many communities have such a strong group.

Levels of Practice	Main Actors	Practice Models	Advantages	Limitations
	Relatives and/or neighbours	- Friends Helping Friends - Lightens load of family caregiver - Provides respite to family caregiver - Improves living environment - Provides transport	- Close to older people and can react quickly	Community is becoming less connected.
	Village institutions (village administration, temple, school)	- Financial, social, and spiritual functions	- Authorised in budget allocation - Receives budget from government	Heavy workload due to high expectations of many government authorities
2.2. Virtual community	- Family member - Neighbour - Religious person - Health personal	- Compassionate Community - Cancer healthcare and co-caring space - I-see-U Community - Last Happiness - Pray for Love - - forOldy	- Flexible space - Voluntary - Expandable - Starts with small capacity - Informal	- Not institutionalised, hence not stable - If institutionalised, not flexible and may lose voluntary spirit

Levels of Practice	Main Actors	Practice Models	Advantages	Limitations
3. Local	- Sub-district administrative organisation (SAO) - Sub-district hospital - District hospital - Provincial hospital	- Joint management of SAO and local hospital - Joint management of SAO and community committee	- Professional health personnel - Knowledge of the rights of older people - Ability to coordinate at higher levels	- Not possible for remote communities - More than half of SAO budget is spent for pension.
4. Network	- Doctor-led local network - Local hospital network - Health information network	- Lamsonthi model - Baan Paew model - Family and Community Assessment Program and Continuity of Care Link	- Compiles several dimensions of care, health, social, and culture - Mobilises resources	Most cases are pilot projects, which need to be followed up.

Source: Initiated by Tantuvanit (2019).

6. Recommendations

6.1. Policy Recommendations

a. Allocate budget for poor family caregivers on a monthly basis. Most family caregivers, especially in rural areas, are socially and economically disadvantaged. They are overlooked and have never received support from the state. Special support is required to have them be recognised as an indispensable part of society.
b. Provide budget to support a health information network. The practice models shown in this chapter were just pilot projects, which succeeded in efficiently allocating resources for long-term care. This type of network should be expanded and sustained so that more resources can be mobilised efficiently.
c. Develop policies not only to cover healthcare but also to focus more on socio-economic development and the improvement of the living environment of older people and caregivers. Encourage joint management of long-term care amongst SAOs, community committees, and local hospitals. Some local hospitals succeeded in developing linkages and networks. The success of these cases, as discussed in this chapter, depends on personal ability. It is necessary to provide training for knowledge and experience sharing from successful cases to inexperienced ones.

6.2. Practice Recommendations

This set of practice recommendations is to encourage routine work of government organisations and local networks. There are many practice models that have already been realised as policies but not yet been implemented.

a. Organise regular training of village health volunteers (VHVs). Trained and experienced VHVs are key for community long-term care, but only a small number of VHVs receive regular training.
b. Encourage local hospitals to set up special units for care of older people and organise regular mobile home healthcare.
c. Support village temples to set up day-care centres and/or community schools for older people. Abbots of community temples play important roles in communities that have successful long-term care. These day-care centres not only provide healthcare but also social and spiritual support to older people.

6.3. Research Recommendations

a. Study the practice of virtual communities. Even though they are expanding, there is no research on their practice. Information about their activities comes from leaders of the communities, not from the members and the older people who receive the services.
b. Develop a national long-term care database. The two health data systems discussed in this chapter were pilot projects that aimed to collect information on health and well-being of people in rural areas. However, the focus of data

utilisation was on healthcare. A long-term care database must be developed. A unified data system for long-term care will allow healthcare providers to access the older people's health records and ensure their socio-economic well-being.

c. Study how virtual communities provide care for older people.

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Chapter 4

Institution-based Long-term Care

Supaporn Asadamongkoln and Duangjai Lorthanavanich

The World Health Organization (WHO) referred to long-term care as indispensable in the healthcare system and social services because it assists the disabled and chronically ill. Care can be short or long term, at home, in the community, or at a seniors' nursing home (WHO, 2000).

Mostly female, caregivers feel powerless. One-third have chronic health problems. Caregiving imposes a considerable economic, physical, and psychological burden on the families of older people who need care. Most caregivers had never provided long-term care. One in nine cares for more than one older person. Long-term care depends on family caregivers, typically because of a sense of gratitude.

