Kingdom of Thailand

Research on the International Cooperation Projects for Response to Population Aging in Thailand

FINAL REPORT

January 2022

Japan International Cooperation Agency (JICA)

Registered Non-Profit Organization Asia SEED

HM
JR
22-028

ABBREVIATION

ADL	Activities of Daily Living
BMA	Bangkok Metropolitan Administration
CLTC	Community-based Long-term Care
CCG	Community Care Giver
CG	Care Giver
CGD	The Comptroller General's Department
CKD	Chronic Kidney Disease
CM	Care Manager
CP	Care Plan
CR	Civil Registration
CSMBS	Civil Servant Medical Benefit Scheme
CTOP	Project on the Development of a Community-based Integrated Health Care and Social Welfare Service Model for Older Persons
DLA	Department of Local Administration (Ministry of Interior)
DM	Diabetes Mellitus
DOH	Department of Health (Ministry of Health)
DMH	Department of Mental Health (Ministry of Health)
DPHO	District Public Health Office
ECV	Elderly Care Volunteer
FCT	Family Care Team
GGP	Grant Assistance for Grassroots Human Security Project
HHC	Home Health Care
HSS	Department of Health Service Support (Ministry of Health)
HT	Hypertension
JOCV	Japan Overseas Cooperation Volunteer
JICA	Japan International Cooperation Agency
JPP	JICA Partnership Program
LAO	Local Administrative Organization
LHSF	Local Health Security Fund
LTC	Long-term Care
LTOP	Project on Long-term Care Service Development for the Frail Elderly and Other Vulnerable People
MOI	Ministry of Interior
MOPH	Ministry of Public Health
MOS	Mobile-One-Stop-Service
MSDHS	Ministry of Social Development and Human Security
NCDs	Non-communicable Diseases
NCE	National Committee on the Elderly
NESDC	Office of the National Economic and Social Development Council
NHA	National Health Assembly
NHC	National Health Committee
NHCO	National Health Commission Office
NHSB	National Health Security Board

NHSF	National Health Security Fund
NHSO	National Health Security Office
NHSC	National Health Security Commission
NSO	National Statistic Office
OAA	Old Age Allowance
ODA	Official Development Assistance
OPP	Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups
PCU	Primary Care Unit
PHC	Primary Health Care
PPHO	Provincial Public Health Office
PSDHS	Provincial Social Development and Human Security Office
SSS	Social Security Scheme
TAI	Typology of the Aged with Illustration
TAO	Tambon (Sub-district) Administrative Organization
TCP	Technical Cooperation Project
THPH	Tambon Health Promotion Hospital
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
UIN	Unique Identification Number
VHC	Village Health Communicator
VMV	Village Malaria Volunteer
VHV	Village Heath Volunteer
WHO	World Health Organization

TABLE OF CONTENTS

FIGURES

APPENDICES

Background of the Study and Report Structure

Population aging is a global phenomenon, with the share of persons aged 65 years[1] or over in the world predicted to increase from 9% in 2019 to 16% by 2050, meaning that one in six people will be age 65 years or older in 2050, up from one in 11 in 2019. During this period, East and Southeast Asia will be the regions with the most significant percentage point increase in the share of older people, with Thailand being one of the top-ten countries (United Nations 2019).

The Government of Thailand is well aware of the situation. It has made efforts to cope with this highly rapid population aging with well-prepared national policies and programs on aging since the1980s. At the same time, it considered the experiences and lessons learned of Japan, which saw its population go through similar aging 30 years ahead of Thailand. These experiences and lessons are helpful models for Thailand's implementation of policies and measures for older citizens, especially in the case of Community-based Long-term Care (CLTC) that has been a priority area of Thailand since 2002[2].

The Government of Thailand sought good practices of a community-based model for integrating health care and social welfare services and a model for CLTC for frail older adults. As a part of its effort, experiences and practices of Japan were introduced to Thailand through the implementation of "Project on the Development of a Community-based Integrated Health Care and Social Welfare Service Model for Older Persons (CTOP)" (8 November 2007-7 November 2011), and "Project on Long-term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP)" (14 January 2013-31 August 2017). Cooperation with JICA continued as **"**Project on Seamless Health and Social Services Provision for Elderly Persons (S-TOP)" (8 November 2017-31 October 2022) to find a model for the continuum of care from the acute phase in hospitals to the maintenance phase in the community. Other Japan's Official Development Assistance (ODA) schemes were also implemented to support Thailand's efforts to address population aging. These schemes include Public-Private Partnerships (PPP) (SDGs Business Supporting Survey), JICA Partnership Program (JPP), Grant Assistance for Grassroots Human Security Project (GGP), and Japan Overseas Cooperation Volunteer (JOCV) (see Appendix 1 for details).

This "Research on the International Cooperation Projects for Response to Population Aging in Thailand" was conducted with the purpose to a) review JICA's cooperation in conjunction with measures taken by the Government of Thailand on population aging, and b) analyze the practice of Japan's international cooperation in Thailand to draw implication and lessons for further cooperation in other aging countries.

Chapter 1 provides general information on elderly care in Thailand. The focuses are on Thailand's prominent features, especially Thailand's centralized and public dominant health system, the existing

[1] Though the Thailand Elderly Act defines people 60 years of age as "older people," World Bank Data, in which older people are defined as those 65 years of age or over, will be utilized for comparison.

[2] The 2nd National Plan 2002 stated that older people shall be supported so that they can live with their family; **community-based health and social services will be fully accessible to and usable by older people**, by emphasizing the home-care model that integrates health care and social services (Measure 4.2 of Strategy 3)

computerized civil registration system, the Universal Coverage Scheme (UCS) and its management system, and informal human resources or volunteers in under-resourced environment[3]. These are pre-conditions for a new Long-term Care (LTC) system, and the chapter illustrates a path dependence in shaping it.

Chapter 2 provides information on Japan's cooperation in dealing with aging issues, along with the policies and measures of the Government of Thailand. The information in this chapter shows that Japan's cooperation was implemented as part of or complemental to the recipient country's national plan or strategic plan, which is a critical point for development partner's cooperation in any country. This chapter also describes impacts of CTOP and LTOP[4], together with details of the immediate and well-planned actions by the government of Thailand that contributed to the realization of high impacts.

Chapter 3 analyzes Thailand's practices of CLTC development as a model for JICA's cooperation on population aging in other developing countries. Implications and lessons learned are laid out, with expecting that they would be useful both for other developing countries and JICA in implementing projects to address challenges in an aging/aged society.

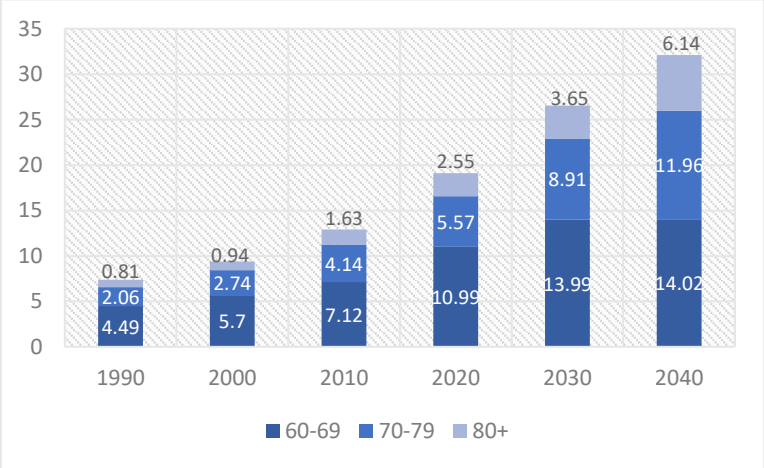
[3] When Thailand and Japan officially became aging societies in 2002 and 1971, respectively, Thailand's GDP was US$134.3 billion, with 0.29 doctors and 2.2 beds per 1000 people. This is much lower than the equivalent figures for Japan in 1971, when its GDP was US$240.2 billion and it had 1.1 doctors and 12.5 beds per 1000 people.
[4] The impact of S-TOP is not assessed since it is an ongoing project.

Chapter I General Information on Elderly Care in Thailand

1.1 Major Characteristics of the Population Aging in Thailand

Thai population is rapidly aging, in terms of both the number and share. Especially alarming is a growth of the older segment. The ratio of people over 60[5] in the total population in Thailand doubled from 9.38% in 2000 to 19.11% in 2020, and is projected to reach 32.12% in 2040. Moreover, the percentage of the oldest-old population (age 80 and over) is increasing significantly, up from 0.81% in 1990 to 1.63% in 2010 and 2.55% in 2020. This percentage is expected to increase two-fold in 20 years, reaching 6.14% in 2040 (Figure 2). The oldest-old population is the fastest-growing segment and needs for assistance or caregiving with activities of daily living (ADL) are projected to increase due to the dependency of the older-age population.

Figure 1: Percentage of older people in Thailand's population 2010-2040



Source: 1990-2010: NSO, 2020-2040: NESDC

Rapid aging will pose a significant burden on the health system in Thailand. As their functional ability declines as they age, older adults' needs for health and social care increase. Non-communicable diseases (NCDs), which increase with age, often result in long-term health impacts and require long-term medical treatment and care. Co-morbidity, frailty, and mental health issues, which characterize the health in older age, lead to a greater demand for LTC. This, in turn, puts significant cost and service pressures on the health system and social services. The old-age dependency ratio[6] of Thailand increased from 6.7 in 1971 to 9.4 in 2000 and up to 18.4 in 2020, growing at an average annual rate of 2.10% (World Data Atlas 1950-2020).

With an improvement in life expectancy and continuing low fertility, the aging in Thailand will be even more rapid than in Japan. Highly rapid population aging in this country is partly due to an improvement in life expectancy, resulting from adequate access to health care, economic well-being, increasing levels of education, and the government's efforts on Primary Health Care (PHC) since the 1970s. In Thailand, life expectancy at birth was only 49.32 years in 1950 but increased to 70 years in 1991 and 77.19 years in 2020 (World Population Prospects). Thai people are not only living longer, but the fertility rate has also sharply declined since the early 1970s. It reached 1.50 births per woman in 2020 and could decrease to 1.20-1.40 by 2040 (NESDC 2019). This resulted in a highly rapid population aging in this country, with 20 years of

[5] Article 3 of Thailand's Act on the Elderly 2003 defines "the elderly" as Thai people age 60 years or older.
[6] This is the ratio of the number of people aged 65 or older to the number of people in the population aged 15-64 years.

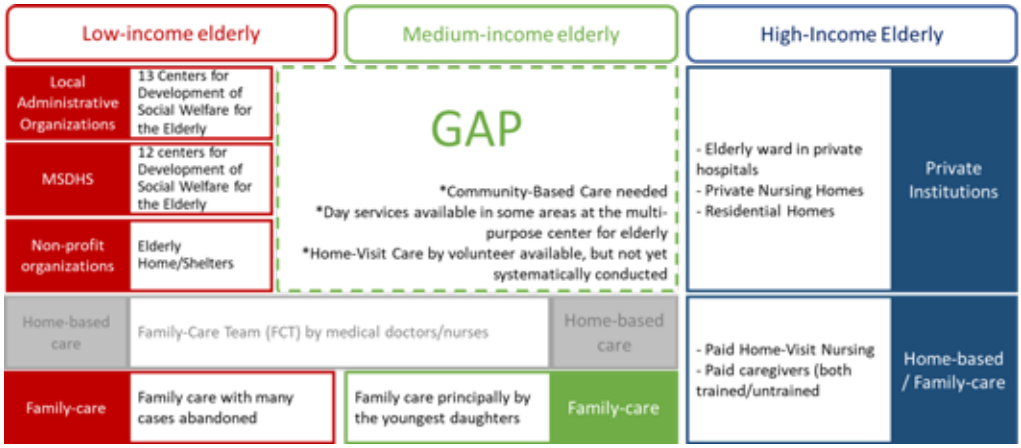
transition from an aging society in 2002 to an aged society in 2022[7], and expected to become a "super-aged society[8] only ten years later (2022-2032). This is faster than Japan, which had a 24-year transition from an aging society to an aged society (1970-1994) and a 14-year transition period from an aged society to a super-aged society of 14 years (1994-2007).

1.2 Elderly Care in Thailand

In Thailand, families have been primary caregivers for their older members. The concept of elderly care as a parental repayment is deeply rooted in Thai society. Until the 1970s, elderly care across the world was provided primarily by families (Muiser J., and Carrin G. 2007). Governments in high- and low-income countries mainly provided institutional care for the poor who were not cared by their families or relatives. Also, in Thailand, families have played primary roles in caring for older people. There is a deep-rooted sense of obligation to parents and cultural norms that parents must be cared for in their old age as repayment, assuming that bad consequences will be suffered by those who do not live by these norms. A report found that 86.5% of Thai people disagreed with the idea of sending their parents to live in nursing homes (MSDHS et al., 2011).

Shrinking household size makes parental care difficult, while the social care system for middle and low-income households is inadequate. Apart from family care, geriatric care support systems in Thailand, before the government's focus on CLTC for older people, were as follows.

Figure 2: Geriatric Care Support System prior to the Government's Focus on CLTC

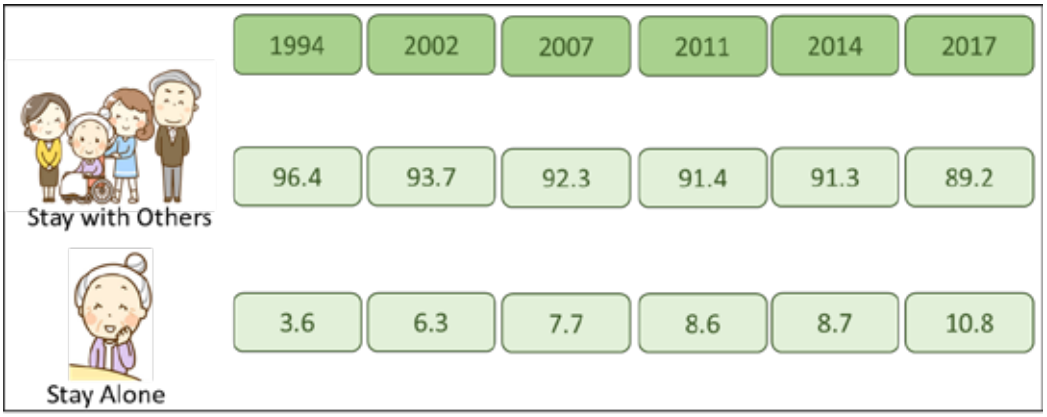


Source: Adapted from Suwanrada W. (2014)

There is not only a lack of a care system for low-income and medium-income older adults, but social change also affects the forms of elderly care. Although cultural norms that govern the care of older adults have been well-rooted in Thai society, particularly in rural areas, potential supports within the family have been decreasing due to the change in family structure. The average number of people per household declined from 5.2 persons in 1980 to 3.1 persons in 2017 (NESDC's Statistics), and the percentage of older adults living alone has been increasing over time (NSO 2017).

[7] Aging rate surpasses 14%
[8] Aging rate surpasses 21%

Figure 3: Living Situation of Older People in Thailand: 1994-2017



Source: Developed by the researcher based on information from the NSO 2017

For low-income older adults in rural areas, access to health care services is a problem, to which the Thai Government responded with the CLTC as an effective, practical, and feasible approach. Though all ages were included in the UCS in 2002[9], utilization of out-patient care services by UCS beneficiaries decreased after age 75, while that of in-patient care services decreased after age 85 (World Bank Group 2016), arguably due to the lack of affordable transportation to health care centers and dependence on families or relatives to bring them to health facilities[10]. To cope with the situation, the Government of Thailand considered "a CLTC with more professional practices of home-visit volunteers, planned outreach services by health professionals and scaled-up involvement by Local Administrative Organizations (LAOs)[11]," an effective, practical, and feasible approach for the care of older people in Thailand.

1.3 Specific Features of Thailand as Pre-Conditions for Implementing CLTC

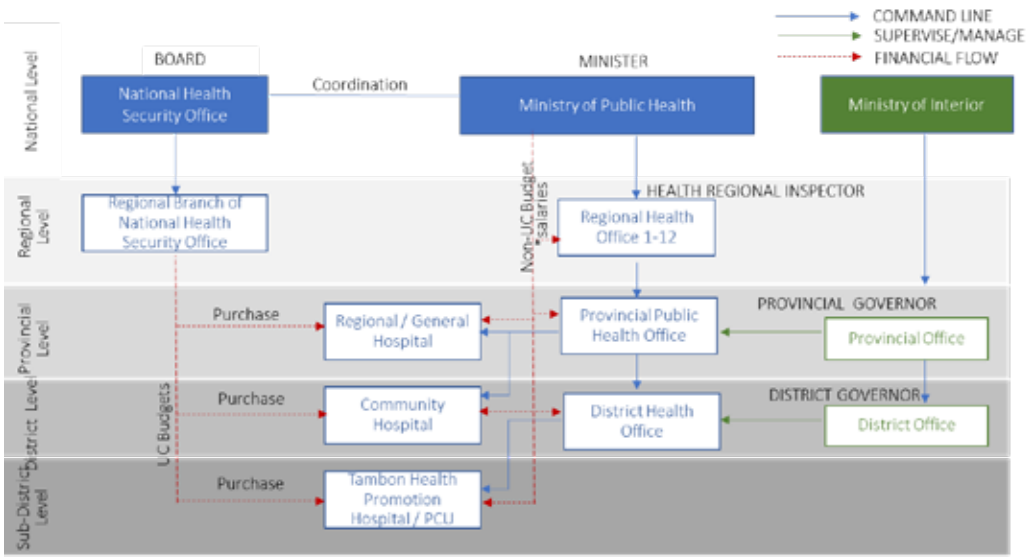
To understand JICA's intervention through the course of developing CLTC policy in Thailand, it is essential to understand the specific features of the Thai health system which serve as pre-conditions for the current CLTC system.

1.3.1 Centralized and Public Dominant Health Care System

One of the critical features of the Thai health care system is its highly centralized structure. With a robust primary health care system, this feature worked favorably in implementing new initiatives. Ministry of Public Health (MOPH) has been the leading agency responsible for policy formulation, regulation, workforce development, service provision, program implementation, and monitoring & evaluation since its establishment in 1942. Although the Determining Plans and Process of Decentralization to Local Government Organization Act was enacted in 1999 and budget functions for health service provision were mostly transferred to the National Health Security Office (NHSO) in 2002, MOPH maintains other functions with a traditional line of command and control from central government to district level.

[9] UC Scheme: A tax-funded health insurance scheme introduced in 2002 to cover around 75% of the population who are not beneficiaries of CSMBS (1980) or SSS (1990).
[10] UC does not cover transportation cost, but the WB survey found that average transportation costs by rural residents are more than 10 times that of urban residents (World Bank Group 2016).
[11] Sub-district (Tambon) Municipality and/or TAOs.

Figure 4: Thai Health Care System



Source: Developed by the researcher based on the information from Jongudomsuk P. et al, 2015 (page 23) and information from National Health Commission Office

[12].

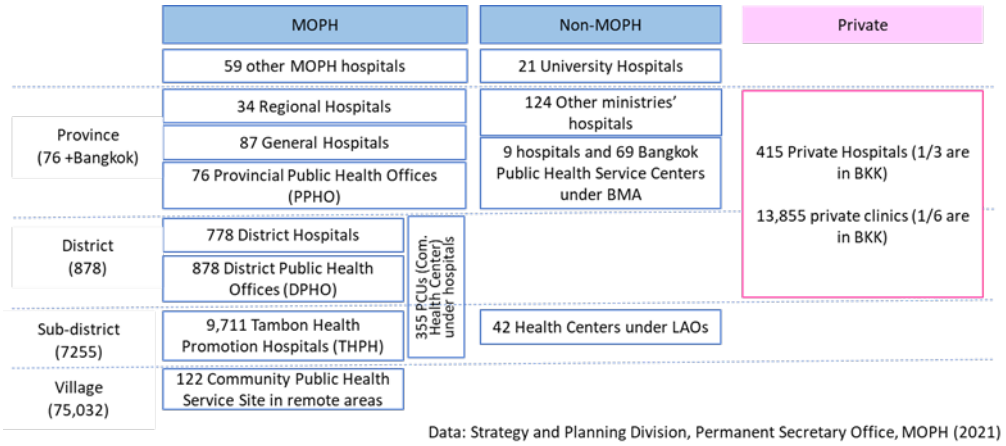
Another specific feature is that the public sector dominates Thailand's health delivery systems. 75% of hospitals are public (Jongudomsuk P. et al. 2015, page 86), with most hospitals at the district and sub-district levels owned by MOPH (see Figure 6). 70-85% of doctors and nurses are also in the public sector (See Figure 7). The prior expansion of a PHC system that extended geographical coverage of MOPH's health care facilities to the sub-district level by 2001[13] and the existing health workforce[14] was a good foundation for the implementation of UCS in 2002, the Local Health Security Fund (LHSF) in 2006, and the LTC Fund in 2016 since people living in rural areas can access the services of the said schemes through health care facilities with medical professionals located nearby in the community (Tangcharoensathien, V. et al., 2019). With the aspects mentioned above, MOPH could efficiently expand newly developed programs or mechanisms to reach nearly the country's entire population.

