

Chapter 3

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

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Chapter 3

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

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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

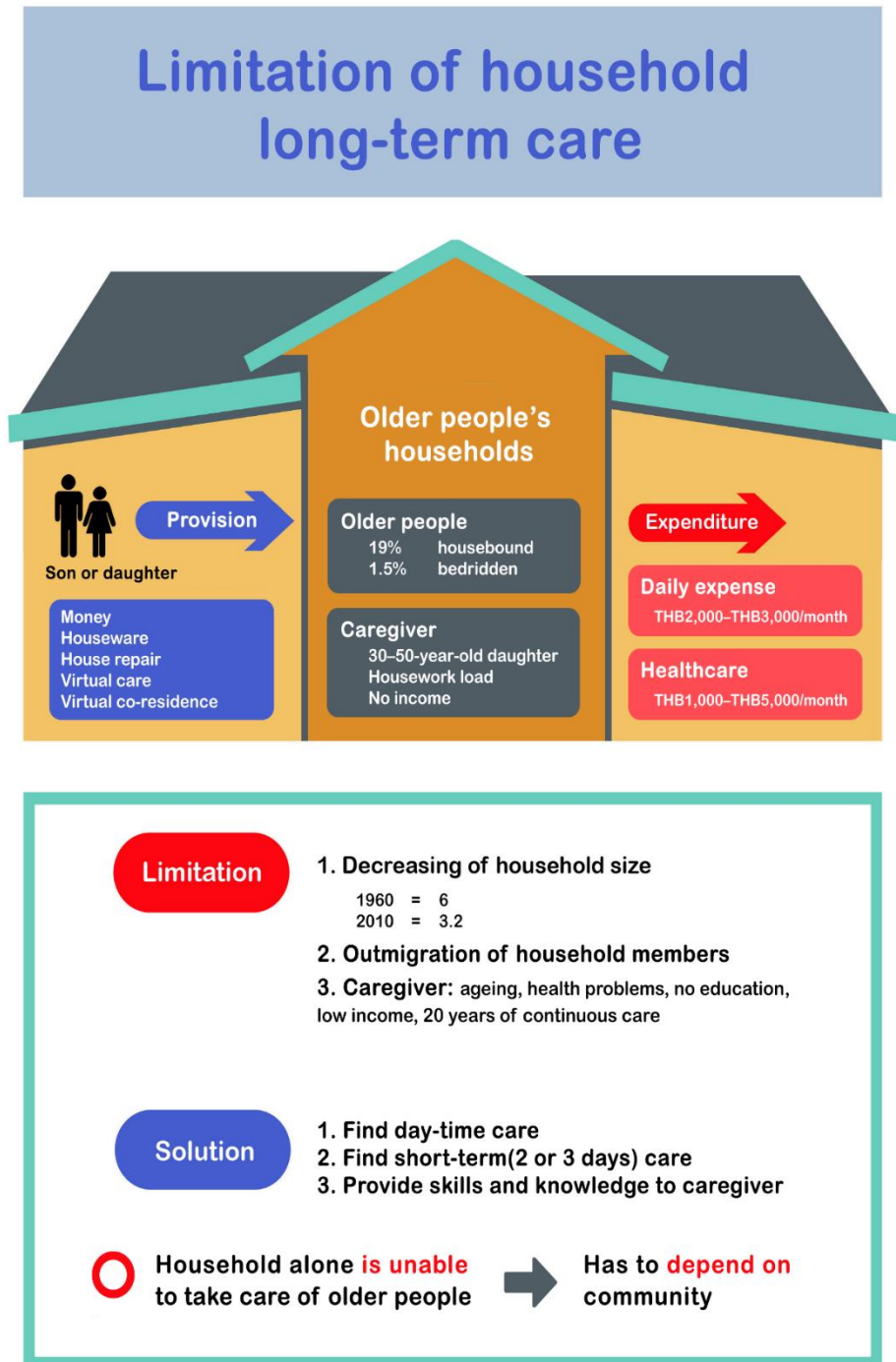
1. have no symptoms of brain disorders and can move by themselves but have difficulties eating and/or toileting,
2. have activities of daily living limitations as described in the first category and have brain disorder symptoms,
3. cannot move by themselves and might have difficulties in eating and/or 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, Rattanawitton, 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 Pakpooon, 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 Pakpooon, 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 (Sitthiwanthana 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 (Sitthiwanthana 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 a substitute 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.