Most families are not ready to provide long-term care and community support is inadequate. A support system for family caregivers should be developed so that they have more options to care for older people in communities. For instance, the following measures can be considered to ensure the sustainability of long-term care: (1) develop primary healthcare facilities, (2) strengthen local administrative organisations' role in managing the long-term care system, (3) build the capacities of family caregivers, and (4) develop standards to ensure the quality of long-term care (Sihapark, Chuengsatiansup, and Tengrang, 2013).

A sense of gratitude to older people is the fundamental principle of long-term care. The state policy is to support family care at home because the family is believed to provide the best caregivers for older people. However, with social and economic transformation, the family cannot always play a key role in long-term care. Families with older adults who have deteriorating and increasingly complicated chronic conditions need help from medical professionals or specialists. Stakeholders in the care for older people are encouraged to develop nursing services in healthcare centres or medical institutions.

1. Five Types of Institution-based Long-term Care Facilities

Institution-based long-term care facilities are grouped into the following: (1) residential homes, (2) assisted living settings, (3) long-term care hospitals, (4) nursing homes, and (5) hospice care (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]).

1.1. Residential Homes

The facilities are designed for older people who can carry out activities of daily living independently. The facilities are also called 'independent living communities' and 'retirement communities'. Residents should be able to walk without the assistance of nurses or caregivers even if they use canes or walking aids and be able to perform other activities of daily living such as bathing or dressing. A couple of model cases will be presented in this chapter.

1.2. Assisted Living Facilities

These are residences for older people who need help in activities of daily living. The institutions are designed for people who cannot modify their home's living arrangements in accordance with their functional limitations and cannot ensure their own safety. The facilities offer basic geriatric services but usually do not provide specialised medical services. Canteens are available and emergency alert systems are installed.

Thailand does not have many such facilities. Some have been set up by Christian missionary organisations, which run them as non-profit long-term care facilities, offering help in activities of daily living and rehabilitation services. Their service provision is not based on public policy but on Christian philosophy. the missionaries could offer estimable services, believing that caregiving is a means of fulfilling God's wish to love one's neighbour as one's self (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]).

1.3. Long-term Care Hospitals

Long-term care hospitals provide care and medical treatment for 3 months or more. Both state-run and private hospitals provide such services, but the cost of private long-term care hospitals can be higher.

Some state-run hospitals designate special wards for providing long-term care for seniors who have functional limitations and need rehabilitation. Staff members create care plans for each patient in accordance with the individual's functional status. Items included in care plans cover a variety of services, such as support for activities of daily living, rehabilitation, medical treatment, alternative medicines, amongst others, which are provided by caring teams consisting of multiple professionals. In these wards, equipment and facilities should be arranged to optimise patient's functional recovery. Services must develop in accordance with the standards of Thai Healthcare Accreditation (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]).

1.4. Nursing Homes

Nursing homes accommodate people who have difficulties in activities of daily living because of chronic conditions such as sequelae of brain injury and cannot rely on family or community care. The clients do not need acute care but do need intensive long-term care. Care services – medication, feeding, amongst others – are provided 24 hours a day and 7 days a week. Basic medical treatment can also be provided. The outcome, effect, and safety of rehabilitation are carefully monitored. In case of complications caused by rehabilitation, clients' conditions and service plans are discussed by a team comprising

physicians, pharmacists, nurses, and physical therapists (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]).

1.5. Hospice or Palliative Care

The aim of hospice care is to diminish the pain of dying patients so that they can spend the last stage of their lives happily and peacefully with family members and friends. An interdisciplinary professional team provides integrated services adjusted to the needs of individual patients. Spiritual care is encouraged. A model case of hospice care –a hospice ward in a hospital for Buddhist monks – is discussed in this chapter (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552BE]).

Thailand has long-term care hospitals and nursing homes but they are mostly in Bangkok or the central region. The facilities are expensive and unsupervised because clear regulations are lacking.

We recommend developing a long-term care system that involves local communities, local authorities, and hospitals. We believe it is the most effective long-term care model for Thailand. Local authorities are encouraged to take more responsibility in this aspect and to optimise their capacity and capability.