Figure 5: Health Facilities in Public and Private Sectors (2021)

[12] Though the Plans and Process for Decentralization to Local Administrative Organizations Act of 1999 urged ministries, including the MOPH, to decentralize its functions, resources and staff to Local Administrative Organizations (LAOs), progress was slow in health care decentralization and MOPH still has authority and regulating power over many public health facilities at all levels. (For example, only 42 health centers were transferred to TAOs, while 9,711 THPH are under MOPH, as shown in Figure 6.)

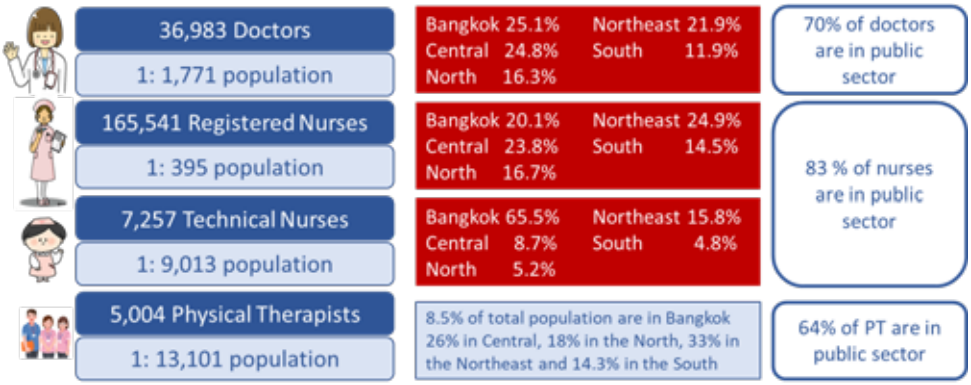
[13] In the 1950s, provincial hospitals were established nationwide. Investment in district hospitals began in 1977 and covered all districts in 1990. This was followed by the establishment of at least one health center (which became THPH in 2009) in all sub-districts by 2001 (Tangcharoensathien, V. et al., 2018)

[14] The Government of Thailand has focused on training community health care workers and increasing the number of rural doctors working at the community level during the 1970s and 1980s (Tangcharoensathien, V. et al. 2018, PHCPI). For example, in 1972, the MOPH introduced the policy of requiring that all medical and nursing school graduates serve a three-year mandatory term in rural health service; this was subsequently extended to dentists and pharmacists. The numbers of doctors per population improved from 1:2,931 in 2008 to 1:1,771 in 2018 and the number of registered nurses per population improved from 1:576 to 1:395 (NESDC"s Statistics 2018).



Source: Developed by the researcher based on MOPH's data

Figure 6: Number of doctors, nurses, and physical therapists (2018)



Developed by the researcher based on NESDC's data (2018)

1.3.2 Ministry of Interior (MOI)'s Unique Identification Number (UIN) and Central Computerized Civil Registration (CR) System

The unique identification number and the central computerized civil registration system were foundations for identifying beneficiaries and obtaining their health information. In Thailand, the UIN program assigned an 11-digit code to each household and a 13-digit code to each individual in 1982, before the central computerized CR system was developed and completed in 1987. The use of UIN and this computerized CR system helped to identify and verify those who were on the Civil Servant Medical Benefit Scheme (CSMBS)[15] and Social Security Scheme (SSS)[16] beneficiary rosters. The remaining citizens in the CR system were automatically enrolled in the UCS, allowing the UCS registration systems to be finished

[15] CSMBS is a non-contributory tax-funded health insurance scheme for government employees, pensioners, and their dependents, utilizing the fee-for-service payment method for outpatient services and diagnosis-related group (DRG) for in-patient services (the latter from 2009). Reimbursements are made by the Comptroller General Department, Ministry of Finance.

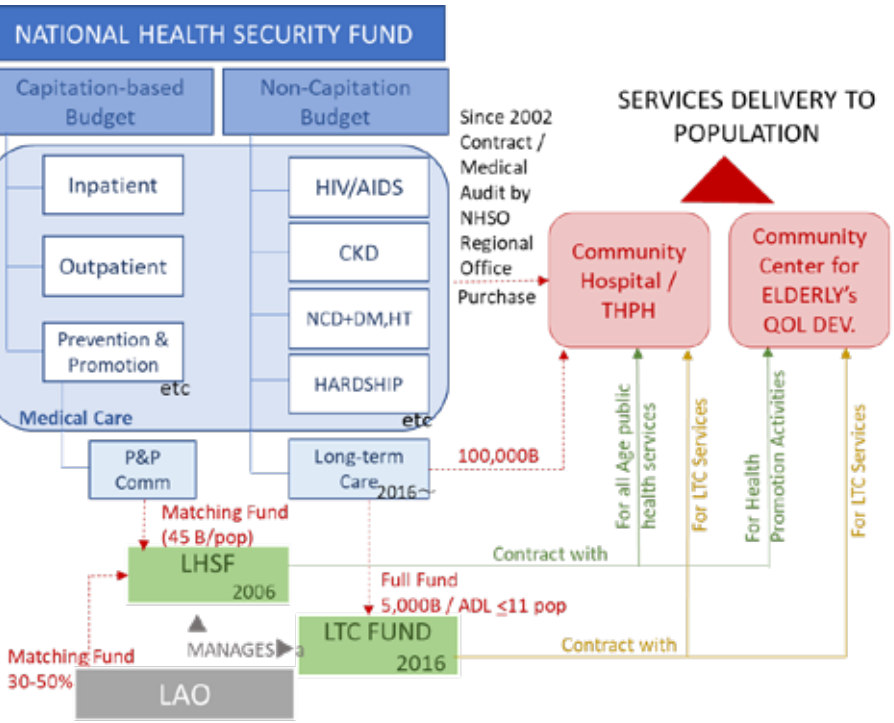
[16] This is a tripartite (employee, employer, government) contributions social insurance scheme for private employees in the formal sector, utilizing capitation as the primary payment method. The Social Security Office, Ministry of Labor, is the purchaser of services, and public or private hospitals are contracted as health service providers based on an annual capitation fee.

within one year (Pannarunothai S.et al., 2019). This UCS database made it easier to identify LTC fund beneficiaries from among UCS registrants. The CR system facilitates the registration of beneficiaries, and allows insurers to administer the fund without any duplication and pay claims efficiently. Links between the CR system and the health sector[17] make it possible not only for health care providers and hospitals to access health insurance registries at any time but also for MOPH and insurers of each scheme to access the health information of each patient entered by hospitals at any level. This also enables effective policy planning and monitoring of health policy effects.

1.3.3 Existing management system of National Health Security Fund (2002) and Local Health Security Fund (2006), leading to Rapid Roll-out of LTC program

LTC fund under LAOs made maximum use of the management capacity of hospitals and LAOs established by other programs. The existing management systems of NHSO's National Health Security Fund (NHSF) for implementation of UCS under the National Health Security Act 2002, as well as the LHSF, which was established in 2006 in accordance with Section 47[18] of the afore-mentioned Act, provided a good foundation for the establishment of the CLTC system.

Figure 7: Management of NHSF, LHSF and LTC Fund



Source: The researcher

UCS depended on several health benefit schemes for coverage before the decision was made in 2002 to

[17] Sharing data in MOI's CR system with other governmental agencies became possible after the Registration of Residential Inhabitant Act in 1991.

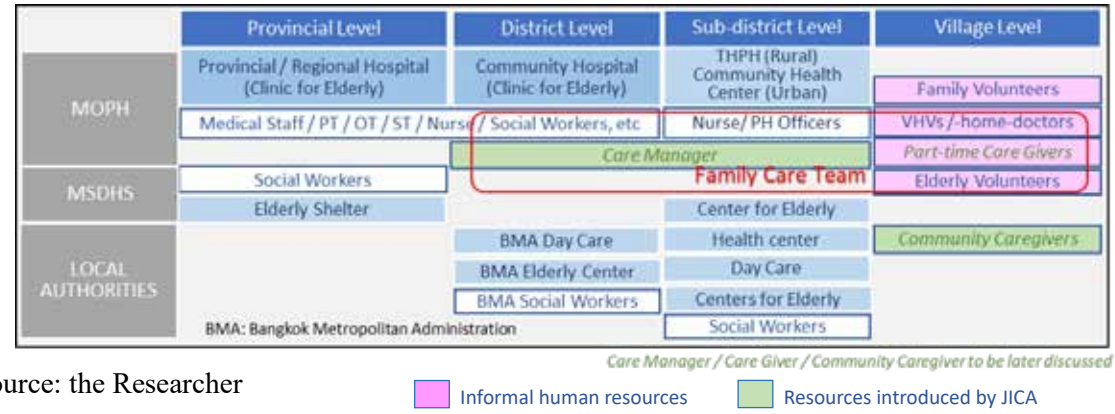
[18] Section 47: With a view to establishing national health security for people in local areas by promoting the participatory process in accordance with their readiness, appropriateness, and need, the Board shall support and coordinate with local government organizations and prescribe rules entrusting such organizations to implement and manage the national health security system at the local level with the expenses provided by the National Health Security Fund, established by the Act.

utilize the public contract model based on the capitation system[19]. As the contracting unit, a hospital needs to provide services based on the contract but and manage budgets allocated by the NHSO. LHSF, established in 2006, also relied on the capitation system, with the prevention and promotion (P&P) budget for communities distributed to LHSF under the management of LAO. This means that, when the LTC fund was designed, hospitals already had management capacity as contracted units and LAOs had the capabilities needed to function as management units to contract out services to hospitals or the Community Center for Development of Quality of Life of Older Persons. This led to LTC's establishment in a very short time.

1.3.4 Availability of Informal Human Resources at Community Level

Village Health Volunteer, Elderly Care Volunteer, and other volunteer programs established by ministries became significant workforces in providing informal support in the community.

Figure 8: Existing Resources for Elderly Care and Informal Human Resources



Source: the Researcher

Being aware of the limitations of human resources at the community level, Thailand put efforts into nurturing volunteers to be the backbone of the PHC delivery system. Volunteers are one of the prominent features of Thailand in implementing CLTC, as Village Health Volunteers (VHVs) and Elderly Care Volunteers (ECVs) already conducted home visits to most households in their community[20]. They were able to immediately become vital human resources in providing care to older adults after the LTC program was

[19] The payment system for UCS was designed based on the experiences of three existing models: the MOPH public integrated model (MOPH served both the functions of payer and health care service provider) used by the Lower Income Scheme (1975) and the Public Voluntary Health Insurance Scheme (1984); the public reimbursement model (fee-for-service model) used by CSMBS (1980); and the public contract model used by SSS (1990). In light of the evidence of the benefits of cost control by SSS, UCS adopted a public contract model, at the same time adding advanced design features such as age-adjusted capitation for outpatient services and Diagnostic Related Group payment within an annual global budget for inpatient care, etc. (Tangcharoensathien V. 2019).

[20] VHVs worked purely as volunteers, without receiving any payment, for more than three decades, until they began receiving a gratuity of 600B/month in 2009 and 1000B/month in 2017, while ECV received 300B/month only in the first two years. VHVs and ECVs are primarily friends or neighbors living in the same village. Sometimes, they are considered "more likely to be a relative rather than a friend" in Thai society, and volunteering without pay has been quite common. Besides, volunteering is a widespread activity in a society in which nearly 100% of the population believes in one of the religions, supporting the results of surveys conducted in 140 countries that showed that religious people are more likely to volunteer than those who are non-religious (Pelham B., Crabtree S. 2008). The belief in "helping others" in Muslim or Christian contexts or "doing something good with the hope that positive consequences will occur" in the Theravada Buddhism context means that it is highly likely that these volunteer activities aimed at helping the older people in communities will continue not only in Thailand, but also in countries with similar features.

launched by the government (a more detailed explanation of VHV and ECVs can be found in Appendix 2). Apart from VHVs and ECVs, MOPH also initiated two other human resources schemes, which were essential for implementing CLTC. One is the Family Care Team (FCT: 2014). This team integrated the health workforce and informal human resources at the district and sub-district levels to provide home health care services to people in the community. The other is the Family Volunteer (FV: 2016), a scheme that ensures family caregivers are equipped with care skills and knowledge (details about FCT and FV can be found in Appendix 2).

1.3.5 Availability of Social Care Organizations and Facilities

Elderly clubs and senior citizen's centers also contributed to the rapid rollout of the CLTC program In the LTC system, elderly club members are essential resources who support older adults in need of assistance, such as paying a home visit to other older adults in the same community or inviting them for activities at elderly centers, among other activities. Apart from these existing human resources, several existing facilities in the social sector were part of the LTC system after its launch.

(A) Elderly Club[21]

Since the 2000s, the central government and local authorities have promoted the establishment of elder clubs to promote the social participation of older adults through social activities, vocational development, recreation, health promotion activities, and others. As of 2017, there were 28,245 elderly clubs registered with the Elderly Council of Thailand and 394 elderly clubs registered with the Bangkok Senior Citizen Club Federation (Sangkawan D.et al., 2017). Most elderly clubs in Bangkok are established in community health service centers or hospitals, while those in other provinces are in health centers or elderly centers run by local authorities.

(B) Elderly Centers / Centers for Community-based Social Welfare Services

There are several forms of centers providing social welfare services, rehabilitation services, daycare services, or recreation services at the community level with different names and functions, e.g., multi-purpose centers for older people, community rehabilitation centers, community centers for older people, centers for older people in temples, Elderly School, Quality of Life Development and Career Promotion Centers for Older Persons of Ministry of Social Development and Human Security (MSDHS) in some pilot areas, Community Centers for Development of the Quality of Life of Older Persons managed by LAOs.

Figure 9: Sample Model of the Social-Welfare Service Center (Elderly Center)

[21] The first Elderly Club was established in a neurological hospital in December 1962 and was extended to every province in 1984.

Source: Developed from information from MSDHS

As noted above, the rapid roll-out of the CLTC program in Thailand was possible because Thailand already had a firm foundation for implementing the scheme: extensive MOPH-owned health facilities and human resources down to the sub-district level, a computerized CR system, NHSO's management system established for the implementation of UCS in 2002, and the precedence of LHSF. This revealed that path dependence has led to the success of establishing the LTC program in several ways.

The following chapter will lay out how the Government of Thailand, with cooperation from JICA, systemized the CLTC system in the country and the extent of the impact that the projects co-conducted by the Thai government and JICA had.

Chapter II Community-based Long-term Care System Development and JICA's Intervention in Thailand

2.1 Development of Community-based Approach for Elderly Care and JICA's Cooperation

The current CLTC system in Thailand emerged from decades of efforts by the Government of Thailand through policy planning, research studies, and pilot projects. Before the launch of CLTC, initiatives to develop community-based approaches were taken by the Government of Thailand, with pilot projects including JICA's cooperation implemented to find appropriate models for the country.

A community-based integrated health and social service system initiative emerged in the 2nd National Plan on the Elderly (2002-2021). The first policy and plan related to older adults were the First National Plan on the Elderly (1982-2001), developed after the First World Assembly on Aging in Vienna in 1982. In this plan, there were directions for supporting older adults to reside with family members and be provided with social protection. However, there were no specific strategies or action plans to prepare people for old age or any outcomes, partly due to many changes of governments during the 1980s and 1990s. The groundwork for CLTC was also laid with the Second National Plan on the Elderly (2002-2021)[22], a well-designed plan using a life-course planning approach, and the Elderly Act 2003[23], leading to many research studies, actions, and pilot projects. The Second National Plan states that older people shall be supported so that they can live with their family; community-based health and social services will be fully accessible to and usable by older people by emphasizing the home-care model that integrates health care and social services (Measure 4.2 of Strategy 3); and LAOs, religious entities, private entities, and entities with public interests will help to provide for the welfare of older people, emphasizing a community-based approach (Measure 4.3 of Strategy 3).

An evaluation of the first five years of this plan revealed unsatisfactory results. That is primarily on Strategy 1: Preparing people for quality aging, and Strategy 3: Providing social protection for older people. Though indicators were set for each strategy, it is thought that a lack of practical service models led to unsuccessful community-based health and social care for older people. One of the attempts to find integrated health and social service models for community-based care for older people is the CTOP**,** a Technical Cooperation Project (TCP) jointly implemented by the Government of Thailand and the Government of Japan through JICA.

2.1.1 Details of CTOP and its Effects

CTOP is a TCP co-conducted by the Government of Thailand and JICA to find a model of community-based integrated services for older adults. It is a four-year project conducted in four sites, where local stakeholders identified priority challenges, which were addressed through dialogues and cyclical process management.

The model of each site as follows.

---

[22] The five strategies in the 2nd National Plan can be found in Appendix 3.

[23] This went into effect on 1 January 2004, with significant issues on rights for older people, national mechanisms for matters related to older people (National Committee on the Elderly), tax privilege for children taking care of parents, and the elderly fund. The Act led to mandates requiring that all agencies work for older people in a comprehensive manner.