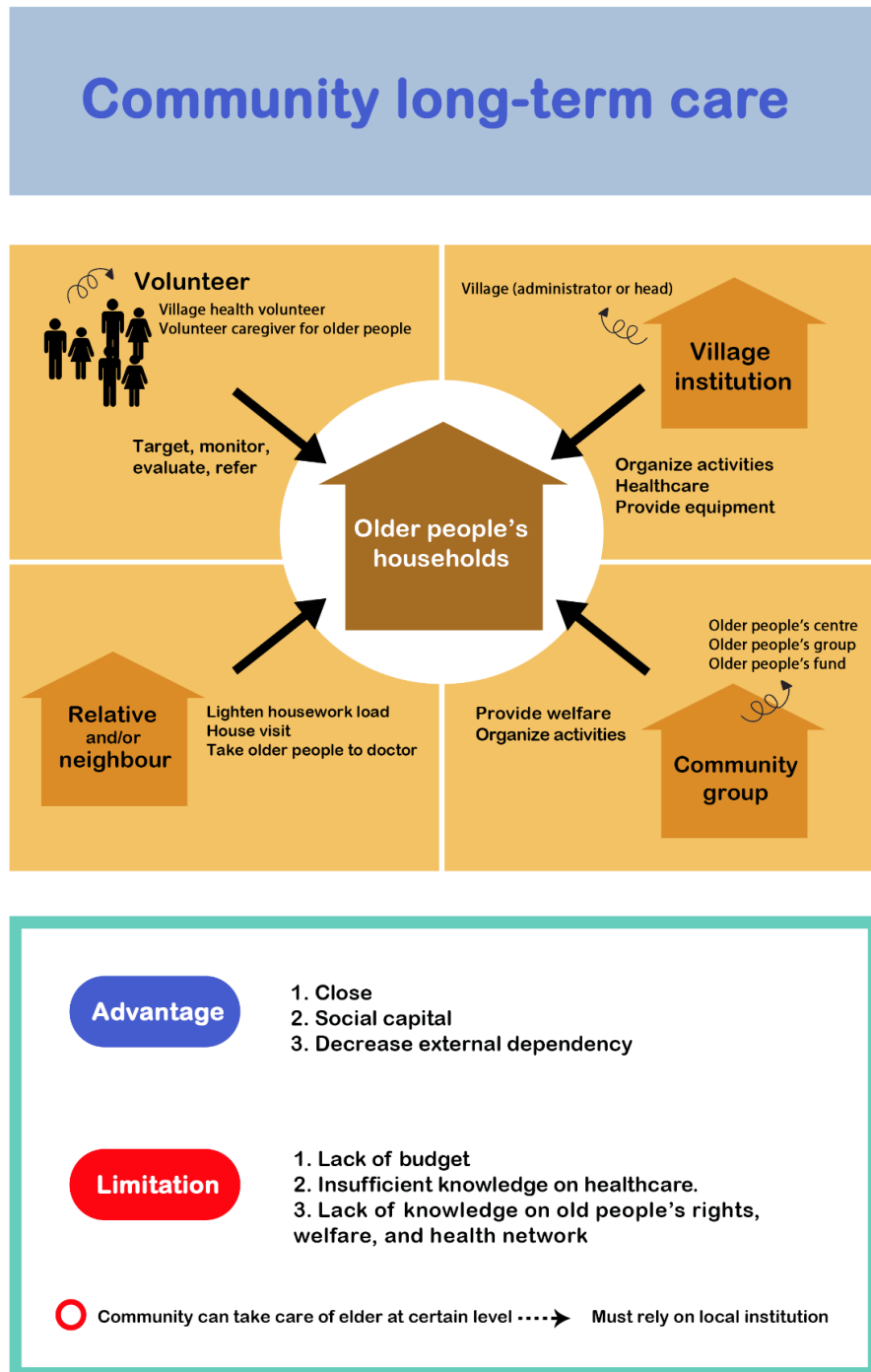
The forOldy Shop

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 SAO⁶ 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; Pakpoo 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, Buriram 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, Buriram 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.