2. Preferred Models and Innovations of Long-term Care Facilities

2.1. Models of Long-term Care Facilities

In 2015, the National Reform Council–appointed systems reform committee for responding to population ageing proposed long-term care for frail and dependent older people. The government allocated budget to the National Health Security Office to support the plan to develop long-term care programmes (Knodel et al., 2015). Since then, long-term care services have been developed more systematically. Government policies focus on how older people can age with their families in the same communities. Most people have a negative view of families who consign their older family members to long-term care institutions such as nursing homes. The international trend of 'ageing in place' encouraged the development of day-care centres, which is more acceptable in Thailand than residential services. A senior residential home should be the last option when older people who do not have any relatives to care for them. To promote happy ageing, older people should be provided with places to live within their communities even if they can no longer live independently in their own houses (Department of Older Persons, 2017 [2560 BE]).

Although the government and long-term care providers focus on family care and community care, some models of institutionalised care offer alternatives when families and communities can continue taking responsibility for care of older people even after institutionalisation. The practical models are described below. Some fall into categories already introduced, whilst some adopt mixed approaches that cover both institution- and community-based care to provide suitable services.

1) Residential Homes

Residential homes offer services to independent older people who do not need much assistance from nurses or caregivers. The institutions provide social services, healthcare, rehabilitation, referral, and a variety of activities, amongst others. Residential homes are operated by the government, the private sector, or public welfare organisations.

A possible residential home model is state-run residential homes. A good example is Baan Bangkhae, discussed here, or welfare management centres, which have been established in several provinces.

Residential homes may jointly work with other organisations such as local education institutes to optimise the potential of other sectors to promote the development of long-term care. For example, Baan Thammapakorn in Chiang Mai jointly worked with researchers from Chiang Mai University's Faculty of Nursing to establish service quality standards.

State-run residential homes that can be considered models of residential homes are discussed below.

a) Baan Bangkhae Senior Living

Baan BangKhae is operated under the Department of Social Development and Welfare, Ministry of Social Development and Human Security, and aims to provide social welfare for older people who have low income, no residence, and nobody to care for them, or who are unhappy staying with their family. The state-run residential home provides not only basic services such as accommodation, food, and day-to-day care but also rehabilitation and referral services for residents who need expert medical treatment. Residents can participate in health promotion activities and self-care programmes.

This residential home provides various services in cooperation with other agencies:

- regular health check-ups provided by Poh Teck Tung Foundation;
- nursing care provided by faculties of nursing of various universities;
- a post-surgery rehabilitation programme in cooperation with the Japan International Cooperation Agency, which supports physical therapist volunteers; and
- referral of the residents for further medical treatment, supported by the Bangkok Metropolitan Administration public health centre.

To strengthen the financial fundamentals of the residential home, the Baan Bangkhae Foundation was set up to receive donations. It is helping transform Baan Bankhae senior living from a rigidly managed system to a more flexible and efficient one (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

b) Sawangkanives Senior Living

Developed by the Thai Red Cross Society, the residential home has 20 acres in Samutprakarn province and 468 housing units for older people in good health and able to live independently. The target group is those who are 55 years or above, with a middle-class income. Residents are required to make a lump-sum payment when they are admitted (Sawangkanives, n.d.). Of the residents, 70% are single and divorced women.

The distinctive points of the two residential homes are their quality services –health management, referral services, social activities, and rehabilitation – and living arrangements. Their management systems are similar to those of private facilities in flexibility, regular staff meetings, clear job descriptions, and routine reporting of client status to families. Residents' activities are closely monitored by staff members to avoid risk of injuries by falls, for example. The residential homes collaborate with the nursing faculties of various universities. Nurses are sent there to help manage residents' health (Sasat, Choowattanapakorn, and Letrat, 2009 [2552 BE]). The success of developing senior living or residential home projects depends on effective partnership amongst estate developers; hospitals providing healthcare services, including for mental health; and social service providers.