Chiang Rai (North):	"Hypertension" (Change behavior promotion)
Khon Kaen (North-East):	"Health problems related to the eyes and mouth" (Health check and referral)
Nonthaburi (Central):	"Rehabilitation Center" (Tailor-made rehabilitation program)
Surat Thani (South):	"Mobile One-stop Services" (Health screening and consultations)

Project: CTOP
Period: November 2007-November 2011
Target: Direct beneficiaries: central and local government officers/service providers engaged in health care and social services for older people
Indirect beneficiaries: Older people (Independent, dependent, bed-ridden) in four pilot sites

Pilot sites:

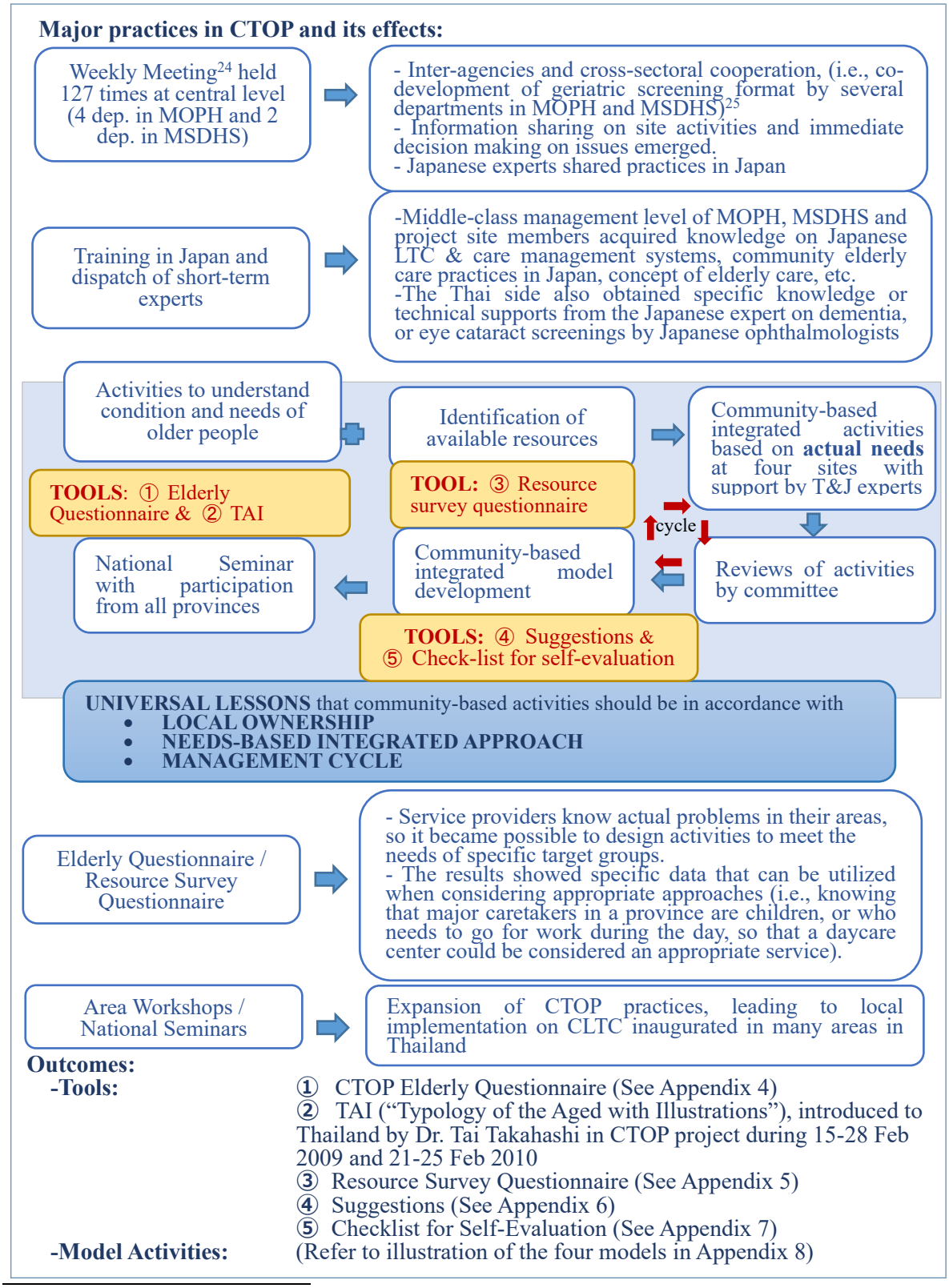
North: Yanghom Sub-dist., Khuntan District, Chiang Rai: 134.8 km^3: Rural lowland/mountain(agri-lowest income) <15,000B/m/hh), hh size:3.3	Older people 11.1%, 1 ECV: 32.55 older people, 1 VHV: 12 hh, HHC/health checkup, HV, OAA, eyeglasses
Northeast: Sa-ard Sub-district, Namphong District, Khon Kean: 82 km^3: Rural lowland (agri-low income: <20,000B/m/hh), hh size: 4.5	Older people 9.1%, 1 ECV: 9.2 older people, 1 VHV: 12 hh, health checkup/screening, HV,
Central: Bangsithong, Bangkruai Dist, Nonthaburi: 5.8 km^3: City (civil servants>36,000/m/hh), hh size:2.5	Older people 12.5%, 1 ECV: 14.89 older people, 1VHV: 55hh, mental health checkup, HV, OAA,
South: Banna Sub-dist., Bannaderm D., Surat Thani: Rural/City (parawood farmers >36,000/month/hh) hh size: 4.8	Older people 10.4%, 1 ECV: 25.50 older people, 1 VHV: 10 hh, mtg of EC, OAA, HHC, dental, eyeglasses, multi-purpose center, house

hh= household, HV: home visit, EC = older people club, OAA=Old Age

Pink = major activities implemented by each area at initial stage of PJT

CTOP Major Characteristics:

1) **Utilization of local resources** (Health Centers/THPHs, Community Hospitals, TAOs/Municipalities, ECVs, VHVs, ECs) in identifying community problems and providing health care, social welfare, and social services in an integrated manner. Coordination was made by the LAOs and/or community hospital.
2) **Close dialogue throughout the management cycle**, from initiating the model activities, implementing, reviewing, adjusting to re-implementing activities, has led to **strong partnership** between authorities and community people. Participation by local people (community leaders, elderly club members, volunteers, and community people) was active and a sense of **Local Ownership** emerged.
3) Variety of services/activities (social activities, health promotion, training, health check, rehabilitation, home care, and cash benefits) targeting all groups of older people (independent older people, dependent older people, and bed-ridden older people), **based on the specific**



[24] The Weekly Meeting was firstly established in CTOP in January 2008 as a "regular and informal forum," after learning that the Joint Coordinating Committee (JCC), conducted biannually, and the Steering Committee Meeting, conducted quarterly, could not function well as a platform for practical discussion.

[25] As shown on p. 46 of the CTOP Terminal Evaluation and in "A Challenge for Thailand in Community-based Integrated Health Care and Social Welfare Services Model Development fort Older People," an article in the Journal of Health Science, Vol.20, 2554, the Weekly Meeting has changed the situation from no regular meetings among different departments in the same ministry to close cooperation among officials in MOPH and with MSDHS.

Through the implementation of CTOP, all four pilot sites acknowledged the importance of surveys of older people, data analysis, and the design of services to cope with the actual needs of older people. Four different models were developed, implying that no single definition or best practice model for integration, but service patterns can take various forms in different contexts. However, there were shared values that all the pilot sites strived to realize, which were the local ownership, needs-based integrated approach, and the managed process based on the PDCA cycle. The lessons obtained through activities were summarized as suggestions, and the checklist consisting of 20 points for self-evaluation. Details of each model can be found in Appendix 8.

2.1.2 Impacts of CTOP

(1) Achievement of the Overall Goal

After the project, the implementation of community-based integrated health care and social services for older adults gradually increased. With regards to the Overall Goal of CTOP, which is to have the Community-based Integrated Health Care and Social Welfare Services Model for Older Persons utilized nationwide, it was found that 13.43% and 27% of a total of 7,255 sub-districts achieved the MOPH's indicator of "Sub-districts meeting the criteria for LTC services" in 2014 and 2015, respectively. This indicates a high impact in achieving the Overall Goal, which had an indicator of "more than 15% of sub-districts utilizing the model."

Promoting factors include ownership in the Thai government and the synergy effects with other MOPH projects conducted in parallel with CTOP. Firstly, the Government of Thailand had a strong sense of ownership toward the project jointly implemented with the Government of Japan. MOPH showed a solid commitment to achieving the Overall Goal as the Department of Health (DOH) set the indicator of having 15% of sub-districts meet the criteria for LTC services in 2014[26]. In interviews, the CTOP's counterparts mentioned that the former Director-General of DOH, who was also the Project Director CTOP, was very motivated to achieve the Overall Goal that the Government of Thailand and Government of Japan had agreed upon, so the above MOPH indicator was set. Secondly, the MOPH implemented the Pilot Project on Integrated Health Care and Social Welfare for the Elderly in parallel with CTOP's activities at four other sites[27] from 2008 to have more model practices. Thirdly, DOH implemented Pilot Projects on Sub-districts LTC Services[28], starting with 12 selected sub-districts in 2009 and expanding to 861 in 2012 (NHSO 2014, pp.10).

These three factors, and the community-based integrated care provided by sub-districts after learning from

[26] The criteria set in this 2014 indicator are; grouping information on older people by ADL level, having standardized club(s) for older people, having volunteers provide services to older people, medical professionals providing home health care services, having prevention and promotion activities for dental health, having a care service system for home-bound and bed-bound elderlies, having more than 20% of temples meet the criteria of good health promotion temples, and having involvement by local authorities.

[27] North: Lampang Province, North-east: Udon Thani Province, Central; Kanchanburi Province, South: Pang-nga Province (MOPH, 2015)

[28] LTC in the pilot projects implemented until 2012 was not restricted to dependent older adults but also covered the development of health care, mental care, and social care for three groups of older adults, namely, independent older adults, home-bound older adults, and bed-bound older adults, as in CTOP.

area workshops and national seminars held by CTOP have contributed to the high achievement of the CTOP's Overall Goal. Given the extent to which the concept of community-based integrated services models was expanded, the LTC Fund initiated by NHSO in 2016, the Lamsonthi Model, and the LTOP need to be discussed, as several criteria based on practices in the Lamsonthi district and in LTOP were added on to the concept of LTC services (details can be found in 2.2).

(2) Impact at Policy Level (Prefecture)

The project's effects were reflected in the policy of PPHO, leading to the establishment of more daycare centers in the province. According to the Nonthaburi PPHO's answer to the questionnaire surveys, after the two rehabilitation centers of Bangsithong were successfully operated, Nonthaburi PPHO came up with the policy to establish at least one daycare in each district. There are now 42 daycare centers out of 52 sub-districts in the province. (Results of questionnaire surveys by Nonthaburi PPHO's)

District		Muang	Bang kurai	Bang yai	Bang bua thong	Sainoi	Pak kred	Total
CM	No. of CM	42	35	20	36	24	33	296
	1 CM: Dependent Older People	1:21	1:9	1:17	1:9	1:12	1:12	-
CG	No. of CG	167	169	100	160	117	163	876
	1 CG: 5-10 Dependent Older People	1:6	1:2	1:4	1:2	1:3	1:3	1:3
Day care	Target: 52 Daycare Centers	5	6	6	7	7	11	42

Source：MOPH 2020

(3) Impacts and Changes at Organizational Level

A. Organizational Empowerment

a. Service Improvement at Community Hospital

CTOP's practices led to more coverage of hospital services to meet the needs of older adults. According to Banadoem Community Hospital in Surat Thani Province, after participating in the Mobile-One-Stop-Service (MOS), they re-designed its routine medical services, with indicators adequately set, to ensure their services practices for older people include knee osteoarthritis assessment in the geriatric screening and include services provided by social-related ministries. During home-visit by the hospital, staff will assess the home environment and confirm whether the older persons are entitled to and appropriately received benefits of older people, the vulnerable, or the disability according to the existing laws.

b. Empowerment of LAOs

CTOP empowered LAOs and other local stakeholders for more active roles in decision-making in responding to older people's needs in the community. In the initial stage of CTOP implementation, the project sites had no practices for utilizing the results of the analysis of surveys given to older adults in designing services to meet the needs of different target groups. At that time, services to older adults in many

areas were limited to the de-concentration[29] of tasks and responsibilities of the central government to local authorities, i.e., the distribution of disability allowance to persons with disabilities and Old Age Allowance (OAA) to persons aged 60 and above, etc. On the other hand, when CTOP launched its activities, it encouraged the decision-making process of communities, starting from identifying needs in the area through surveys of all older adults living in the area, analyzing results, designing projects based on the analyzed results, decision-making by a community committee, and reviewing and adjusting activities using the PDCA cycle, with involvement in the whole process by all stakeholders, including VHVs, ECVs, people in the community, and others. The empowerment of LAOs and participation of all stakeholders in the community development process could be considered unexpected impacts resulting from the practices of CTOP.

The following are some examples from interviews and questionnaire surveys.

- The nurse coordinator in Khuntan District Hospital made efforts to involve LAOs in the activities of CTOP by taking both municipality mayors and councilors along on home visits. With more understanding on the need to tackle the issues, the Yanghom Tambon Municipality started including programs on health promotion targeting older adults and training programs for ECVs in its community plans after the CTOP period (Khuntan Community Hospital at the Chiang Rai Site).
- After Sa-ard Tambon Municipality participated in CTOP activities, it took active actions in LTOP. For example, the municipality took the lead in submitting a proposal for financial assistance by GGP, established and operated a daycare center, supported a caregivers (CGs) team to take care of older people in the community and at the daycare center, and other actions (Namphong Community Hospital at the Khon Kaen site).
- Bangsithong Tambon Municipality included projects for the care of older adults, persons with disabilities, and vulnerable people, and training projects for VHVs/ECVs in the community development plan. Budgets were allocated accordingly for conducting project activities and procuring assistive devices for the rehabilitation centers (Bangsithong Tambon Municipality at the Nonthaburi site).
- Banna Tambon Municipality gradually acknowledged the importance of services for older adults and allocated higher budgets, such as assistive devices for rehabilitation (Bannadoem Community Hospital at the Surat Thani Site).

B. Expansion of Elderly Care Practices

Models and services at the project sites were expanded to other areas by the initiatives of counterparts of each project site. People working on the CTOP project, through sharing the project's activities in regular meetings and occasional workshops, inspired people from other places to create new initiatives in their setting.

The following are some examples given in interviews and questionnaire surveys.

- Khun tan District Hospital always reported CTOP activities at district meetings, in which all LAOs in the

[29] De-concentration is the lightest form of decentralization. While decentralization means transferring power from a central authority to local administrative authorities, de-concentration means that decision-making power is not shifted away from the central government, but the responsibilities and tasks of the central government are moved to lower levels of government.

district participated. All LAOs in the Khuntan district started working on older people issues, with a kick-off event organized by the district office during the period between CTOP and LTOP (Khuntan Community Hospital, Chiang Rai Site).

- The practice of MOS at Surat Thani site was shared with nearby provinces in the area workshops other sub-districts in Bannadoem district. It was found that the MOS practice was applied at least in the Bannatai sub-district and Nasarn sub-district in the Bannadoem district (Bannadoem Community hospital at the Surat Thani Site, and the Department of Mental Health).
- Exchanging knowledge and experiences with Bangsithong and observing activities conducted at the rehabilitation center in Nonthaburi convinced counterparts in Surat Thani site that a daycare center was necessary, and they decided to establish one. The daycare center was established at the end of LTOP, with Banna Tambon Municipality providing a location and helping to raise funds, Bannadoem hospital and Banhuaiyai THPH providing staff and CGs to take care of the patients and older adults at the daycare center from 2017 through the present (Bannadoem community hospital at the Surat Thani site).

C. Impact to LAOs from Audits and Requests for Repayment.

A mismatch between LAO's initiative and the administrative regulations came to an issue when the Office of Auditor-General requested LAO to pay back its payment to ECVs during CTOP. This problem was remedied later when related laws and regulations were revised in 2018. At the Nonthaburi site, the Bansithong Tambon Municipality included elderly care projects in its community plan for FSY 2007-2009, with a budget for payment to ECVs to provide care services as the main activities of Bangsithong in CTOP. In an audit, the Office of the Auditor-General requested that these budget items be repaid, claiming that elderly "care service" was not the responsibility of sub-district municipalities as per the Municipality Act[30]. This request for repayment was a one-off, unexpected negative impact on Bangsithong. Still, it had a minimal effect on elderly care services in the area since Bangsithong was able to subsequently manage to have CGs work without pay and continue elderly care activities as of this date. Lamsonthi and other municipalities were also asked for repayment before the Government of Thailand revised the related laws and regulations about LTC in 2018 (details can be found in 2.2.4).

(4) Changes at Community and Individual Levels

A. Expansion of Services to Other Vulnerable Groups

During the CTOP project, situations of non-older populations with vulnerabilities were shared among population groups and with stakeholders. PSHDS started responding to the needs of these people through PSDHS's assistance programs. At the Chiang Rai site, four hill tribes—Mien, Tai Lue, Tai, and Hmong—reside in the Yanhom Sub-district. In earlier days, there was no relationship among hill tribes nor with governmental officers. When CTOP started, representatives of each hill tribe participated in the activities of CTOP. Midway through CTOP, not only were governmental officers able to enter their houses, but these hill tribes also started sharing information. Once they could enter their houses, government

[30] Governmental bodies in Thailand are governed by public law, which states that authorities may **only act within** the law (*secundum et intra legem*). This means that the municipality cannot conduct anything not specified in relevant acts. Looking at the mandates of sub-district municipalities as described in the Municipalities Act (1953) and Determining Plans and Process of Decentralization to Local Government Organization Act (1999), sub-district municipalities like Bangsithong have no mandate to provide care services to older people (refer to details in Responsibilities of Municipality and TAOs in Appendix 9).

officials found older adults in need of special care and some children with physical or developmental disabilities. This was an unexpected impact and has meant that further assistance could be provided to other vulnerable groups since then.

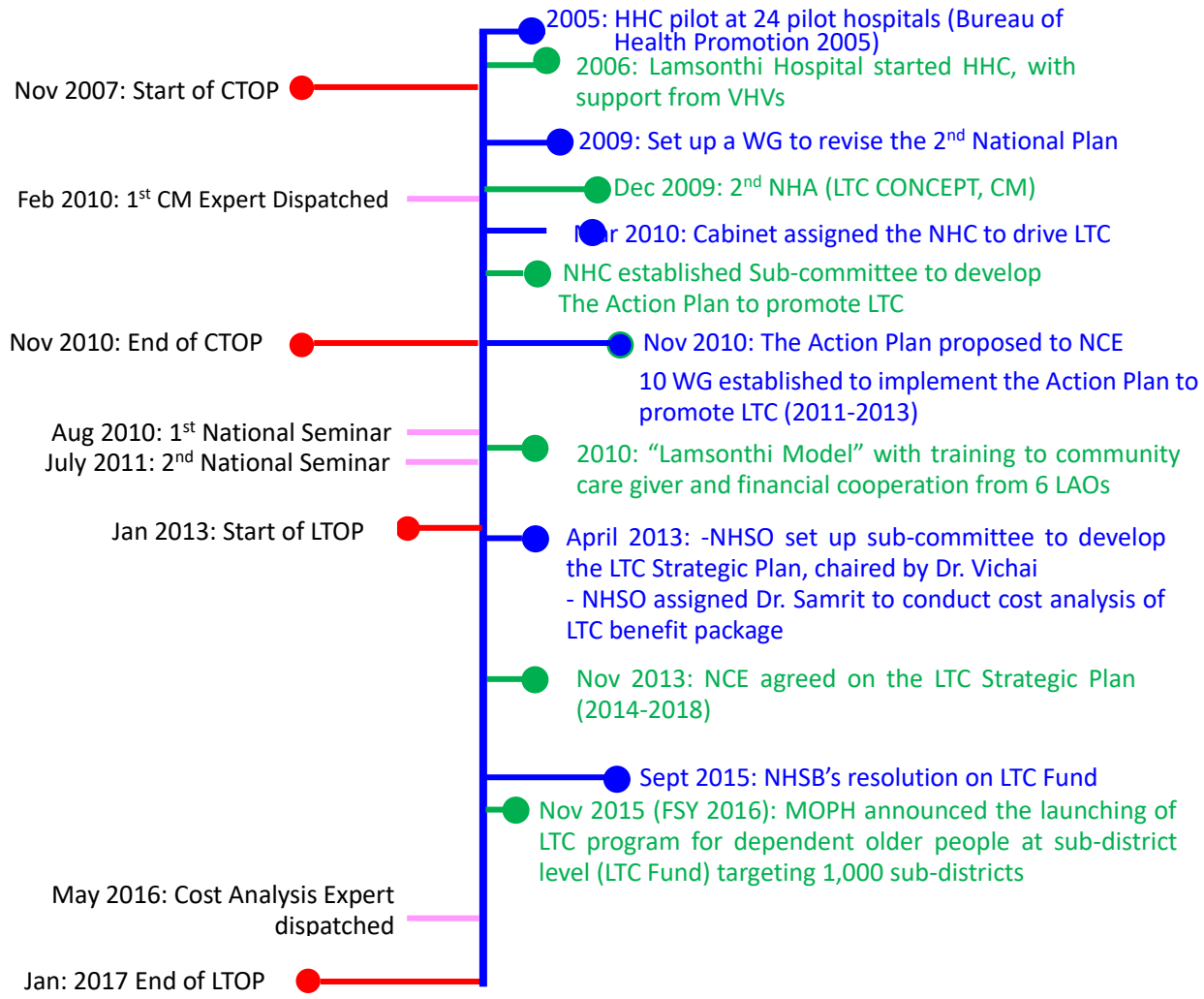
B. Empowerment of Elderly Care Volunteers

Some empowered elderly care volunteers made a way to be a part of the Tambon Municipality's formal decision making. Some ECVs paying home visits at the Chiang Rai site and Nonthaburi site during CTOP were selected as municipality council members. As stated in 2.1.2 (2) A, being involved in the project empowered them, and gave them a good reputation among community members after conducting home visits during CTOP implementation.

C. Behavior Change of Community People

Community people's mindset for their roles changed from the government's welfare service receivers to supporters for neighbors. Involving older adults in the project development process led to a strong sense of ownership among all stakeholders in the pilot sites. They changed the assumption that government agencies should be service providers and community people were just welfare recipients. One specific sample is that some of the older adults at the Chiang Rai site, formerly target groups, became service providers and disseminated practices to other older adults within the community and other areas.