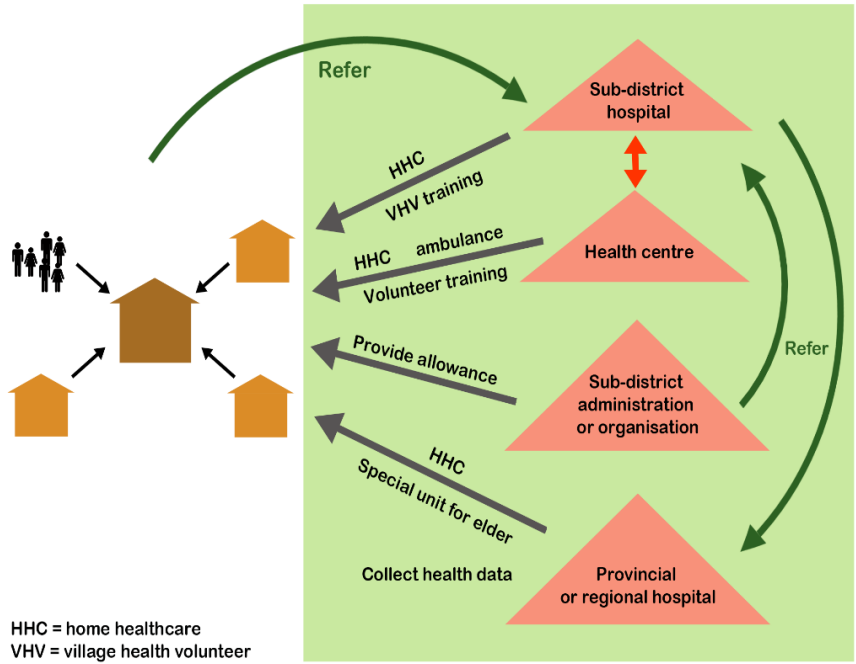
Limitations of Local Administrative Organisations

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

Local long-term care



Limitation More than half of the sub-district budget for older people goes to allowance. The remainder is spent on equipment.

○ Local level is able to take care of elder→ Support from network will be very helpful

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 (Khonchai 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 Lamsonthi, 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 University and Family and Community Assessment Program Health Data System

Walailak University gave scholarships to nursing students from Pakpoo 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. Pakpoo 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, Pakpoo 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)	<ul style="list-style-type: none"> - Health map - Revival of traditional rites - Friends Helping Friends - Older people's clubs 	<ul style="list-style-type: none"> - Receives regular training - Has voluntary work experience - Has coordination skills - Brings together health and administrative personnel 	<ul style="list-style-type: none"> - Small number of trained VHVs - VHVs have their own household chores.
	Community group or fund	<ul style="list-style-type: none"> - Elderly welfare - Home visits - Encouragement of Buddhist teachings - City-based practice 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Friends Helping Friends - Lightens load of family caregiver - Provides respite to family caregiver - Improves living environment - Provides transport 	<ul style="list-style-type: none"> - Close to older people and can react quickly 	Community is becoming less connected.
	Village institutions (village administration, temple, school)	<ul style="list-style-type: none"> - Financial, social, and spiritual functions 	<ul style="list-style-type: none"> - Authorised in budget allocation - Receives budget from government 	Heavy workload due to high expectations of many government authorities
2.2. Virtual community	<ul style="list-style-type: none"> - Family member - Neighbour - Religious person - Health personal 	<ul style="list-style-type: none"> - Compassionate Community - Cancer healthcare and co-caring space - I-see-U Community - Last Happiness - Pray for Love - - forOldy 	<ul style="list-style-type: none"> - Flexible space - Voluntary - Expandable - Starts with small capacity - Informal 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Sub-district administrative organisation (SAO) - Sub-district hospital - District hospital - Provincial hospital 	<ul style="list-style-type: none"> - Joint management of SAO and local hospital - Joint management of SAO and community committee 	<ul style="list-style-type: none"> - Professional health personnel - Knowledge of the rights of older people - Ability to coordinate at higher levels 	<ul style="list-style-type: none"> - Not possible for remote communities - More than half of SAO budget is spent for pension.
4. Network	<ul style="list-style-type: none"> - Doctor-led local network - Local hospital network - Health information network 	<ul style="list-style-type: none"> - Lamsonthi model - Baan Paew model - Family and Community Assessment Program and Continuity of Care Link 	<ul style="list-style-type: none"> - 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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