2) Long-term Care Hospital

Long-term care in a hospital is a feasible model. A 60-bed hospital in a small district in central northeast, for instance, offers long-term care, including rehabilitation services to older people who have chronic conditions and mobility problems, in parallel with medical services as a general hospital. Most patients have stroke-related motor function impairment. A variety of rehabilitation courses are available, such as acupuncture, Thai massage, and physical therapy, in special wards for older people. To transition seamlessly from hospital to home and community, families and relatives are given guidelines on geriatric care. Follow-up is made a week after discharge by telephone. Patients can use either the social security or welfare schemes to claim healthcare benefits (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

3) Day-care Facilities in Hospitals

Day-care facilities have been developed to support the urbanised lifestyle, in which fertility rates are low and most people work outside their homes. In urbanised societies, older people often cannot find anybody who can care for them at home. In traditional societies, family members are expected to care for older people at home, which discourages family caregivers from finding other work. Day care is crucially important in urbanised societies, where family members can no longer provide care at home. Day care can give older people quality care during the day, when family members are not at home. Family members do not have to worry about leaving older people at home alone, and older people in day-care facilities can participate in a variety of activities. Day-care centres should be small (capacity of about 10) so they can be set up anywhere in communities. The following are good examples of day-care facilities in hospitals:

a) Talaysap sub-district health promotion hospital

The hospital is in Pa Tiew district, Chumpon province. It has a day-care centre for older people whose adult children work outside the home. Clients are brought to the centre in the morning and picked up in the evening. The centre offers various activities but sometimes encounters problems, such as when clients prefer to stay home. The centres have recently started training clients to become caregivers of bedridden older people. It turns out that many prefer working as caregivers. The day-care centre was therefore upgraded to a training institute of care for older people. Several older people in Pa Tiew trained as caregivers, following the curriculum of the Department of Health, Ministry of Public Health. The project obtains financial support from local authorities and the National Health Security Office. The senior caregivers have the skills to work as volunteers and care for the bedridden as if they were their own relatives (Health Assembly, n.d.).

b) Collaboration between Local Authorities and Hospitals

Potaram municipality, Ratchaburi province, set up a day-care centre for older people and people with disabilities in cooperation with Potaram hospital and community-based organisations. This programme is supported by various stakeholders, including businessmen, volunteers, and community residents, to enable people in need to have access to basic healthcare , live happily, and improve their quality of life. The centre provides rehabilitation services as well as training in rehabilitation to clients and their family members at the centre and at home so they can continue rehabilitation at home. Cooperation between volunteers and public health organisations plays a crucial role in assisting people who need care (Chiyo Ratchaburi, 2017 [2560 BE]).

4) Nursing Homes with Combined Facilities

Some nursing homes provide combined care services both for self-reliant and bedridden older people. Facilities have day-care centres and services for people who are more dependent and need rehabilitation. The nursing homes can respond to clients' needs at any time, providing short-stay care, intermediate care, and institutional care. This type of nursing home is affordable only to middle- or high-income people. Clients should select facilities near their original homes and communities to avoid moving from one institution to another.

2.2. Other Models of Institution-based Long-term Care

This section describes potential models of institution-based long-term care designed for dependent and/or bedridden older people.

1) Assisted Living Based on Religious Principles

The non-profit 60-bed institution is run by the Foundation of the Church of Christ in Thailand with financial support from various Christian agencies in Thailand and around the world.

One of the home's constraints is shortage of equipment. Some physical equipment is too old, whilst caregivers need further education and skill training.

The home was established in 2009 to provide rehabilitation. It was designed to provide comprehensive geriatric care, including for those in good health and those with dementia, regardless of race or religion, and including those suffering chronic illnesses and those at the last stage of life.

The institute used to be a licensed hospital when it was first established under the Universal Coverage Scheme (THB30 co-payment package) of public medical services. The institute was not financially sustainable, however, and was forced to become a nursing home.

The institution provides all the services needed by older people. Residents are encouraged to participate in exercise programmes provided by the expert nurses. Rehabilitation is provided by physical therapists but requires approval from physicians and consent from residents' families or other relatives as it costs extra (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

2) Community Hospital Model with Holistic Care

A hospital in the central north-east is a good model of a community hospital that provides alternative and modern medicine, including general and geriatric medicine. The hospital has outreach programmes to communities and training courses.

The hospital uses a patient-oriented holistic care approach, combining alternative and modern medicine. The hospital offers acupuncture, traditional Thai massage, herbal massage, and chiropractic treatment. The environment is designed to make patients feel at home. The hospital organises religious rituals.

The hospital follows the standards of general community hospitals in Thailand, whilst the geriatric ward is based on those of the Department of Health and Social Care of the United Kingdom, which encourages a multidisciplinary approach to geriatric care. The issues that often arise are emergency care, pain management, pressure sore care, wound care, bowel movement control, and cleanliness.