2.2 Development of Long-Term Care System for Dependent Older People in Thailand



Source: The researcher

2.2.1 Development of LTC Policy and Strategies in Thailand

The 2nd National Health Assembly held in 2009 was the starting point for LTC service development as a national policy agenda. In 2009, two years after the CTOP project started, the Government of Thailand set up "a working group to revise the country's second National Plan on Older Persons (2002-2021)." The working group recommended establishing "Community-based Integrated Long-Term Care," inclusive of medical and social care provided primarily at the residences of older people in the 1st revised edition of the National Plan (Suwanrada W. et al. 2014).

The wording of Measure 4.2 of Strategy 3 was changed from:

> "Older people shall be supported so that they can reside with family, with community-based health and social services fully accessible to and usable by older people, by emphasizing the home-care model integrating health care and social services."

to:

> "Establish and develop health and social services including CLTC that are fully accessible to and usable by older people by emphasizing the home care model integrating health care and social services, which cover the following services":
>
> 1. LTC service;
> 2. Palliative care;
> 3. Treatments for significant chronic diseases such as hypertension, diabetes, and cerebrovascular disease;
> 4. Community volunteers; and
> 5. Support CGs to gain knowledge and skills in elderly care.

At this Assembly, 'LTC for older people' was defined, and a recommendation to nurture CM was made.
The specific concept of a national LTC program for "dependent older people" first appeared in the resolution of the 2nd National Health Assembly (NHA) held on 18 December 2009 (NHA 2010)[31]. At the Assembly, all agreed that the government shall be responsible for the care of dependent older people, principally through home-based and community-based care, with support from private and governmental institutional services. There was also a recommendation to nurture CMs, one of the major activities conducted by LTOP in 2013-2017[32].

LTC for older people was defined in this NHA as follows:

> LTC for older people refers to comprehensive care that covers all dimensions of care, including social, health, economic, and environmental aspects, for older people who are experiencing difficulties due to chronic disease, disabilities, or infirmities and who are partially or totally dependent on others for daily living activities. Care can be given formally by health and social work professionals or informally by family members, friends, and neighbors. The care may be given in the family setting, community, or institution.

[31] The National Health Act passed in 2007 designated that the National Health Commission Office is mandated to organize an annual NHA, a platform for participatory public policy development. Cabinet Resolution endorses many resolutions by this NHA.

[32] According to interviews with CTOP"s counterparts and Thai scholars, the concept of care manager discussed in the NHA came from research results on LTC conducted extensively by academics during the mid to late 2000s and from some of the CTOP"s counterparts who participated in the meeting. During CTOP, care management, CM, and CG concepts were introduced to Thai counterparts, both through training in Japan and by the Chief Advisor and short-term experts dispatched to Thailand. The dispatch of a short-term expert on care management was planned around three to six months before the first dispatch in February 2010, which demonstrated that activities in CTOP were conducted in line with measures and decisions made by the Government of Thailand.

The Action Plan to promote LTC for Older People (2011-2013) developed in 2010 laid out the foundation for implementing the LTC program, with working groups from different ministries to support LTC in the local community, preparation at the national level for service deliveries, and design financial support for LTC. The National Health Committee (NHC) endorsed the Resolution on the development of an LTC system for dependent older people and presented it to the Cabinet on 28 December 2009, before being approved on 23 March 2010 (Cabinet Resolution No. NR0506/4879)[33]. The Cabinet assigned the NHC to be a core mechanism in translating NHA resolution into actions. The NHC established a Sub-steering committee on LTC Issues of Older Persons chaired by the Permanent Secretary of MOPH and developed an Action Plan to promote LTC for Older People (2011-2013)[34]. The Action Plan was proposed at NCE's 5th Meeting on 18 November 2010, and 10 working groups were set up to implement the Action Plan. The Action Plan has three major parts as follows:

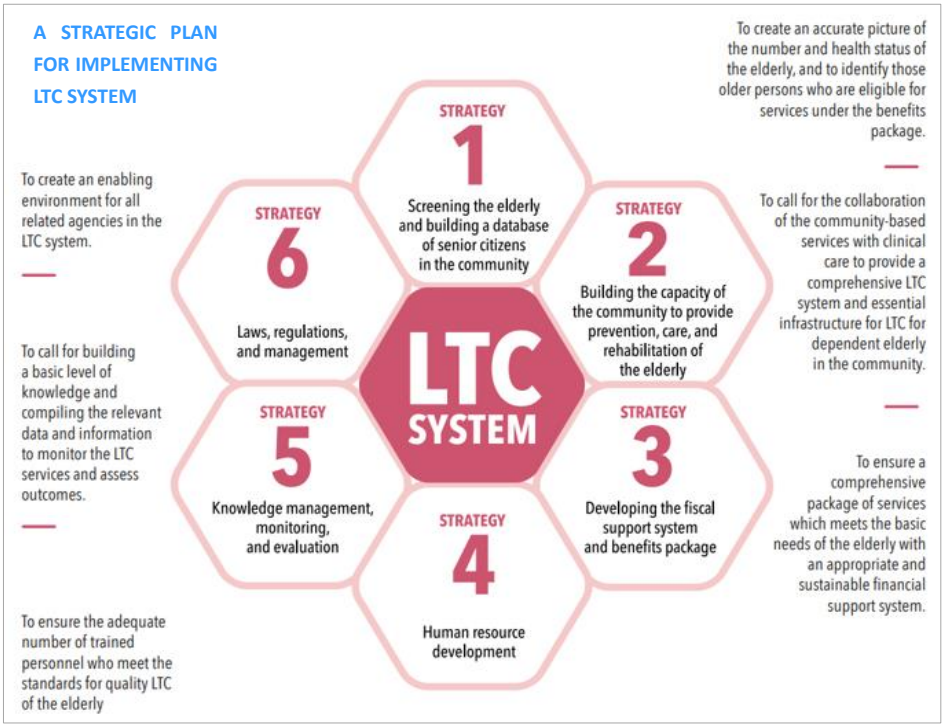
- ❖ Promotion and support of LTC in the local community
    - Developing assessment tools, providing care services, and training for family CGs and volunteers
- ❖ Implementation by the national government
    - Setting criteria and assessment procedures for older people, and standards for residential homes and nursing homes; establishing daycare centers and information centers; policy development on home nursing services, home-based and community services, day hospitals & intermediate care, and nursing care at hospitals; promoting home health care, and developing human resources on LTC.
- ❖ Financial support
    - Financial support for the family with dependent older people, tax incentives for private or NGO nursing homes, and financial support for home maintenance or renovations for LTC

NHSO developed the Strategic Plan for Implementing LTC System for Dependent Older People (2014-2018). In April 2013, right after LTOP was launched, NHSO set up a sub-committee to develop the Strategic Plan for Implementing LTC System for Dependent Older People (2014-2018) (NHSO 2014) and assigned Dr. Vichai Chokwiwat[35] to be the chairman[36]. In the same year, Dr. Samrit Srithamrongsawat was appointed by NHSO to research appropriate costs for the LTC benefit package for dependent older people. The plan was developed based on academic research and studies of Japan's experiences, highlighting CM and CG

[33] Details of the resolutions on the development of LTC and the responsible agencies are provided in Appendix 10.
[34] Detailed results of actions implemented by relevant ministries and organizations during 2011-2013 are provided in Appendix 11
[35] In "Learning from Japan: LTC System for Home-bound and Bed-ridden Older People," written in 2019, Dr. Vichai stated that "Thailand had an expert from Japan who provided inputs for developing this Strategic Plan in 2013. The Japanese expert strongly emphasized that the Government of Thailand needs to empower family and community to provide LTC to dependent older people rather than increase nursing homes or elderly care homes, which may weaken the family and community system in the country."
[36] The National Health Security Board"s Order No. 1/2556 on "Establishment of Sub-Committee to Develop LTC system for Dependent Older People," dated 9 April 2013.

training, development of service delivery standards, and development of daycare centers in communities.

Figure 10: Strategic Plan for Implementing a System of LTC for Older People



Source: NHSO

In implementing the strategy, NHSO focused on developing a benefits package with a sustainable financial mechanism. NHSO agreed on the Strategic Plan (2014-2018) on 5 August 2013 (NHSO's Resolution No.9/2556_2), and NCE followed suit on 21 November 2013 (NCE's Meeting 4/2556). A national budget of 6,652 million Baht was allocated, with priority on Strategy 4: "Human Resource Development" (83.8% of total budget) and Strategy 2: "Building Community Capacity to Provide Comprehensive LTC System and Infrastructure for LTC for Dependent Older People in Community" (11.6% of total budget) (NHSO 2014, pp. 31). The former included the development of curricula and the provision of training programs for CMs and CGs. The latter included the development of service delivery standards and systems, and daycare centers in communities. Both strategies were mainly implemented by MOPH, MSDHS, and LAOs, with technical cooperation provided by JICA through the LTOP Project (details in 2.2.3). On the other hand, NHSO was principally in charge of Strategy 3: "Development of Fiscal Support System and LTC Benefit Package for Dependent Older People"[37].

LTC fund for dependent older people at sub-district level was launched in November 2015. Dr. Samrit Srithamrongsawat conducted a cost analysis research by using the Lamsonthi Model in his case analysis, LTC practices of Lamsonthi hospital, and service delivery systems and human resources development in

[37] The concrete action plan for each strategy and the responsible agencies are provided in Appendix 12.

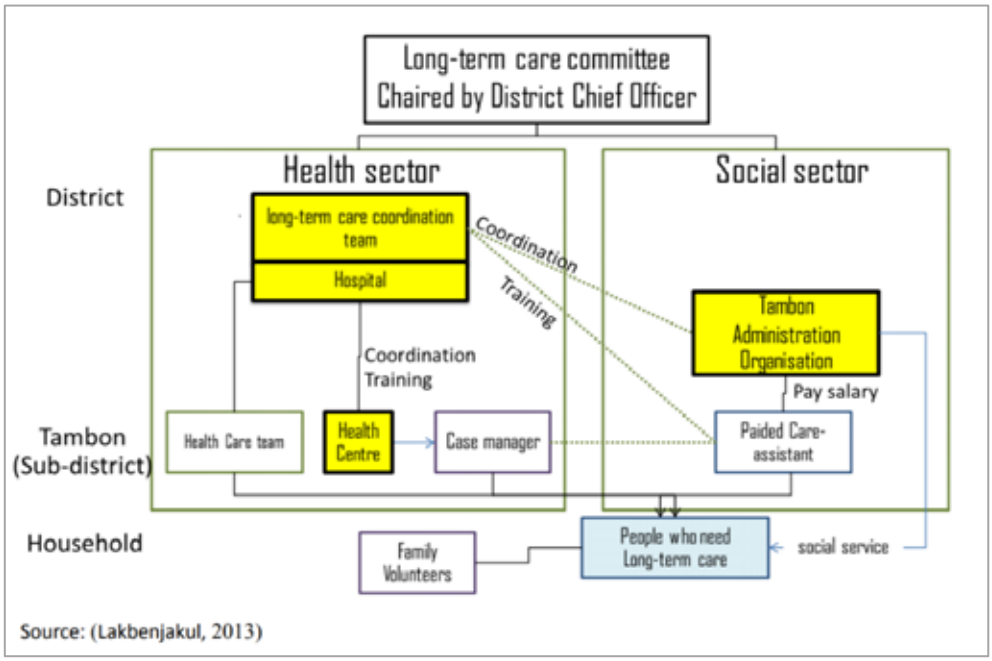
LTOP. Based on his research, MOPH finally announced the launch of the "LTC Program for dependent older people at sub-district level" on 30 November 2015 (hereinafter referred to as the "LTC Fund"), after the resolution by the National Health Security Board (NHSB) on 14 September 2015 (NHSO's Resolution No.9/2556_2). Details concerning the local initiative Lamsonthi Model and LTOP should be understood before the mechanisms of the LTC Fund can be grasped.

2.2.2 Lamsonthi Model[38]

The local Thai initiative of Lamsonthi, which integrated services of the health sector and social sector, with cooperation from Tambon Administrative Organizations, was utilized as a service model of the LTC fund. The Lamsonthi Model is a local initiative for LTC for dependent groups developed by Dr. Santi Larpbenjakul, Director of Lamsonthi Community Hospital, with the slogan of "Lamsonthi mai thod thing kun" or "No one left behind in Lamsonthi" (Khonthai Foundation 2017). In 2006, the "Care Team for the Handicapped and the Underprivileged" of Lamsonthi Hospital consisted of one hospital director, one nurse, and one physical therapist, who conducted home visits for nursing care and rehabilitation in six sub-districts. Between 2007 and 2010, the Health Care Team was established and worked as a "Case Manager for Health," with the district hospital functioning as a facilitator and sub-district health units and health volunteers working as service providers for children with special needs. Between 2010 and 2012, health care services for older people were not enough, and a social care team was established. Six Tambon Administrative Organizations (TAOs) agreed with the concept of "No one left behind." They emphasized home-based care, with the structure of family volunteers at the household level, medical care team and social care team at the sub-district level, LTC coordination team at the district level, and the District LTC committee as a directing body to guide other teams in the same direction.

[38] Since 2015, MOPH has adopted the Lamsonthi Model in all 77 provinces of Thailand and later included the model in the 20-year National Strategic Plan on Public Health (2017-2036) as an LTC service policy for dependent older people. MOPH has also accepted the Family Volunteer concept as one of the policies of the Thai government since 2016.

Figure 11: Lamsonthi LTC Model (2010)



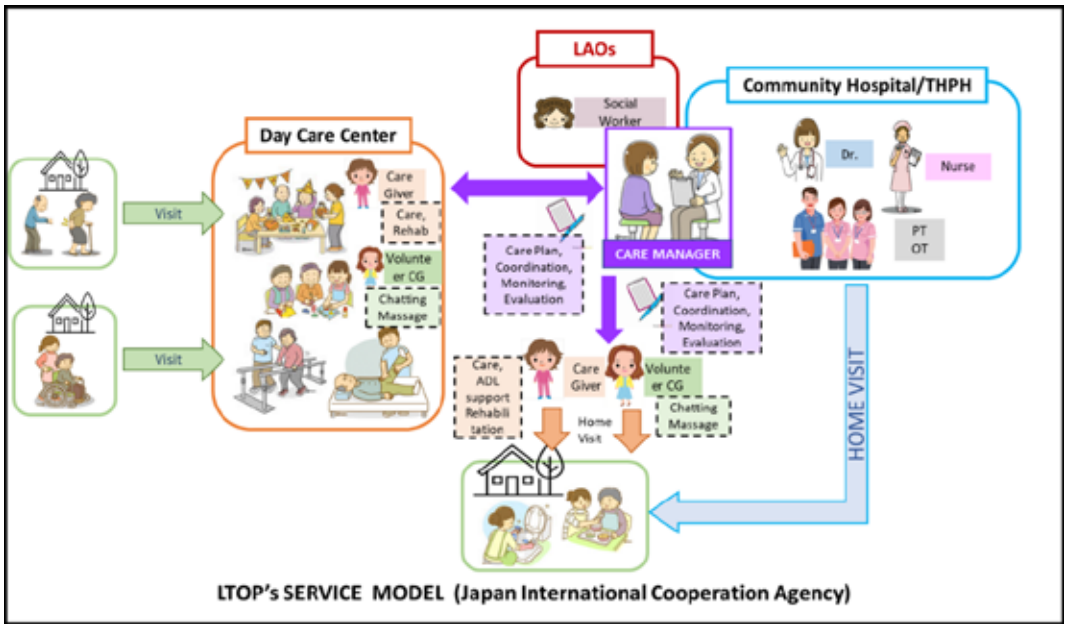
Source: Amorim A, and TRAN H.V. Edition (2018)

Under this model, the LTC Coordination Team (District Health Office and District Hospital) is a coordinator and trainer for the health care team and social care team. The family is the core caregivers, with social service supports from TAOs (house environment support and formal caregiving by paid care assistants), and health care service supports from the health care team and health care unit at the sub-district level. Morning conferences between the health care team and paid care assistant and a tailor-made individual plan made it possible to provide integrated care for individual older adults in need of care. This Lamsonthi Model was considered a non-complicated community health management model, utilizing resources within the local areas, involving local authorities as the primary actor for elderly care, and only costing one-third of what hospital care would cost (Lamsonthi Model 2019).

2.2.3 Details of LTOP and its Effects

LTOP was conducted as a part of LTC Strategic Plan 2014-2018, especially on human resource development (CM/CG training and curriculum development), service delivery system development (Care Management/Care Plan), and operations of daycare centers. As stated earlier, the Project on Long-term Care Service Development for Frail Older People and Other Vulnerable People (LTOP) was initiated and implemented during the Action Plan (2011-2013) and the Strategic Plan (2014-2018). Activities conducted by LTOP supported the Action Plan and the Strategic Plan, including implementation of LTC service models, development of CM training curricula and the provision of CM training, development of 70-hour and 420-hour CG training curricula, and conduct of CG training, the establishment of daycare centers, and other. Target groups in LTOP were mainly older adults with dependency. The background factor of selecting them as a target group was the prevalence of care-dependency among older adults in the community. CTOP found that family members usually took care of home-bound, bed-bound older adults without a systematic approach. The gap between necessary care and actual care provision for older adults led to a lower quality of life. The design of LTOP aimed to reduce the burden of family members and fill this gap, as well as provide evidence-based recommendations from LTC service model development at six pilot sites.

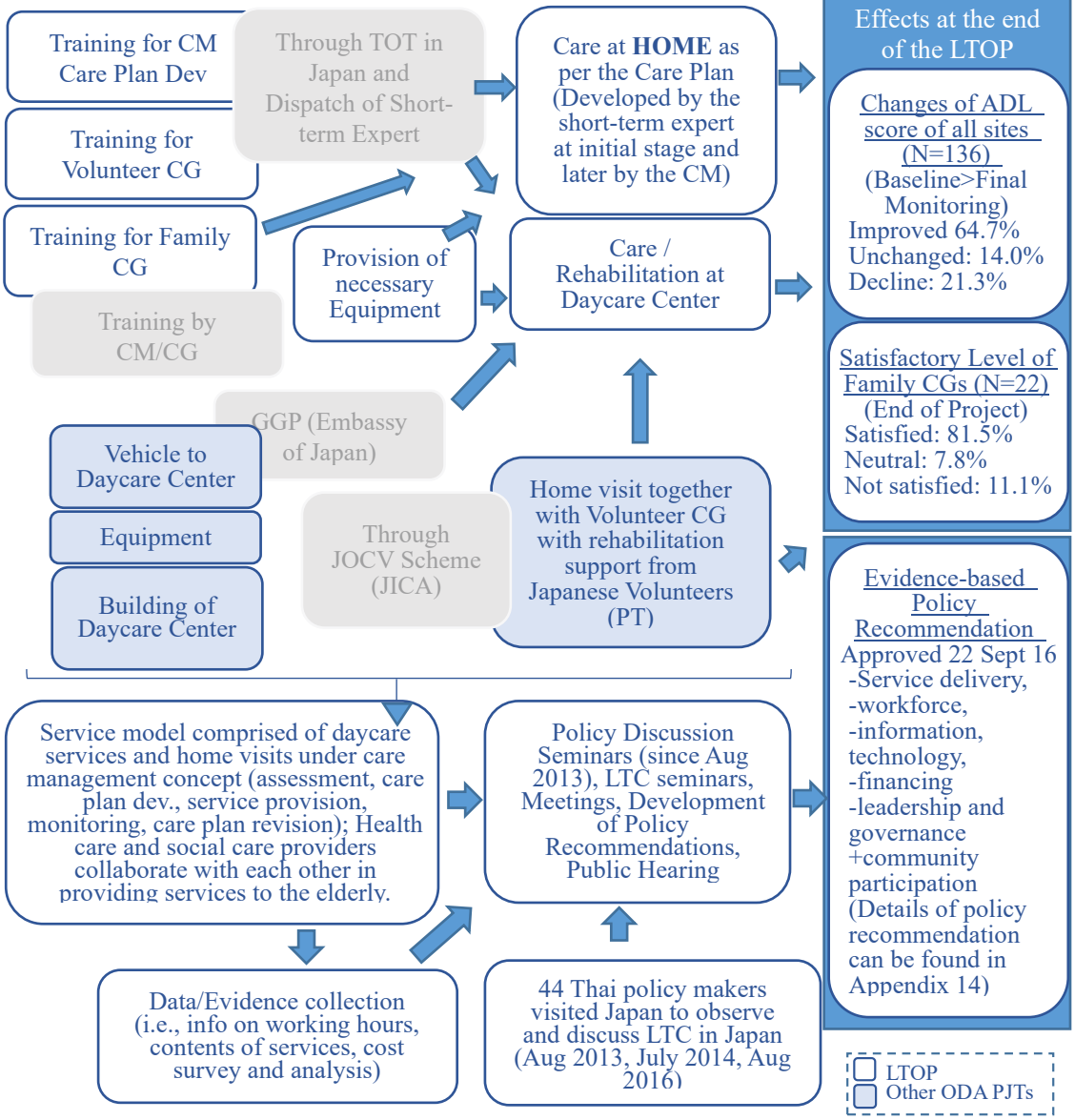
Figure 12: LTOP Service Model (2013-2017)



Source: Illustration from LTOP Terminal Evaluation Report

The LTOP service model, which consisted of home care and daycare services, was developed based on the care management concept. The service model developed in LTOP was comprised of a home care service and daycare service. These services are provided under the concept of "care management," with the CM assessing older adults and families' situations and developing a care plan, and CGs providing nursing care after being trained. In this model, health service providers (Tambon Health Promotion Hospitals: THPH, and Community Hospitals) and social support providers (LAOs and volunteers) collaborated to cover the health and social aspects of older adults' needs. The service model implemented in LTOP was as shown in Figure 13, with pilot sites in six different areas. Four out of six were the same sites as those of CTOP. Two additional sites, i.e., Nakorn Ratchasima and Bangkok, were in urban areas to study different practices in the case of urban and rural areas. Specific characteristics of each site are described in Appendix 13

Major practices in LTOP / Other Japan ODA's Cooperation and major Effects:



Outcomes: ① **Care Plan (See a sample in Appendix 15)**
② **CM Training Curriculum (See Index in Appendix 16)**

Major Characteristics of LTOP:

1) **The utilization of several ODA schemes,** namely, JOCV and the GGP, with LTOP enhanced the project's efficiency. The JOCV dispatched to the project sites were principally physical therapists, who transferred rehabilitation techniques and the Japanese work culture to the CMs, CGs, and other ECVs. Counterparts at some sites mentioned that if JICA provided only the concept of Care Management without dispatching JOCVs, who helped them complete the services specified in the Care Plan, the pilot site could not have improved the ADL score of the target groups this much. Besides, having a JOCV working at the daycare center has led to more participation of older adults in the center's activities, since community people were excited about receiving services from a foreigner. Likewise, the provision of daycare center and/or wheelchair-lift car by the GGP helped project sites provide services with higher quality /standards.

2) **Evidence-based results utilized in LTC Policy Recommendations:** LTOP deliberately collected data and analyzed services delivered and necessary costs, which were utilized in developing solid policy recommendations, with concrete evidence from pilot sites (see policy recommendations in Appendix 14).

2.2.4 Impacts of LTOP

(1) Achievement of the Overall Goal

The LTOP project's overall goal was that its policy recommendations on LTC for older people would be reflected in the Thai government's policies (LTOP's Overall Goal). Regarding this goal, three significant impacts were observed, which include A. the LTC Fund, which is the national LTC program, B. Expansion of care plan usage nationwide, and C. Expansion of numbers of CM/CG.

A. Initiation of LTC Fund by NHSO

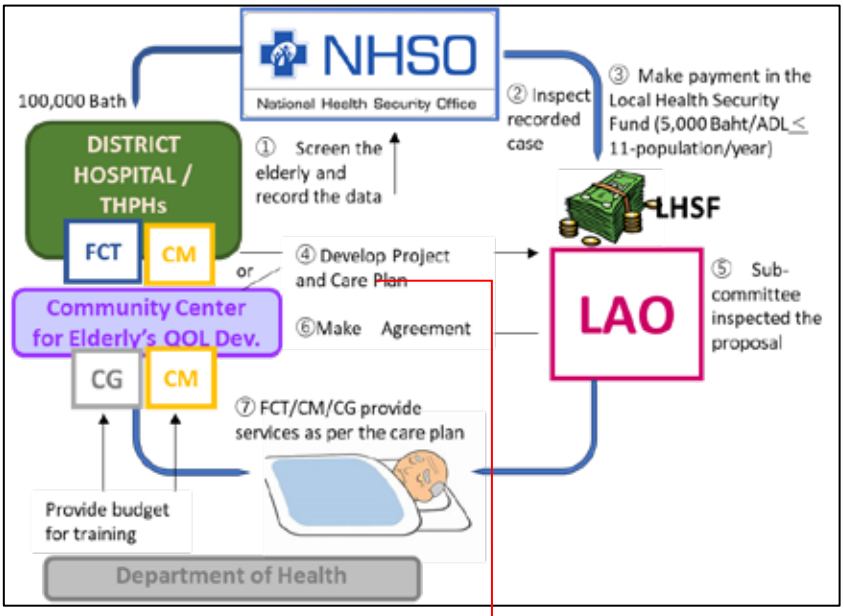
LTOP practices on CM, CG, and Care Plan were incorporated in the LTC program launched by NHSO. The LTC Fund, launched by NHSO in November 2015, was one of the impacts. It was achieved by synthesizing the results of the cost-analysis research carried out by Dr. Samrit, the Lamsonthi Model, and LTOP. The cost-analysis study analyzed care services provided by CGs principally in Lamsonthi and came up with a budget of 5,000 Baht per care-dependent older adult. Lamsonthi's practices of having a community hospital provide health care service and LAOs providing social services were applied[39]. The LTOP service model was adopted as standard practice for the LTC Fund, especially having a CM who systematically plans, coordinates, monitors, and evaluates services for older adults using a care plan and ensuring that CGs are appropriately trained.

In 2016, the first year of the LTC service system, the government of Thailand allocated 600 million Baht through NHSO to support the LTC system. Of this amount, 500 million Baht went to the existing LHSF (or Tambon Health Fund) to provide LTC services to 100,000 dependent older adults in 1,000 LAOs, including Bangkok. Another 100 million Baht went to the service units registered with NHSO (i.e., district community hospitals or THPHs) to screen older adults and database development.

The budget's amount and the target population have been gradually increased since then. In 2017, the budget was increased to 900 million Baht (750 million Baht to the LHSF and 150 million Baht to service units) to cover 150,000 care-dependent elderly persons. In 2018, the budget further increased to 1.159 billion Baht (984 million Baht to the LHSF, 25 million Baht to NHSO Bangkok, and 150 million Baht to services units except for Bangkok) to cover 193,200 care-dependent older adults. The steps to utilize the LTC Fund are described in Appendix 17. As of April 2021, 85.18% of LAOs with LHSF[40] participate in the LTC program (NHSO website).

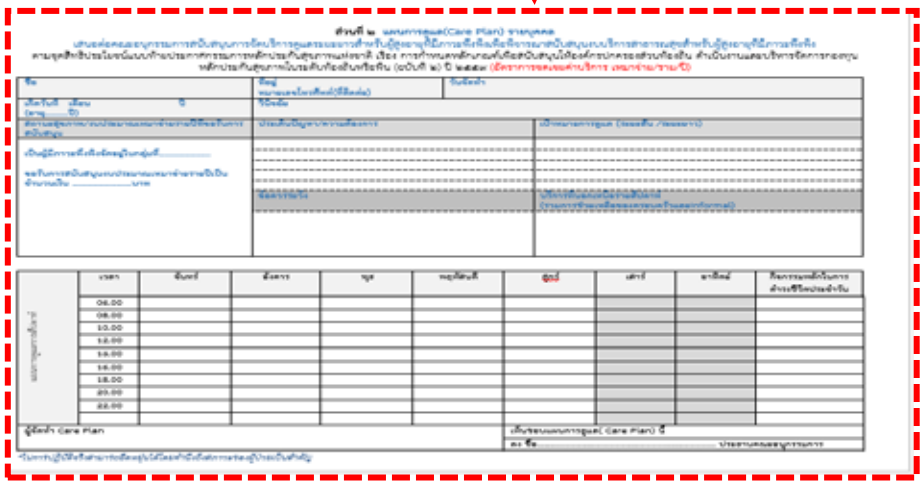
[39] It should be noted that the practice of having a community hospital provide health care services and LAOs providing social services was also introduced in CTOP. However, according to the interviews with the person who developed the LTC Strategic Plan and the person in charge of the LTC fund, the Lamsonthi Model was used as a reference.
[40] Only LAOs with LHSF can participate in the LTC Program.

Figure 13: LTC Service System



Source: Developed from NHSO's information

Figure 14: Care Plan to be Attached with the Project Detail and Service Proposal

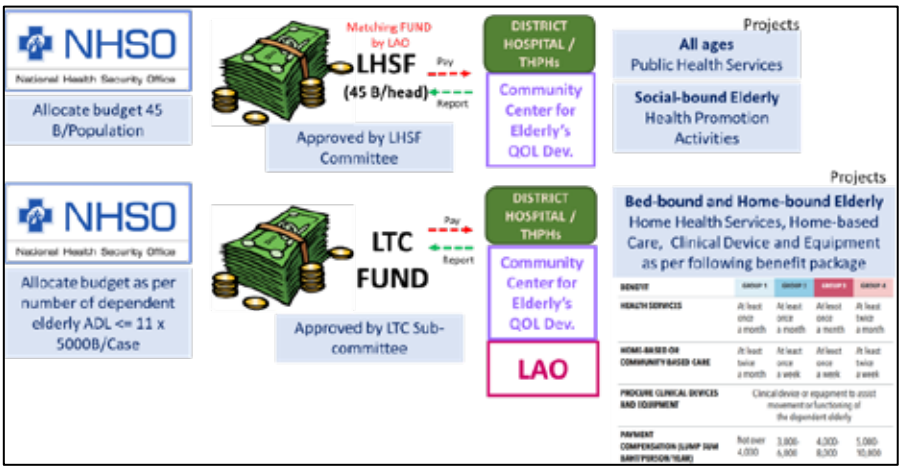


Source: NHSO Regional 6 *Note: Originally introduced by LTOP[41]

[41] See Appendix 15 for the version utilized in LTOP.

The budget topped up to the existing system will be in a different pocket of LHSF. A sample of the fund usage from the two pockets for older people can be as follows:

Figure 15: Sample of Fund Usage



Source: Developed based on information from NHSO Regional 6

B. Expansion of Care Plan Usage Nationwide

Development of a care plan for an individual older adult was recommended in the Policy Recommendation. The Policy Recommendation approved by the JCC on 22 September 2016 recommended service delivery for LTC are as follows.

> *A care management system should be set up consisting of a care plan developed by a care manager to address the care needs of frail older people (care-dependent/bed-bound) and older people who have a limited ability to perform their daily activities (partially dependent/homebound), and their family by considering suitability, efficiency, and standards. A care plan should be developed for the individual under an agreement between a service provider and a service receiver.*

One of the factors was the indicator set by MOPH for expansion of care plan usage nationwide. Care plan usage was promoted accordingly. Major actions taken by the Government of Thailand, which acted as promoting factors for using this care plan, were the setting up of the MOPH's indicator "the percentage of dependent older people served under the care plan."

Another promoting factor was the 3C online program developed by DOH. It was developed after learning that some LAOs and service units were having difficulties making a care plan and could not request the LTC fund, launched in 2016. In 2018, DOH and counterparts from the LTOP pilot sites cooperated with Maejo University to develop the 3C (**C**are manger, **C**aregiver, **C**are plan) online program, which allowed registration of CMs and CGs in the database system. This program facilitated the development of a care plan (refer to images of the 3C program in Figures 16, 17, and 18). The achievement of the indicator "the percentage of dependent older adults served under a care plan" can be found in Table 1. The number of dependent older adults under UCS served under a care plan in 2019 increased after the 3C program was introduced. In 2020, the government decided to extend services utilizing the LTC Fund to cover the older adults outside the UC scheme. However, it was still limited to older people registered in the LTC program. In 2021, the coverage was expanded to **any** older person in Thailand.

Table 1: Achievement of “the percentage of dependent older adults served under a care plan”

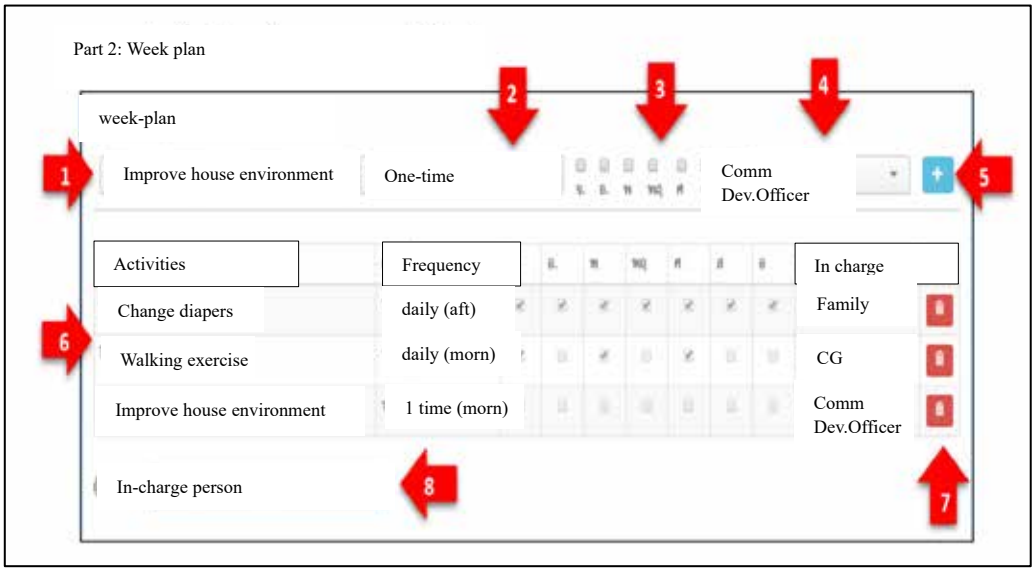
Year	Percentage*	Remarks
2016	86.44%	Dependent older adults under UCS only
2017	84.02%	Dependent older adults under UCS only
2018	88.90%	Dependent older adults under UCS only
2019	92.42%	Dependent older adults under UCS only Started online registration in 3C program
2020	89.56%	All dependent older people registered in LTC program

Source: Healthkpi (MOPH) 2020, 2021
* Care plan approved/Dependent older adults registered in LTC Program
Note: The Government of Thailand decided to expand the services to **any** dependent older people in 2021.

Figure 16: Sample image of 3C program

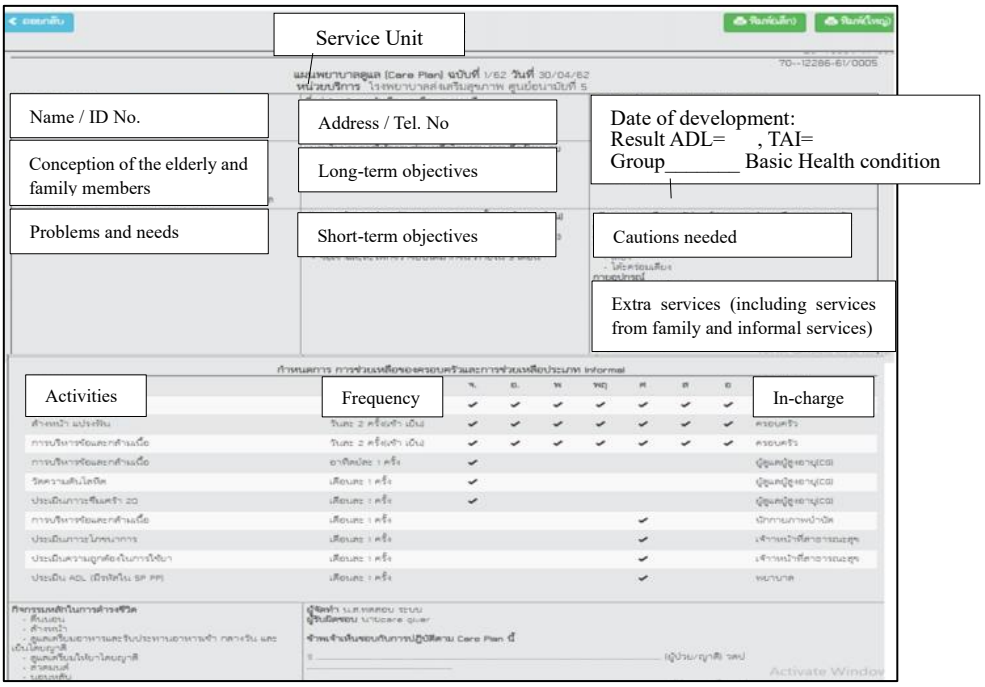
Source: Department of Health

Figure 17: Sample image of 3C program (Input information in a care plan)



Source: NHSO

Figure 18: Sample image of 3C program (Filled-in care plan for printing)



Source: NHSO

C. Expansion of Numbers of CM/CG

In the LTOP project, JICA provided hands-on training to four CMs from the six pilot sites. They were expected to be the key persons that would develop CM and CG training curricula and be trainers to nurture CMs in Thailand. The CM curriculum was first designed by counterparts in MOPH together with JICA-LTOP experts in 2015.

The number of CM has been gradually increased since the CMs trained by JICA then provided training to staff both within and outside the pilot sites[42]. In 2014, the Government of Thailand also set the indicator on "the number of CMs trained" in line with the strategy on human resource development in the LTC Strategic Plan (2014-2018). The target number was 100 and 500 CMs trained by December 2014 and April 2015, respectively.

As for the LTC workforce, LTOP made a policy recommendation on the roles of CM/CG, necessary numbers, their skills, and their qualification. The Government of Thailand has set an indicator on "the number of CMs trained" and placed an importance on curriculum development, leading to the expansion of CMs and CGs nationwide.

Thailand strategically planned to increase the numbers of CM/CG and set an indicator to ensure the numbers have expanded nationwide after completing pilot training and curriculum development in LTOP. CM's number has been gradually increasing due to the strategies and budget support from DOH and NHSO to train CMs nationwide. As of April 2021, 14,474 CMs and 92,348 CGs had been trained in Thailand. The Government of Thailand further developed the CM Re-training Curriculum in 2020. The development of 70-hour and 420 hour CG guidelines was done initially by the Thai side, with extra information added from experience gained from the training in Japan.

Figure 19: Guidelines for CM Training and re-training curriculum[43]

Source: Cover page of the guidelines provided by DOH

[42] By the end of the Project, seven CM had been trained in Chiang Rai, six in Khon Kaen, sixteen in Nonthaburi, six in Surat Thani, eight in Bangkok, and seven in Nakorn Ratchasima.

[43] The Index for the CM Training Curriculum can be found in Appendix 16.

Three factors seem to have led to this high impact. First, as specified in the Strategic Plan (2014-2018), the Government of Thailand had a clear policy and strategy to develop training curricula and conduct training to nurture CMs and CGs (see Strategy 4 in Appendix 12). Second, LTOP collaborated in providing effective human resource development programs that supported this Strategic Plan effectively and with good timing. Third, the Government of Thailand took immediate action to set the indicator on "number of CM trained," which has led to the training of CM in every province.

(2) Impact at Policy Level

A. Revision of LTC-related Laws and Regulations

After the Office of Auditor General asked many LAOs, including Bangithong Tambon Municipality and those in Lamsonthi, for repayment for the budget used for CGs, other LAOs became reluctant to use LTC Fund. As mentioned earlier, there was a negative impact found in the case of Bangsithong Tambon municipality. They were asked for repayment of their expenditures for older people care activities it had provided because it was not the responsibility of the municipalities as per the existing laws and regulations in the period of CTOP/LTOP implementation. Lamsonthi also faced a similar problem after utilizing LAO's budget to reimburse ECVs taking care of dependent older adults. After the LTC program was launched by NHSO in 2016, some LAOs were reluctant to utilize the fund, worrying about audits by the Office of Auditor General. They were particularly concerned about payments to CGs.

The appropriate number for CGs was the issue concerned by service providers the most. Many notifications were released before it concluded 600B or 1,500 per month. Regarding the payment to CGs, Clause 7/1 paragraph 2 in the Notification of the National Health Security Commission (NHSC) on "The Guideline for LAOs to Manage NHSF No. 2," dated 7 April 2016, stated that "payment to CGs for older adults at a different rate than specified by service providers or as designated by the LTC sub-committees is possible if less than minimum wages." On 23 December of the same year, MOPH sent a letter (No. 0941.03w1051) to all Provincial Public Health Office (PPHO) directors stating that CGs shall receive a lump sum of 300 Baht/month. The rate rose to 600 Baht/month for CGs taking care of less than five dependent older people and 1,500 Baht/month for CGs taking care of 5-10 dependent older people (MOPH's letter to PPHO's Chief No. 0941.04/w762 dated 5 October 2017).