The state-run hospital does not need to be concerned about profit and loss but it cannot ignore sustainability. To ease the burden on the healthcare system, people with chronic conditions are strongly encouraged to take care of themselves. The hospital organises mobile community clinics to examine those with noncommunicable diseases. If patients can live independently and enjoy good mental health after illness, that is considered an achievement of the hospital's outreach.

The hospital set up a training centre offering programmes in preventive care, medical treatment, disease control, improvement of sanitation and the community environment, and rehabilitation. The programmes target residents of the whole district. Capacity building of long-term personnel is considered urgent because a growing number of people have frailty and chronic illnesses, which undermine independent living and require more resources for rehabilitation (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

3) Palliative Care in a Hospital for Buddhist Monks

The hospital is a model case of palliative care, providing it exclusively for monks suffering from terminal cancer and who are not expected to live more than 3 months. Some patients are self-reliant whilst some are not. The hospital provides temple-like amenities, treatment to reduce pain, and appropriate food. An interdisciplinary team offers integrated services, which are adjusted to individual patients. Physical therapists provide rehabilitation services and assistance in bathing, feeding, and moving, including out of the palliative care ward for medical examinations.

The hospital attaches great importance to spiritual care. Staff members are required to undergo training in spiritual care for dying patients. Patients' wishes and wills are given the highest priority. The hospital organises traditional religious events for the deceased, such as ceremonies for bathing, paying respect, and forgiveness. The ward is designed to look like a monastery, taking patients' social status and dignity into account.

The hospice has 10 beds, whilst the number of monks seeking this kind of service is on the rise. Patients admitted to the ward generally believe that their continued existence depends on their meritorious deeds and faith. Support to monks is considered an activity of religious merit, and the hospital has a network of faithful donors. Services are free of charge, thanks to them.

Palliative care does not generally cost much since it does not provide resuscitation procedures or transfer patients to acute care hospitals. Expensive medicine and technology are of no use and only minimal medical treatment is needed to alleviate patients' symptoms (Sasat, Choowattanapakorn, and Lertrat, 2009 [2552 BE]).

2.3. Capacity Building of Long-term Care Personnel

Ensuring skilled human resources for long-term care that meets growing demand is important in institution-based care.

The Kasikorn Research Centre (2018 [2561 BE]) published *The Care Business for Older People in Thailand* with the expectation that developing businesses related to long-term care would bring prosperity to rapidly ageing Thailand. The proportion of older people 60 years old or above in Thailand is expected to reach 27% in 2030 (United Nations, Department of Economic and Social Affairs, Population Division, 2019). The report focused on businesses related to nursing homes, day-care centres, and retirement communities, and revealed that demand for healthcare professionals and skilled care workers has been growing quickly. The need for nurses and nursing assistants increased by 16% in 2007–2014 and demand for professional care workers grew by 18%. By contrast, demand of unskilled domestic workers who care for older people decreased by 13% (Kasikorn Research Centre, 2018 [2561 BE]).

Many long-term care facilities encounter shortages of nurses and physical therapists. Even if the facilities have care workers, a limited number are skilled. Such shortage of skilled long-term care personnel could limit care-related businesses. The problem is well

recognised and several organisations, including government bodies, have established guidelines and curricula for caregiver training.

1) Department of Health, Ministry of Public Health

The department developed a 70-hour curriculum for caregivers of dependent older people. The training courses are given by not only the department but also related agencies, including higher educational institutions such as universities or colleges, provincial public health organisations, and provincial hospitals, amongst others. The training course content covers the role and duty of caregivers, from routine activities to health management of dependent older people.

2) Ministry of Education

The ministry designed two curricula in caregiving: (a) a 70-hour curriculum for care volunteers living in communities or people with older relatives, and (b) a 420-hour curriculum to create professional care workers.

3) Thailand Nursing and Midwifery Council

The council provides various training courses to build the capacity of nurses so they can acquire specific expertise as, for example, gerontological nurses, nurse practitioners, or nursing personnel supervisors.

4) Ministry of Social Development and Human Security

The ministry carried out a project to support family caregivers as well as volunteer caregivers in communities during 2011–2013. A series of training courses were provided for 7,961 volunteers in 1,539 local administrative areas.