In utilizing the LTC Fund, procedures became complicated if a hospital contracted as a service unit. In the case of the Center for Development of Quality of Life of Older Persons, which is a non-government body, payment to CG is made according to the above NHSO's notifications. However, in the case of hospitals, the budget for services under the care plan would be transferred to the "hospital revenue" account, from which direct payment to CGs is not possible. Hospitals need to comply with the Government Procurement and Supplies Management Act B.E. 2560 in paying CGs. It requires several steps, i.e., setting up a procurement committee/person-in-charge to define the scope of work, preparing procurement documents (report), selection procedures, service order, report, etc., before the payment.

After learning that LAOs had no authority or responsibilities on elderly care, related governmental agencies made strenuous efforts to issue notifications. They amended the regulations to ensure older adult's entitlement to LTC services and LAOs' authority and duties to provide LTC services. In the case of LAOs, they had no responsibilities in providing care to older adults, and related activities were not possible. This implied that the training on care plan development and the training of CMs and CGs provided by the Government of Thailand, with JICA cooperation, would not fully function without revising related laws and regulations. In terms of the responsibilities of LAOs, the Government of Thailand put years of

effort into issuing notifications and regulations as follows,

Table 2: Notifications on and Amendments of Regulations on LTC

Notification and regulations	Details
Notification of National Committee on the Elderly "specifying the rights of elderlies in Section 11 (13) in the Elderly Act" On 11 Sept 2018	Specifying the rights of dependent older people to receive LTC in the Section 11(13)[44]
The 3rd Notification by Prime Minister's Office on "Agencies responsible for the protection, promotion, and support of elderlies in accordance with the Elderly Act" On 20 Sept 2018	Adding responsibilities of LAOs on LTC for dependent older people to the list of agencies responsible for protection, promotion, and support of older people[45]
Notification of Decentralization Committee In decentralizing tasks to LAOs On 21 Nov 2018	It shall be the authorities and duties of LAOs to provide LTC services to dependent older people.

Source: Presentation by Dr. Santi Larpbenjakul at the Academic Conference on Integrated Health and Social Care for Longevity on 3-5 March 2021.

This problem was solved when a notification was issued for giving LAO's authority and duties in providing LTC services for older adults. A series of notifications were issued in 2018 to ensure the care-dependent older adult's entitlement to LTC services and LAO's responsibility for providing such services. After that, the MOI was able to issue regulations on CCG, allowing LAOs to employ CCG on a full-time basis and pay compensation at the rate of 5,000-6,000 Baht. Details on the CCG are found in Appendix 18.

B. Achievement of the indicator on sub-districts meet the criteria for LTC services

The percentage of sub-districts that meet the criteria of LTC services increased after having the LTC Fund and care management system. Regarding the indicator on "the percentage of sub-districts meet the criteria of LTC services," only 27% of sub-districts were able to meet the criteria in 2015, as stated in 2.1.2. After the care management system (CM, CG, Care Plan) was introduced by LTOP, together with financial support by NHSO through the LTC Fund, and samples of Lamsonthi's local initiative was introduced to all 77 provinces[46] in the country, Thailand achieved the goal of having sub-districts meet the criteria for LTC services as follows. It should be noted that, in 2017, the requirements of "having CM, CG and/or ECVs" and "LAOs and/or community employs care management system and develops care plans" were added to this indicator. That underscores the synergy effect of NHSO's LTC program, which employs the care management system (CM/CG/CP), in the Thai Government's strategic and systematic move to a nationwide expansion of care management system through MOPH's indicator.

Table 3: Achievement of sub-districts meet the criteria for LTC services

Year	Percentage	Remarks

[44] The rights and welfare of older people in Section 11 (13) of the Act on the Elderly was "Others as specified by the National Committee on the Elderly (NCE)." It was changed to "Rights of dependent older people to receive LTC."
[45] The Notification on 20 Sept 2018 and responsible agencies prior to this notification are in Appendix 19.
[46] Since 2015, MOPH has adopted the model in all 77 provinces of Thailand and later included the model in the 20-year National Strategic Plan on Public Health (2017-2036) as an LTC service policy for dependent older people.

2014	13.43%	Out of total sub-districts
2015	27.00%	Out of total sub-districts
2016	94.98%	Out of 1,067 sub-districts participating in NHSO's LTC program
2017	82.40%	Out of 4,469 sub-districts participating in NHSO's LTC program
2018	71.59%	Out of total sub-districts
2019	83.90%	Out of total sub-districts
2020	92.78%	Out of total sub-districts

Source: MOPH's KPI Template 2020,2021

(3) Impacts and Changes at Organizational Level

With LTOP's counterparts' continuous efforts at project sites, elderly care practices were expanded in various forms and through different approaches. The following are some examples from interviews and questionnaire surveys.

-Practices at Sa-ard sub-district in Khon Kaen and Bangsithong sub-district in Nonthaburi became Thailand's elderly care models as the "Namphong Model" and "Bangsithong Model," respectively. Both models were introduced nationwide through television broadcasts and newspapers. They became a learning site on elderly services in a daycare center and the community for educational institutions, Thailand Nursing and Midwifery Council, WHO, and governmental agencies within and outside Thailand. In addition, counterparts of LTOP also extended LTOP practices to other areas. For example, the Deputy Chief Administrator of Bangsithong conducted training for other

LAOs both at the Bangsithong site and at other LAOs (see Picture 1). The staff of PPHO and Namphong community hospital became instructors on care management and daycare operations at the provincial level. As a result, daycare operations and care plan practices were utilized in other areas inside and outside the province (Sa-ard THPH and Namphong Community Hospital, Khon Kaen Site, and Bangsithong Tambon Municipality at the Nonthaburi Site).

Picture 1: Training by the deputy chief administrator of Bangsithong and a JOCV at Photharam Daycare Center, Ratchaburi Province (Non-project site)

Source: Website of Photaram Muang Municipality

(4) Changes at Community and Individual Levels

A. Upgrading of services at the pilot sites

Counterparts at project sites properly extended their knowledge and skills gained from Training in Japan, leading to quality services at the pilot sites. LTOP's Training in Japan was found helpful for local authorities in upgrading services for older adults. Bangsithong municipality, one of the most successful communities in providing health and social integrated home care services and rehabilitation services at elderly centers through cooperation with a multi-disciplinary team[47] even before the CTOP project, praised Japan's experiences with elderly care. The municipality staff applied the knowledge gained, such as developing a hoist for shoulder exercises after seeing modern assistive devices utilized and rehabilitation programs conducted in Japan. The municipality used a budget of only 200 Baht or around 700 Yen. In contrast, the same device costs around 58,000 yen in Japan.[48] The counterparts in Bangsithong Tambon Municipalities and other pilot sites, including Public Health Center 4 in Bangkok and Joho Tambon Municipality in Nakorn Ratchasima, testified their enhanced awareness of the safety of older adults after they obtained the knowledge on "fall prevention in elderlies" in Japan.

Picture 2: Hoist for shoulder exercise introduced in a local television program as an innovation by Bangsithong Tambon Municipality

Source: MCOT News

Picture 3: Safe transfers at the training sessions conducted by Bangsithong Tambon Municipality to volunteers and to other organizations, both from inside and outside the country

[47] Municipality mayor, deputy chief administrative, nurses from Bangsithong THPH and Bangkurai community hospital, Physical Therapists (PT) from Nontapoom Home for Children with Disabilities, ECVs and VHVs, and members of the elderly club

[48] https://tinyurl.com/sw8yft3r

Source: Bangsithong Tambon Municipality

Picture 4: Utilization of a wheelchair lift car for safety[49]

Source: Bangsithong Tambon Municipality

B. ADL Improvement after Care Plan Usage

The effort of the Government of Thailand in promoting care plan usage resulted in better or stable ADL scores of dependent older people nationwide. Usage of the care plan originally introduced by LTOP had a significant impact in improving the quality of life of dependent older people nationwide. 22.6% of the care-dependent older adults served under care plan for more than nine months saw an improved ADL. For 53.12%, their ADL remained the same[50]. One factor promoting this achievement was the expansion of care plan usage that resulted from the efforts of the Government of Thailand in setting the indicator "the percentage of dependent older people served under the care plan," and the development of the 3C program by the DOH, as earlier stated[51].

- The interviews and questionnaire surveys revealed that the counterparts of all LTOP project sites felt that the care plan led to greater coverage of services older adults need. Many dependent older adults improved their health conditions, gained better life quality, and were able to get back to work or daily activities after being taken care of by CGs at daycare centers or through home-visit services. Nampong Community Hospital reported that 20-21% of older adults served by care plan improved their ADL score, and 60%

[49] A request for a car with a wheelchair lift for older people and other vulnerable people was made to the GGP in 2016, with assistance from the JOCV dispatched to Bangsithong. This enabled older people and people with disabilities at Bangsithong to travel back and forth to the Rehabilitation Center more safely.

[50] http://ltc.nhso.go.th accessed on 20 April 2021

[51] The indicator and 3C program are promoting factors for Care Plan usage nationwide. The expansion of Care Plan usage is the promoting factor for ADL improvement.

could maintain it. Besides, after establishing a daycare center, at least ten people could live a normal life after rehabilitation treatment and care. (Joho Tambon Municipality at the Nakorn Ratchasima site; Bannadoem community hospital at the Surat Thani site; Khun Tan community hospital at the Chiang Rai site; Bangsithong Tambon Municipality, Bangkurai community hospital, Bangsithong THPH at the Nonthaburi site, Namphong Community Hospital at the Khon Kaen site)

(5) Other Impacts

The care manager curriculum was accepted as a training course for nurses. The CM training curriculum developed by the DOH, MOPH, with support from JICA, was authorized by the Thailand Nursing and Midwifery Council as equivalent to 50 credits, which are the numbers of credits needed by Thai nurses for the upskill training every five years.

2.2.5 Other Japan's Cooperation in relevant with LTC and its Impacts

(1) 'Community Based Comprehensive Elderly Care Project in Chonburi Province, Thailand-Project in Saensuk Municipality as a Pilot Area' (JICA Partnership Program: JPP[52])

In 2016, a JICA Partnership Program was started between Saku City and Saku University, Japan, and Saensuk Municipality, Thailand, to promote community-based home care and care prevention activities. Before 2016, Saku University, Burapha University located in Saensuk City, and the city had academic exchanges. That exchange developed into exchange studies between Saku City and Saensuk Muang Municipality. Between January 2016 and December 2018, in the 1st phase of JPP, Saku City Office partnered with hospitals and caregiving facilities to provide training services to nurses, PTs, and CGs of Saensuk and dispatched experts from Saku to Saensuk to conduct training, including guidance during providing home-care services. As a result of the 1st phase activities, CGs in Saensuk improved their care skills, which further enhanced the situation of the older people. The 2nd phase of 'Elderly Care Project by Multi-disciplinary Team in Saenskuk Municipality, Chonburi Province (January 2020-December 2022) is under implementation[53].

(2) Preventive Long-Term Care (PLC) Promotion Project in Bangkok (JICA Partnership Project)

PLC Promotion Project was conducted during February 2017 and January 2020 to enhance knowledge and understanding of staff and CGs of BMA on preventive LTC. The project focused especially on the preventing locomotive syndrome and dementia and nurtured instructors and community trainers to provide

[52] JICA Partnership Program (JPP) is a technical cooperation program implemented in collaboration with Japanese NGOs, Japanese universities, and Japanese local governments to utilize their knowledge and experiences in assisting social and economic developments of developing countries at a grass-roots level. Details are in Appendix 1.

[53] The 2nd phase aims to strengthen multi-disciplinary supporting teams to improve the health conditions of older people, with the vision of zero bed-ridden. Activities included the following: Improving local elderly care network, nurturing health care professionals and health volunteers to work on prevention of dementia, strengthening care professionals' knowledge and skills on disease-specific rehabilitation, promoting dementia prevention activities, and sharing information of assistive devices utilized in the day-care center and households to private companies, etc.

preventive health care services to pre-senior citizens in 2 pilot sites, Dindaeng Service Center 4 and Tabchareon Service Center 56. The cooperation by Asian Aging Business Center and Aso Education Service Company from Fukuoka prefecture during these three years provided excellent results, leading to establishing a committee to expand project effects to other services centers under the management of BMA (BMA Data Center 2020).

Chapter III Implication of JICA's cooperation on the aging society in Thailand

What are the implications of JICA's cooperation on aging society in Thailand? Global aging requires collaborative efforts to adapt our societies to the demographic shift more than ever. In promoting cooperation in the middle- and low-income countries on aging issues, what does JICA's cooperation in Thailand mean? What are the implications to JICA? What can other middle and low-income countries that are rapidly aging learn?

Though some practices of Japan as a forerunner with the issue are considered worthwhile, the practices in a country with a different economic, social, cultural, and health system[54] obviously could not be directly and immediately applied in another country. That means that when considering the practices and impacts of JICA cooperation in Thailand as a model for JICA cooperation in other countries, not all practices can be accepted without understanding the Thai health system and other specific features of Thailand. Thailand has put substantial and prolonged efforts into coping with rapid population aging, with many policy research studies and strategic plan/program development that also took the experiences and lessons learned from Japan into account.

Thailand decided to focus on community-based care at a very early stage of aging[55], considering its financial, institutional limitations and an insufficient number of health professionals[56]. On the other hand, it had a substantial foundation to implement and extend the CLTC program, as explained in 1.3 of Chapter I. Extensive MOPH-owned health facilities and human resources down to the sub-district level, existing informal human resources at the community level, the computerized CR system, NHSO's management system established for the implementation of UCS in 2002, precedence of LHSF, and others served as the foundation of all activities in developing the CLTC system, including implementing JICA's cooperation. Further actions and the dedication of the staff at ministerial levels, local government staff, and informal human resources at a community level, etc., also acted as key factors leading to impressive success.

The model practices based on the contributions of the Government of Thailand and lessons learned, both for other developing countries and JICA, can be summarized as follows.

---

[54] Given its preferable economic situation, Japan focused on increasing the number of elder care facilities and fostering older people's health care and nursing care professionals, before launching several measures and systems, including the LTC insurance system, care management system, and—as a result—the Integrated Community-based Care System. The system enables older people to live in familiar environments while receiving comprehensive health care, nursing care, preventive care, housing, everyday living support, and other services.

[55] Thailand became an aging society (the aging rate surpassed 7%) in 2002. The 2nd National Plan on the Elderly (2002-2021) stated that older people should be supported to reside with family, with community-based health and social services fully accessible to and usable by older adults

[56] When Thailand and Japan became aging societies in 2002 and 1971, respectively, Thailand's GDP was 134.3 billion, with 0.29 doctors and 2.2 beds per 1,000 population. These figures are much lower than those for Japan in 1971, with a GDP of 240.2 billion, 1.1 doctors, and 12.5 beds per 1,000 population.

3.1 Implications to Other Aging Middle- and Low-Income Countries

3.1.1 Importance of solid strategic planning and utilizing JICA's cooperation in developing and implementing the strategic plan

As stated earlier, the current CLTC in Thailand resulted from academic research on LTC extensively conducted since the mid-2000s, solid strategic planning by the Government of Thailand, and practices extracted from LTC pilot projects implemented in the country. In developing the CLTC system, the Government of Thailand had a clear vision for utilizing external cooperation to develop and implement its Strategic Plan. First, it extensively conducted researches, including studying Japanese experiences and their viability. And it incorporated the results into the LTC Strategic Plan (2014-2017). Secondly, the LTOP project was, for the Government of Thailand, one of the pilot practices necessary to develop the service delivery system and effective human resources development program that were critical as a foundation for the implementation of the CTLC, under the Action Plan and Strategic Plan developed. While implementing pilot projects, the Government of Thailand paved the way to generalize the service delivery system nationwide by designing a financial mechanism to support the LTC, as with the LTC Fund initiated by NHSO. As a result, it was relatively easy for the government to launch the LTC program nationwide soon after it specified a service delivery and workforce development system because a financial system was already in place.

<u>The implications of these findings include the following:</u>

- ***A donor project enhances its effectiveness when implemented as part of or complementary to the recipient country's national or strategic plan.***
- ***At the time of project planning, it is essential to ensure that the government has a financial system available so that it can immediately roll out the developed models.***
- ***It is crucial to ensure that the project's expected outputs can be integrated into the country's national program or make sure that the indicators of the project are an integral part of the goals of national plans or programs.***
- ***It is also very imperative to examine whether the recipient country has the capacity and willingness to make the best use of external cooperation to realize its plan.***

3.1.2 Immediate actions of the government of Thailand in developing indicators at the ministerial level by utilizing effects borne by pilot projects

MOPH extended the results achieved in the cooperation projects implemented with JICA by setting related indicators at the ministerial level. Those indicators are:

- “Sub-districts meet the criteria for LTC services,” developed after CTOP;
- “The percentage of dependent older people served by the care plan,” after LTOP introduced and conducted training on care plan development; and
- “The number of CM trained,” after LTOP piloted care manager training and cooperated with DOH, MOPH in developing the guidelines for CM training.

Regarding the first indicator on “Sub-districts meet the criteria for LTC services,” MOPH put the following description in the DOH’s KPI template to be submitted to NESDC. “The indicator was developed based on Tambon LTC (the cooperation between the Government of Thailand and JICA), Indicator No.38 of the 2nd National Plan, and results of the LTC research studies” (refer to Figure 20).

Figure 20: Evidence of JICA cooperation relevant with MOPH’s indicator

Baseline data	หน่วยวัด	ผลการดำเนินงานในรอบปีงบประมาณ พ.ศ.		
		2555	2556	2557
จำนวนตำบลดูแลสุขภาพผู้สูงอายุระยะยาวผ่านเกณฑ์	ร้อยละ	-	15.0	27.0
หมายเหตุ:การพัฒนาต่อยอดจากตำบล Long Term Care ซึ่งเป็นความร่วมมือระหว่างรัฐบาลไทยกับรัฐบาลญี่ปุ่นภายใต้องค์กร JICA และดัชนีวัดที่ 38 ตามแผนผู้สูงอายุแห่งชาติฉบับที่ 2 และการศึกษาวิจัยพัฒนารูปแบบ LTC ในประเทศไทยร่วมกับองค์กรทางวิชาการและภาคีเครือข่ายต่างๆ				

Source: http://203.157.71.139/group_sr/allfile/1418721620.pdf, pp28

This timely action by the Government of Thailand in setting necessary indicators is vital since they act as catalysts that can expand the effects achieved by the pilot projects co-conducted with JICA.

The implications from these findings include the following:

- ***The recipient country must have a clear vision of its goals and how to make the best use of external cooperation.***
- ***Prompt action in reflecting JICA’s project effects in the ministry’s indicators to realize such goals is critical.***

3.1.3 Necessary adjustment of models, systems, etc. introduced by JICA to suit the recipient country

One of the significant adjustments in introducing Japan’s care management process in Thailand the service coverage of care management. In Japan, a care management process is primarily a part of its long-term care insurance, whose service coverage is mainly professional services by paid workers. Therefore, a care manager focuses on professional intervention in making a care plan, although the government encourages care managers to include informal support from local volunteers and neighbors. In Thailand,

where such a scheme doesn't exist, and local volunteers play a vital role in supporting care-dependent older adults, a care manager includes informal supports by trained local volunteers more widely than their counterpart does in Japan.

MOPH developed a simplified online program to support care managers in making care plans. When the indicator "the percentage of dependent older people served by the care plan" was set as a MOPH indicator, it became the mandate of CMs nationwide to develop care plans for care-dependent older adults. When the MOPH found that many CMs were facing difficulties in developing care plans because they could not design appropriate services for older adults, the ministry immediately created an online program to simplify care plan development. That led to the success of care plan development nationwide, as demonstrated by the fact that after the program was launched in 2018, " the percentage of dependent older people served by the care plan" increased by approximately 4% annually in both 2018 and 2019.

The implication from these findings is:

- ***Japanese models or systems cannot be directly introduced or applied as is in other countries. The recipient country must acknowledge how models or methods introduced were effectively used and make necessary adjustments to introduce appropriate models or systems suitable to its own country.***

3.1.4 Involving cross-sectoral agencies and utilizing both existing health care and social welfare resources, and informal human resources

As a consequence of CTOP's practices in promoting inter-agencies and cross-sectoral work culture as part of project activities, the Government of Thailand could handle the issue of limited health and nursing care facilities and workforces by extensively utilizing all existing resources of cross-sectoral agencies in implementing community-based pilot projects for elderlies. In terms of facilities, elderly centers and centers for the social welfare services provided by MSDHS and LAOs were included as functional bodies for delivering care services to older adults or as gathering places for the activities of older people, VHVs, and ECVs. Regarding the workforce, health professionals and informal human resources, such as VHVs and ECVs nurtured by both MOPH and MSDHS, respectively, and members of elderly clubs were involved and given the additional capacity to provide necessary services to older adults. This improved the coverage of community-based service delivery to them when the workforce is limited.

The implications from these findings include the following:

- ***When elderly care is an emerging policy challenge for a country, it requires inter-cooperation among different agencies such as health-related ministry, social welfare-related ministry, LAOs, etc. Such cooperation is also necessary when a country's resources are limited.***
- ***If such collaboration does not occur in the recipient country's working culture, external cooperation, i.e., facilitation by JICA experts, may be utilized to smooth out the operational practices.***

3.1.5 Utilization of several of Japan's ODA schemes for more effects

In addition to technical cooperation, Japan's other ODA schemes could be combined for fulfilling the gaps in addressing population aging challenges. In LTOP, JOCV and GGP programs were efficiently employed, leading to better results of LTC implementation at pilot sites as earlier stated (See page 28). Other Japan's ODA schemes could also be conducted in parallel to respond to Thailand's policy on population aging. They could potentially fill the gaps on the limitation of numbers and capacity of the LTC workforce or strengthen LTC or preventive care by utilizing Japan's advanced technology.

The PPPs and JPPs previously and currently implemented in Thailand are those tackling the workforce issue with advanced technology or enhancing efficiencies and capacities of the workforce on LTC and preventive care (see Appendix 1 for details of PPPs and JPPs). The PPPs scheme potentially corresponds to Thailand's current concerns on the necessity on preventive care to control public spending on LTC and solve the issue of limitation of nursing care workforce comparing to the expected number of care-dependent older people. It is still needed to verify the cost-effectiveness of the introduced technology compared with national spending on LTC.

The implications from these findings include the following:

- ***Utilization of different schemes of Japan's ODA cooperation led to the efficiency of the project, i.e., employing JOCV and GGP schemes in the LTC project.***
- ***Different approaches of Japan's ODA cooperation could be helpful when developing LTC models to fill the gaps and solve the issues with advanced technology or knowledge of the Japanese private sector.***

3.2 Lessons for JICA

3.2.1 Review of the country's health delivery system and social care system

In designing a project on health and social services for older adults, it is crucial to identify appropriate counterpart ministries and agencies in terms of health and social services provision, human resources, financing, and governance structure. The relevant ministries in projects addressing the challenges of population aging may vary depending on the country's health delivery system and social care system in the country.

In the case of Thailand, it is obvious that the MOPH has a good foundation for health care since it has a health infrastructure. It has formal and informal health care human resources at all levels.[57] Besides, nearly 70% of hospitals and 70-80% of health professionals are affiliated with MOPH, which has decision-

[57] Although its professional health workforce was much smaller than Japan, Thailand could utilize VHVs, whom MOPH had nurtured for decades, as informal health resources for its elderly care initiatives. There were were 0.29 physicians per 1,000 population and 1.5 nurses per 1,000 population in Thailand in the mid-2000s when CTOP was developed.

making power and a direct line of command to its resources at the community level. Therefore, having the MOPH as the principal counterpart agency of JICA cooperation was a natural choice and led to success in developing community-based service delivery for older adults to be applied nationwide.

On the other hand, the MSDHS has functional entities and human resources only at the central and provincial levels[58] and is mainly in charge of elderly-policy development and providing social assistance to older adults. The social service provided by the ministry is principally in the forms of public assistance (i.e., in-kind and cash payments to the poor and poor older adults), and social welfare services to the socially disadvantaged, disabled, and older adults (i.e., so-called "social welfare," or institutional services). If a project intended to enhance the equal rights of older adults to claim public assistance and social welfare, an agency with similar characteristics as above needs to be involved. However, the lack of acting bodies at the community level should be a concern since authorities at the community level would need to cooperate with the activities to be conducted[59].

LAOs under the Ministry of Interior is essential in integrating health services with home- and community-based services. When a project considers the need to integrate health and social services for older adults, it is essential to clarify whether the term "social services" refers to social assistance or social care since the agencies concerned differ. When the latter include home-care services and daily care services, incorporating assistance with activities of daily living and personal task management, the possible concerned agencies would be those working closely with people on an everyday basis at the community level. In Thailand's case, LAOs under the Ministry of Interior might become the first candidate. In the case of other countries, another social-related ministry with a good foundation at the community level might also be a candidate. The mandates of each agency/ministry under the existing laws should be studied, as described in 3.2.2.

3.2.2 Review of the mandates of participating agencies/ministries in the project

In Thailand, a change in LAO's mandate was necessary for them to play active roles in delivering social care services to older adults. Therefore, in designing a project on LTC, LAO's authority should have been reviewed more closely, and MOI should have been involved from the initial stage. Various central government agencies cover different aging topics and no governing body has a "direct" mandate on LTC in Thailand. In principle, MOPH is responsible for health care and health care providers. MSDHS is responsible for social assistance and the welfare of older adults, and managing older people's homes. NHSO is responsible for universal health coverage for the Thai population. The Ministry of Interior oversees LAOs,

[58] Lower levels are district level, sub-district level, and village level.

[59] Including provincial officers in community activities might be possible during the project period. However, when it comes to generalization as a national program, inadequate human resources and a need to rely on another agency, such as LAOs, become a problem. The reason is that LAOs are affiliated with the Ministry of Interior, and one ministry has no command line to agencies under the affiliation of the other ministries. As a result, the inability to gain "cooperation" becomes a risk.

which are accountable for enhancing people's livelihood and standard of living in general and managing elder homes and elderly service centers (see "Major Government Agencies and their Mandates on Elderly Care in Appendix 20).

Until November 2018, LAOs in Thailand did not have the authority under the existing Municipalities Act (1953), Tambon Council and Tambon Administrative Authority Act (1994), and Determining Plans and Process of Decentralization to Local Government Organization Act (1999) to provide social care services for older people[60]. That means that, according to the existing acts and regulations, involvement of LAOs in JICA's project activities on social care services for older people since the implementation of CTOP was not possible.

A valuable lesson from project implementation in Thailand was the importance of thoroughly reviewing relevant laws and regulations when initiating a new approach. Another lesson was that when involving LAOs in project activities, its umbrella organization[61] shall be included as a key implementing agency. In the case of Thailand, if the Department of Local Administration (DLA), MOI was involved, the issue of not having laws/regulations specifying the mandates of LAOs might have been resolved earlier, possibly during the term of the project. After the LTOP project concluded, this issue was solved through the collaborated efforts by MOPH, MSDHS, and DLA, as shown in Table 2.

[60] Decentralization Committee's announcement on 23 November 2018 specified that LTC for dependent older people should be a responsibility of LAOs.

[61] The Department of Local Administration, Ministry of Interior in the case of Thailand

Reference

Amorim A, and TRAN H.V. Edition (2018), *South-South and Triangular Cooperation and the Care Economy* Geneva, International Labour Organization, pp.43 https://tinyurl.com/hvnca2wj (Accessed 2021-04-24)

Asian Development Bank (2020), *Country Diagnostic Study on Long-Term Care in Thailand*, ADB, the Philippiines, https://www.adb.org/sites/default/files/publication/661736/thailand-country-diagnostic-study-long-term-care.pdf (Accessed 2021.2.18)

BMA Data Center (2020), *News on Final Report of PLC Promotion Project,* https://tinyurl.com/28w87fpm (2021.6.30)

Bureau of Health Promotion (2005), *Report on Home Health Care Service Development for the Elderly, (Rai-ngan-kronggarn-pattana-rabob-borigarn-duulae-sukaparp-phusoong-ayu-thi-baan),* http://hp.anamai.moph.go.th/soongwai/hhc/statics/hhc.php (Accessed 2021-2-18)

Chokwiwat V (2019) *Learning from Japan: LTC System for Home-bound and Bed-ridden Older People, (Rianruu-jaak-yiipun-rabob-karn-duulae-poosoongayu-tid-baan-tid-tiang)*, National Health Commission Office, Thailand

Department of Older Persons (2016), *Report on Elderly Care Volunteer*, MSDHS
http://www.dop.go.th/download/knowledge/knowledge_th_20162107113623_3.pdf (Accessed 2021-3-30)

Department of Health (2015), *Guideline for Care Manager Training (Kuumue naewthang garn fuk Obrom Care Manager),* Ministry of Public Health, Thailand

Department of Health Service Support, MOPH (2007), *Health Volunteer Training Manual 2007, (Khummu-Arsasamak-Satharanasuk)*, Ministry of Public Health, Thailand

Department of Health Service Support (2016), *Family Volunteer Manual, (Khuumu-Arsaasamak-prajam-krobkrua*), Ministry of Public Health, Thailand

Health KPI (2021), http://healthkpi.moph.go.th/kpi2/kpi/index/?id=1507 (Accessed 2021-4-19)

Jongudomsuk P. et al, (2015) *The Kingdom of Thailand Health System Review*, World Health Organization

Jongudomsuk P., Srisasalux J., (2012) *A Decade of Health-care Decentralization in Thailand: What Lessons can be drawn*, WHO South-East Asia J Public Health 2012:347-56

Khonthai Foundation (2017), *Lamsonthi, No One Left Behind (Khon-Lamsonthi-maithodting-gan)* https://tinyurl.com/cmh8r4xm (Accessed 2021-4-22)

Muiser J., and Carrin G. (2007) *Financing long-term care programmes in health systems with a situation assessment in selected high-, middle- and low-income countries,* Geneva, World Health Organization, pp.5

Lamsonthi Model (2019), https://tinyurl.com/384ebvak (Accessed 2021-04)

Lindelow M., Hawkins L., and Osornprasop S. (2009) Government Spending and Central-*Local Relations in Thailand's Health Sector*, Washington D.C., The World Bank, pp.42.

Masato Kawamori (2009), 『タイに医療福祉制度改革』*Medical Welfare System Reform in Thailand* お茶の水書房

Ministry of Foreign Affairs (2006) 「平成 18 年度外務省 NGO 合同評価：タイ保健分野の概況」*Joint Evaluation by Ministry of Foreign Affairs and NGO: Public Health in Thailand* https://tinyurl.com/ryuau4y9 (Accessed 2021-04-11), pp.10

Ministerial Regulation on Village Health Volunteer 2011

MOPH (2020), *Organizational Performance Report of Public Health Regional Office 4 in the FSY 2020 (Raingan-phol-garn-damneon-ngan-khet-sukkaparp-thii-sii-prajam-pii-ngobpramaan-2563)*, Bangkok, MOPH, pp.66 http://203.157.108.3/ptepho/Fileupload/download/5640e58c5328d29ad8e06e50f4c7d8d3.pdf (Accessed 2021-07-09)

MOPH (2015), 'Synthesis of Integrated Care Service Model for Thai Elderly' (Garn-Sangkro-Rubbaeb-Borigarn-duulae-sukkaparp-phusoongayu-baab-buranagarn), Journal of Health Science Vol. 24 No. 6, November - December 2015 A

MSDHS, NSO, and College of Population Studies (2011) *Survey on Thai Population's Knowledge and Attitude Towards the Elderly 2011 (Samruaj-kwam-kid-khong-prachachon-kiaw-kab-kwam-ruu-lae-tassanakati-tor-phusoonayu 2554')*, Bangkok, NSO, pp.23

NESDC (2019) *Report of the Population Projections of Thailand 2010-2040 (Revised) (Rai-ngan-garn-kard-praman-prachakorn-khong-pratet-thai (Chabab prabpung) 2553-2583)*', Bangkok, NESDC

NESDC's Statistic (2018) *Health Professionals per Population 1994-2018* https://tinyurl.com/f394k6s6 (Accessed 2021-05-12)

NESDC's Statistic, *Household Structure 1980-2017*, https://tinyurl.com/58ytmdv6 (Accessed 2021-04-09)

NHA (2010), *The 2nd National Health Assembly's Resolutions (Ruam-mati-samatcha-sukaparp-krangtii-2)*, National Health Commission Office, Bangkok https://www.sem100library.in.th/medias/b4398.pdf (Accessed 2020-04)

NSO (2017) *Report on 2017 The Survey on the Older Persons in Thailand (Rai-ngan-garn-samruaj-prachakorn-soongayu-nai-pratet-thai 2560)*, Bangkok, NSO

NHSO (2014), *Strategic Plan for Implementing LTC System for Dependent Elderly (2014-2018) (Phan-yuttasat-garn-damnern-ngan-rabob-garn-dulae-rayayao-samrab-phusoonayu-tii-yuu-nai-pawa-puengping 2557-2561)*, Bangkok, NHSO, https://tinyurl.com/42xu5ps5 (Accessed 2020-03)

Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups: OPP (2014) *Work Operation Manual of Elderly Care Volunteer (Khuumu-karn-patipat-ngan-khong-Arsaasamak-duulae-phusoongayu)*, MSDHS

Pannarunothai S. et al (2019) *Thai Civil Registration and Vital Statistics and Unique Identification Number Systems for Universal Health Coverage: A Case Study*, Washington D.C., The World Bank Group, https://tinyurl.com/4ujwc9hm (Access 2021-06-20)

Pelham B., Crabtree S. (2008) *Worldwide, Highly Religious More Likely to Help Others*, Gallup Survey, Washington D.C. https://tinyurl.com/yj76nvvp (Accessed 2021-3-30)

Public Health Care Division (2014) *Development of Primary Health Care in Thailand 1978-2014 (Wiwat-thanakarn-karn-satharanasuk-moonthan-nai-pratet-thai)* (2521-2557), Ministry of Public Health, Thailand, pp.9

Primary Health Care Division (2014b), *The Four-Decade Development of Primary Health Care in Thailand 1978-2014*, Ministry of Public Helath, Thailand

PHC Division's Database, *Village Health Volunteer*, https://tinyurl.com/22fdwzdf (Accessed 2021-04-15)

PHC Division's Database, *Family Volunteer*, http://fv.phc.hss.moph.go.th/ (Accessed 2021-05-15)

PHCPI *Thailand: Improved geographic and financial access to care strengthens primary care*, https://improvingphc.org/promising-practices/thailand (Accessed 2021-04-08)

Royal Gazette (2019.8) *Notification of the Prime Minister's Office 2018 on Designation of Agencies Responsible for Protection, Promotion, and Support the Elderlies in Accordance with the Act on the Elderly B.E.2546 (No.3),* the Royal Gazette No.136-195ng dated 2 August 2019, https://tinyurl.com/7y2mrhf2 (Accessed 2021-5-18)

Royal Gazette (2018.10) *Notification of NHSB on Criteria to Support Local Authorities to Implement and Manage Local Health Security Fund 2018,* the Royal Gazette No.138-261ng dated 18 October 2018, pp.31-32, https://tinyurl.com/rwnfet4w (Accessed 2021-05-18)

Royal Gazette (2016.4) *Notification of NHSB on Criteria to Support Local Authorities to Implement and Manage Local Health Security Fund No 2, 2018,* the Royal Gazette No.133-81ng dated 7 April 2016, pp.4, https://tinyurl.com/ysb4drk2 (Accessed 2021-4-05)

Royal Gazette (2010.12) *Notification of the Prime Minister's Office 2010 on Designation of Agencies Responsible for Protection, Promotion, and Support the Elderlies in Accordance with the Act on the Elderly B.E.2546,* the Royal Gazette No.127-151ng dated 29 December 2010, https://tinyurl.com/xf3v8ww3 (Accessed 2021-05-18)

Rungmuangthong W. (2010) *Evaluation of Elderly Care Volunteer (Karn-pramern-krongkarn-Arsasamak-duulae-phusoongayu-thii-bann)*, NIDA, pp.36

Suwanrada W. (2014) *National experiences from Thailand regarding long-term care of older persons*, Regional Expert Consultation on Long-term Care of Older Persons, 9-10 Dec 2014, https://tinyurl.com/54dcve4y (Accessed 2021-04-08)

Suwanrada W. et al (2014) *Community-based Integrated Approach for Older Persons Long-term Care in Thailand*, College of Population Studies, Chulalongkorn University, pp.64

Sangkawan D, Miankerd W, and Thepphap R. (2017) *Driven Mechanism for Senior Citizens Clubs in Promoting the Status and Roles for Older Persons (Konkal-garn-kabkluan-chomrom-phusoongayu-nai-garn-songserm-satanaparp-lae-botbat-khong-phusoongayu)*, Thammasat Research and Consultancy Institute, pp

TGRI: Foundation of Thai Gerontology Research and Development Institute (2009) Situation of the Thai

Elderly 2009, (Sathanagarn-puusoongayu Thai 2552), TGRI, Bangkok, pp.80-81

Tangcharoensathien, V. et al. (2019) *The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries,* , Health Systems & Reform, 5:3, 195-208, 10.1080/23288604.2019.1630595 (Accessed 2021-06-22)

Tangcharoensathien, V. et al. (2018) *Health systems development in Thailand: a solid platform for successful implementation of universal health coverage*, Lancet, pp.5-6

Whangmahaporn P. (2016) 'Role of Care-for-the-Elderly-at-Home Volunteers: Transforming from Government to Public Governance', *Journals on Politics, Administration and Law Vol.8 No.2*, Sripatum University, Thailand, pp.36

World Bank Group (2016), *Closing the Health Gaps for the Elderly: Promoting Health Equity and Social Inclusion in Thailand*, Washington DC, World Bank, pp.10

World Data Atlas, *Thailand's Dependency Ratio 1950-2000,* https://tinyurl.com/zz8rtkye (Accessed 2021-04-07)

United Nations (2019) *World Population Aging 2019: Highlights*, New York, United Nations, pp.8.

World Population Prospects, https://www.macrotrends.net/countries/THA/thailand/life-expectancy (Accessed 2021-04-08)

APPENDICES

Appendix 1 Japan's Cooperation (Older People) in Thailand during 2007-2020

JICA Technical Cooperation Project (TCP)

TCP is technical assistance to tackle with issues in developing countries through a. dispatch of JICA experts, b. training in Japan for 'capacity development', and c. supply of equipment.

Table 4: TCPs on Older People in Thailand

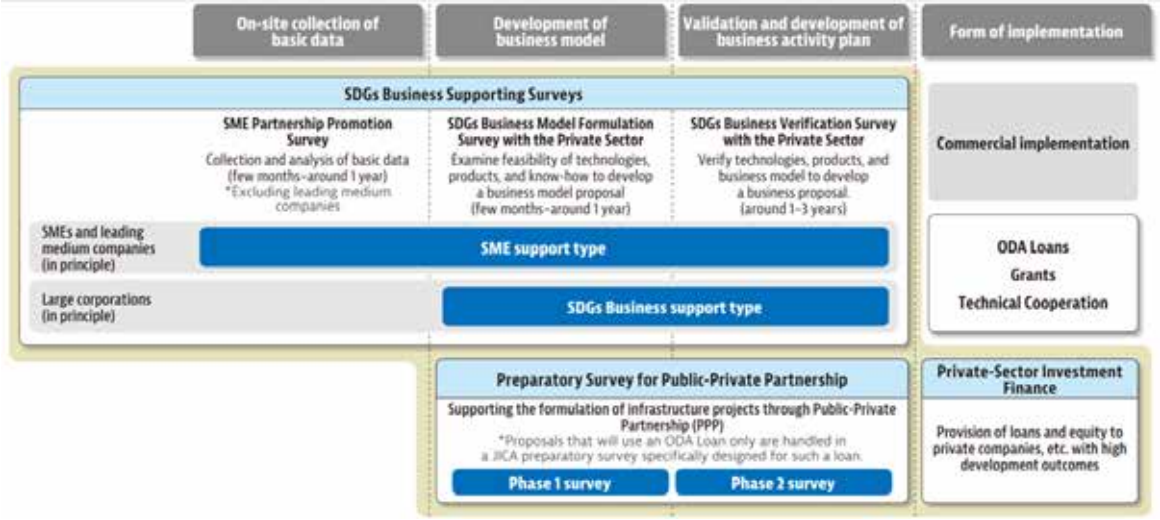
TCP Name	Period	Project Sites	Objectives
*The Project on Development of Community-based Integrated Health Care and Social Welfare Services Model for Thai Older Persons (CTOP)	Nov 2007- Nov 2011	-Chiang Rai (North) -Khon Kaen (North-east) -Nontaburi (Central) -Surat Thani (South)	Developing community-based integrated models integrating health and social welfare services, with utilization of existing resources in the community, i.e. volunteers.
*Project on Long-term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP)	Jan 2013- Aug 2017	-Chiang Rai (North) -Khon Kaen (North-east) -Nakorn Ratchasima (North-east) -Nontaburi (Central) -Surat Thani (South) -Bangkok (Metropolitan)	Developing community-based model on LTC for frail older persons by introducing care management system and developing human resources (care manager and care giver) for LTC.
Project on Seamless Health and Social Services provision for Elderly Persons (S-TOP)	Nov 2017- Oct 2022	Main sites -Chiang Mai (North) -Khon Kaen (North-east) -Nakorn Ratchasima (North-east) -Nontaburi (Central) -Chonburi (East) -Surat Thani (South) -Bangkok (Metropolitan)	Developing models on seamless provision of curative, rehabilitative, social and livelihood support services to prevent frailty in older people.