5) Thailand Professional Qualification Institute

The public institute collaborates with the private sector to organise long-term care training courses to create quality personnel. Those who complete the courses receive the professional qualification of geriatric caregiver in the healthcare category. There are different levels of qualification of geriatric caregiver, from the first level for basic practical skills to the fourth, which requires advanced skills and knowledge of caregiving. The training system is expected to improve the quality of long-term care personnel.

Whilst potential caregivers have training opportunities, the involvement of several bodies has caused inconsistency and disorganisation. Nursing home operators have found that the practices of some caregivers are unsatisfactory although they had taken 3-month theoretical training courses and 3-month practical courses. When they start working in long-term care facilities, the caregivers are required to learn practices suitable for real situations, which may be different from what they had learned through training courses, which was basic and unpractical. It could take 3 or 4 years for rookie care workers to become skilled. Some long-term care facilities provide training courses to newly employed care workers who have not undergone established training in long-term care. The training curricula provided by long-term care facilities include practical subjects, such as how to get along with senior clients, and practical geriatric care. Caregivers learn to observe physical changes in older people, such as in skin colour, hair, fingernails, teeth, and breathing, to know when to send clients to medical professionals. On-site training is highly

effective in enabling caregivers to work efficiently in real situations. Therefore, experts in the field are discussing how to overhaul the geriatric care curriculum.[7]

3. Recommendations to Improve Institution-based Long-term Care

1) A national committee should be set up to oversee the quality of long-term care and a national plan to improve long-term care services developed.
2) All communities should have institution-based long-term care facilities.

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Appendix

Review of the Literature on Long-term Care in Thailand, 2008–2018

Narit Nimsomboon

We reviewed the literature on long-term care in Thailand and developed the Ageing Research Database (http://aging.omeka.net). It has 1,424 entries on the health, social, environmental, and economic dimensions of ageing; 1,376 are from Thai academic databases; 37 are from international databases, including EBSCO Host, ProQuest, and CiteSeerX; and 11 are from databases of international and non-governmental organisations. Table A.1 shows the information resources referred to here.>>

1. Methods

We focused on social sciences and humanities. To search for English documents and articles, we accessed international databases such as EBSCO Host, ProQuest, CiteSeersX, amongst others, using the following keyword search: (ageing OR aged OR elder* OR older) AND (long term care OR care) AND Thailand, whilst for title search, we used (elder care OR older care) AND Thailand. The years of publication were limited to 2008–2018. The search formula for Thai databases was (ผู้สูงอายุ OR คนชรา) AND (การดูแล OR การดูแลระยะยาว). For Thai literature, we first limited the searches to publications that came out in 2008–2018, but because many results focused only on long-term care but did not cover social or other multidisciplinary dimensions, we modified the search criteria in the formula, using only the keyword 'ผู้สูงอายุ', and modified the publication years.

We searched Google Scholar using the same keywords. To ensure the robustness of search results, we limited the domain websites to 'edu', 'ac.uk', 'ac.jp', 'org', and 'net'. The publication years were limited to 2008–2018.

Table A.1. Information Resources

Thailand Government Official Databases	Mainstream Databases and Websites
1. Thailand Development Research Institute 2. Thai National Research Repository 3. Digital Research Information Centre 4. Thai Health Promotion Foundation 5. Health Systems Research Institute (HSRI) and HSRI Alliance 6. Department of Older Persons 7. Department of Social Development and Welfare 8. Department of Physical Education 9. Foundation of Thai Gerontology Research and Development institute 10. Department of Cultural Promotion 11. Community Development Department 12. Department of Local Administration	1. EBSCO Host 2. ProQuest 3. CiteSeerX 4. Google Scholar. Domain names were limited to the following: * foreign universities (e.g. edu, ac.jp, ac.uk, etc.); * international organisations (e.g World Bank, UNESCO); and * research funding agencies (e.g. Toyota Foundation).

2. Inclusion and Exclusion Criteria

After the searches, overlapping entries were cleaned and the remaining results filtered with the following:

1) Inclusion criteria. Articles that discuss long-term care in Thailand in terms of health, social, environmental, and economic dimensions were included.
2) Exclusion criteria. Articles that discuss ageing but are related to medical science, engineering, and technical studies were excluded because they were less associated with our focus of interest (long-term care models suitable for Thailand).

The filtered results were uploaded to the Ageing Research Database, which contains the links to the full text of the publications.