The first two TCPs was targeted for discussing the impacts to development of CLTC system in Thailand in this report.

Public Private Partnership (SDGs Business Supporting Survey)[62]

The Government of Japan also supported Japanese private sector in promoting economic development of developing countries. One of the schemes is 'SDGs Business Supporting Survey' with details as in the Figure 22

Figure 22: SDGs Business Supporting Survey



Source: JICA

Table 5: List of Private Partnership Projects (SDGs Business Supporting Survey: Feasibility Survey and Verification Survey) on Elderly Care in Thailand

Project Name	Period	Company Name	Project sites/ Counterparts	Summary
Feasibility Survey for Extending Healthy Life Expectancy of Elderly by applying Japan's Preventive Care System	May 2015-March 2016	HATACHI Industry Co., Ltd, Shizuoka Prefecture	-MOPH -Udon Thani	"SSM program" is a health support system, which measures scores through SSM test and provides advice for exercise to let older adults build up strength and live a healthy life. This would extend health life expectancy and improve the quality of life of older people and prevent them from being frail and needing to receive LTC. Demonstration was conducted in Udon Thani
Verification Survey with the Private Sector for Disseminating Japanese	January 2018-August 2020		-Udon Thani -Nong Khai	

[62] See details at https://www.jica.go.jp/english/publications/reports/annual/2019/c8h0vm0000f7nzvn-att/2019_20.pdf

Project Name	Period	Company Name	Project sites/ Counterparts	Summary
Technologies for Health Promotion for the Elderly by Applying Japan's Preventive Care System			-Nong Bua Lamphu -Loei -Sakhon Nakhon -Nakhon Phanom -Bueng Kan	province and motivation for exercise of older adults was confirmed, since they could feel their strength improvement. The verification survey was then conducted in 7 provinces in MOPH Regional 8[63], with expectation to verify that the system could reduce numbers of LTC receivers and prevent increasing of public spending of medical and care giving.
Feasibility Survey for "the Elderly Care System" Utilizing ICT towards the Improvement of Welfare, Health Care in Thailand	June 2016-May 2017	AIVS Corporation, Oita Prefecture	-Samut Sakhon	"MIMAMORI (Watching) SYSTEM" , the robotic care devices, were introduced as a pilot in Samut Sakhon Hospital, Krathum Baen Hospital, Banphaeo General Hospital, and some households in Samut Sakhon province to reduce burden of nurses, CMs, and CGs providing LTC and to help preventing accidents in older people. MIMAMORI SYSTEM uses ICT sensor technology to monitor physical changes and movement of older people to prevent them from falling from beds or slipping accidents and notifying necessary information to nurses, CMs, CGs, and/or family members. The System utilized at the 3 hospitals was found contributing to work efficiency of nurses, by reducing their workload and concerns. Usage of the System at pilot households revealed that 76% of 50 older adults, 86% of 36 family members, and 97% of CGs felt being more or much more secured.
Verification Survey with the Private Sector for Disseminating Japanese Technologies for Introduction of "MIMAMORI SYSTEM" for Improvement of Welfare and Healthcare	Dec 2017 – Feb 2020			
Feasibility Survey for Installing Rehabilitation Program with Pedal Wheelchair	November 2016-April 2018	TESS Co.,Ltd, Miyagi Prefecture	-Bangkok -Chiang Mai -Buriram -Surin	Pedal wheelchair "COGY" was introduced to public and private hospitals, rehabilitation institutes, and welfare facilities with intention to improve the rehab potential and mobility in older people and people have difficulty in walking.

Source: https://tinyurl.com/bdw68e2w

[63] Udon Thani, Nong Khai, Nong Bua Lamphu, Loei, Sakon Nakhon, Nakhon Phanom, and Bueng Kan

JICA Partnership Program (JPP)[64]

The JICA Partnership Program (JPP) is a technical cooperation program implemented in collaboration with Japanese NGOs, Japanese universities, and Japanese local governments, to utilize their knowledge and experiences in assisting social and economic developments of developing countries at the grass-roots level. The JPPs conducted in Thailand in the field related to aging are as follows.

Table 6: JPP projects on Care of Older Persons in Thailand

Project Name	Period	LAO in Japan	Details (URL)
Community Based Comprehensive Elderly Care Project in Chonburi Province, Thailand: Project in Saensuk Municipality as a Pilot Area	January 2016 - December 2018	Saku City, Nagano Prefecture	Summary can be found in the report https://www.jica.go.jp/partner/kusanone/country/ku57pq0000124on7-att/tha_03_t.pdf https://www.saku.ac.jp/wp_saku/wp-content/uploads/2017/07/JICA201705.pdf
Preventive Long-Term Care Promotion Project in Bangkok	February 2017 - January 2020	Fukuoka Prefecture	Summary can be found in the report https://www.jica.go.jp/partner/kusanone/country/ku57pq0000124on7-att/tha_06_t.pdf
Elderly Care Project by Multi-disciplinary Team in Saensuk Municipality, Chonburi Province	January 2020 - December 2022	Saku City, Nagano Prefecture	Summary can be found the report https://www.jica.go.jp/partner/kusanone/country/ku57pq0000124on7-att/tha_09_t.pdf https://www.city.saku.nagano.jp/kenko/kenkozoshin/kenkotyozyu/10thsuisinkaigi.files/5jica.pdf https://tinyurl.com/4rywmns4

Source: https://www.jica.go.jp/partner/kusanone/country/thailand.html

[64] See details at https://www.jica.go.jp/english/our_work/types_of_assistance/citizen/c8h0vm0000anzm5q-att/partner_01.pdf

Grant Assistance for Grassroots Human Security Project (GGP)[65]

The GGP is a grant scheme managed by the Embassy of Japan that supports small-scale projects directly benefiting local communities and people at the grassroots level as well as contributing to the socio-economic development based on the Basic Human Needs (BHN). The scheme was established to assist Non-Governmental Organizations (NGOs), community-based organizations, medical institutes (i.e. hospitals, health centers), educational institutes, and local governments (i.e. TAOs) in developing countries in responding to various BHN of local communities and people, especially in the fields of primary health care, primary education, poverty relief, public welfare, and environment.

Table 7: GGPs grants for Elderly Care in Thailand

Types of GGPs grants	FSY	TCP project sites	Non-TCP project sites
The project for the establishment of community-centered models for healthcare and welfare to improve the quality of life of the elderly	2012	-	Kasetsart Kamphaengsaen Campus, Nakhon Pathom
The project for building the daycare center for the frail elderly and other vulnerable people in Saard, Nam Phong, Khon Kaen	2015	Sa-ard Tambon Municipality, Khon Kaen	-
The project for providing a wheelchair lift car for the elderly and other vulnerable people in Nonthaburi	2016	Bangsithong Tambon Municipality, Nonthaburi	-
The project for Providing a Wheelchair lift car for the Elderly and Other vulnerable people in Banna Sub district in Suratthani Province	2017	Banna Tambon Municipality, Surathani	-
The project for providing equipment to support physically and mentally lifestyle for the elderly people in Saensuk municipality in Chonburi province	2017	-	Saensuk Municipality, Chonburi
The project for building and elderly daycare center in Wangnamlad Sub-district Nakhonsawan province	2018	-	Wangnamlad Sub-district, Nakhonsawan province

Source : https://www.th.emb-japan.go.jp/itpr_en/ggp_list.html

[65] See details at https://www.mofa.go.jp/mofaj/gaiko/oda/files/000071825.pdf

Japan Overseas Cooperation Volunteer (JOCV) Scheme[66]

JOCV is a system of dispatching Japanese volunteers overseas operated by Japan International Cooperation Agency (JICA). JOCV dispatched to the TCP project sites are as follows.

Table 8: JOCV dispatched to TCP project sites

TCP Project Sites	Period	Workplace	Occupation	TCP
Chiang Rai	Sept 2015-Sept 2017	Khuntan Hospital	Physical Therapist	LTOP
	Sept 2017-Sept 2019	Khuntan Hospital	Physical Therapist	S-TOP
Khon Kaen	Mar 2015-Mar 2017	Khon Kaen Social Welfare Development Center for Elderly People (Support to Daycare Center)	Social Worker	LTOP
	Sept 2015-Feb 2017	Namphong Hospital	Physical Therapist	LTOP
	Sept 2017-Sept 2019	Namphong Hospital	Physical Therapist	S-TOP
	Jan 2019-Jan 2021	Namphong Hospital	Nutritionist	S-TOP
Nonthaburi	Mar 2016-Mar 2018	Bangsithong Rehabilitation Center	Physical Therapist	LTOP/S-TOP
Surathani	Oct 2014-Oct 2016	Bannadoem Hospital	Physical Therapist	LTOP
	Sept 2016-Sept 2018	Bannadoem Hospital	Physical Therapist	LTOP/S-TOP
	Sept 2017-Sept 2019	Surathani Hospital (Support to Bannadoem Hospital and Daycare Center)	Occupational Therapist	S-TOP
Nakorn Ratchasima	Sept 2015-Sept 2017	Choho Primary Health Care Unit	Physical Therapist	LTOP

[66] See details at https://www.jica.go.jp/english/our_work/types_of_assistance/citizen/volunteers.html

Appendix 2 VHV, ECV, FCT, and FV

Village Health Volunteer (VHV)

Community engagement in the form of Village Malaria Volunteer initiated in 1965 for Malaria Alleviation Program (1965-1972) was succeeded to a concrete form of **Village Health Volunteer (VHV) in 1977**.

Thailand has been recognized and praised by the World Health Organization (WHO) for its success in having public participation in the form of volunteers in the system of PHC. Success of the VHV scheme was owing to the management and supervision of the MOPH from the nation down to the district and lower levels. Along with implementation of PHC programme nation-wide as a part of the 4th National Health Development Plan (1977-1981), clear policy in capacitating grass-root health workers have been launched. From 1977 to early 1990s, MOPH focused on increasing 'village health communicators (VHC)[67]' and VHVs both in terms of quantity and quality (PHC Division 2014). Capacity reinforcement to cope with changing situation, including population aging, has been continuously conducted and led to well-rooted volunteering system as priceless 'social capital' for health care, as well as elderly care, in most communities in Thailand.

During 1977-2009, VHVs worked without pay. VHVs firstly received the payment of 600 Baht/month in April 2009. The amount has been increased to 1,000 Baht/month from December 2018.

Table 8: History of Village Health Volunteers and Capacity Building Scheme

Period	Development of Health Volunteers	Remarks
1977-1981: The 4th National Health Dev. Plan	- The National Committee of PHC (currently, PHC Division, Department of Health Service Support, MOPH) was formed in 1979 and assigned to be responsible for recruiting and training healthcare officers to be 'Trainers' that further train 'village health communicators (VHC)' and VHVs. (Pilot project in one sub-district in all districts in 20 provinces)	-8 PHC essential elements were focused. (Nutrition, Health Education, Basic Treatment, Provision of Basic Medication, Safe Water and Sanitation, Maternal and Child Health Care, Local Endemic Diseases Control, Immunization Promotion)
1982-1986: The 5th National Health Dev. Plan	- Multiply numbers of trained VHCs and VHVs to meet rural coverage over the whole nation. - At the end of 1986, there were 510,286 VHCs and 53,498 VHVs.	
1987-1991: The 6th National Health Dev. Plan	- Focus on quality improvement of VHCs and VHVs. - Budget was allocated to health centers at sub-district level to train these volunteers.	-In 1987, 1991, 6 essential elements were added. (Dental Health, Mental Health, Environment Health, Consumer protection, Accident, and NCDs control, HIV/AIDS)
1992-1996: The 7th National Health Dev. Plan	-All VHCs were upgraded to be VHVs in 1994. -MOPH allocated budgets to establish community PHC centers (Soon-sataranasuk-moontaan-chumchon) as a workplace of VHVs.	-Health centers had no work plan for capacity building of volunteers affecting level of knowledge among VHCs and VHVs in some areas. -No specific work plan for

[67] Later combined to VHVs in 1992

Period	Development of Health Volunteers	Remarks
	-Tools and equipment for work operation were supplied to VHVs.	volunteers leading to fewer operations in volunteer work in some areas. - Community PHC centers function as a meeting or coordinating center for VHCs/VHVs and villagers and as a place providing basic health care service for villagers such as weighing, heightening, blood measure measuring and providing household drug. There are 67,682 centers as of 1996.
1997-2001: The 8th National Health Dev. Plan	- MOPH developed Family's Public Health Leaders to take care of chronic patients and health of family members - Start convincing VHVs to play roles as VHVs for social welfare services - Urged VHVs to get together in the form of VHVs clubs or associations - Most health centers nationwide conducted meetings for VHVs on a monthly basis to inform the latest news and information of MOPH. - As a part of decentralized policy, 7,500B/year was allocated to each village to support HRD to serve PHC works, to solve PHC problems and to support Community PHC center service, but no proper training to VHVs was organized.	-2003, Primary Health Care Division was formed to replace the Office of PHC Committee to carry out PHC mission
2002-2006: The 9th National Health Dev. Plan	- Budget was utilized by local authorities to tackle with healthcare problems, mostly on NCDs, rather than for developing capacities of VHVs. -2008: Increase from 7,500B to 10,000B/village	
2007-2011: The 10th National Health Dev. Plan	- PHC Division, Department of Health Service Support, MOPH set up training curriculum to reinforce 800,000 VHVs nation-wide. - 2008: Start training VHVs on elderly care	
2012-2016: The 11th National Health Dev. Plan	- Improve VHVs' potential to be VHV expert and Village Health Manager.	
2017-2021: The 12th National Health Dev. Plan	**- 2020: VHV-home-doctor, another initiative of MOPH in 2020 to enhance self-reliance of communities by upgrading 80,000 VHVs (1**	**- One of the MOPH's initiative to** strengthening the primary health system in which all Thai people must have 3

Period	Development of Health Volunteers	Remarks
	VHVs/village) to become a home-doctor. The VHV-home-doctor has responsibilities to recruit and serve as a mentor for Family Volunteers, prevent and control communicable diseases, promote health care to reduce chronic diseases or mental health problems, promote traditional medicine, provide health management and referral service for villagers, work as a member of Family Care Team (FCT) in conducting telemedicine and collect information for further planning.	doctors as their own doctors[68]. As of 30 December 2020, there are there are 1,063,845 VHVs (PHC Division's Database: VHV), and 84,712 VHVs-home-doctors (Health KPI 2021) nationwide.

Primary Health Care Division, the Department of Health Service Support (2014), 'The Four-Decade Development of Primary Health Care in Thailand 1978-2014', MOPH, Thailand
Department of Health Service Support, MOPH (2007), 'Health Volunteer Training Manual 2007'

Work responsibilities of VHV as specified in the Ministerial Regulation on Village Health Volunteer 2011 are as follows.

VHV (MOPH: 1977) 【Persons volunteering himself/herself to be a VHV need to be agreed by at least 10 household leaders of the same village and trained by the health care units in his/her areas】
1. Promoting PHC across the country, helping control communicable diseases and providing basic advice to community leaders on health promotion 2. Organizing surveillance activities and preventing public health problems in the village 3. Working at Community PHC centers in the village 4. Providing government's health care information to community people 5. Provide home-visit PHC services, such as primary medical care, first aid, condom distribution, blood pressure monitoring, detection of sugar in the urine, blood sugar test, patient referrals and patient care monitoring 6. Persuading community people to participate in health development activities and improving the quality of life of the community 7. Addressing the issues to and collaborating with local authorities in solving community health problems by utilizing local or external funds 8. Coordinating with and urging community leaders, local authorities and health network to plan and implement community health care, to ensure people are well-equipped with public health benefits 9. Providing social welfare services, i.e. cooking meals, cleaning, shopping support, etc*

* Being friends in the same community, some VHVs naturally conducted these chores when conducting home visits. Since 2000s, all volunteers are urged to also provide these cares as one of their tasks.

Elderly Care Volunteers (MSDHS, 2003～)

The Bureau of Empowerment of Older Persons, the Ministry of Social Development and Human Security (MSDHS) initiated the 'Pilot Project on **Elderly Care Volunteer (ECV)**' in 8 provinces[69] (one sub-district per province, 2 provinces per each region) in 2003-2004 (Department of Older Person 2016), after learning from the survey conducted by the Department of Public Works, Ministry of Labour and Social Welfare[70] in 1999 that 253,360 older people, mostly in rural communities are not getting any care assistance (Rungmuangthong W. 2010). 80 volunteers per province were trained for 18 hours to provide social

[68] a.VHV-home doctor, b. public health doctor, (primary health personnel in Hospital / Municipality / Clinic, etc.), and c.family doctor (family physician)
[69] Petchaburi, Suphan Buri, Khon Kaen, Roi-et, Chiang Mai, Pitsanulok, Songkla and Surat Thani
[70] Changed to Department of Social Development and Welfare in 2002

support for older people having nobody taken care of in the target sites during this 1st pilot project. This Pilot Project was expanded to 15 provinces, 48 provinces and 68 provinces in 2005, 2006 and 2007, respectively and nurtured 40-80 ECVs in each province yearly. As a result of 10-year implementation during 2003-2013, there were 81,883 ECVs[71] trained in 7,776 local authorities, covering all areas nation-wide (Whangmahaporn 2016).

Work responsibilities of ECVs as in the Manual on Work Operation of the ECVs (OPP 2014) are as follows.

ECVs (MSDHS: 2003) 【ECVs will be trained for 18 hours before providing social support to older persons】
1. Visiting vulnerable older persons at least twice a week 2. Preparation of food and medicine 3. Assisting older persons to exercise 4. Taking older persons to health centers 5. Coordinating with health centers for a home-based nursing care 6. Taking older persons to participate in community or religious-related activities 7. Improving housing environment 8. Providing knowledge and useful information to older persons 9. Collecting information of older persons

Family Care Team（MOPH, 2014～）

Family Care Team (FCT) is a team collaboration between health sector people at district/sub-district level and informal human resources at village level. FCT was initiated by MOPH in 2014, with the vision that it would reduce the unnecessary hospital walk-in or visits, facilitate smoother transition from the hospital to home, lessen inequality and improve accessibility to health care especially for the poor who cannot afford to go to hospitals, etc. As of 2020, there are 66,353 FCTs along the country.

Table 9: Family Care Team and its Members

Level of FCTs	Members	Roles
District teams	Physicians, dentists, pharmacists, nurse-practitioners, PT, OT	Supervise medical care, improve knowledge and skills of lower team, support resources, monitor referral process, etc
Sub-district teams	Nurse-practitioners, dental assistants, junior sanitation personnel	Conduct health promotion activities and disease prevention
Community	VHVs, members of local authorities, community leaders, CGs	Promote self-care to family and patients, cooperate with health professionals for referral of patients

Family Volunteers (MOPH, 2016～)

Family Volunteer is the policy of MOPH to enhance self-reliance of communities and to ensure older people and/or patients are being appropriately cared daily by a family member or neighbors, who have an extent of care skills and knowledge. Family members registered to be a Family Volunteer will be trained on **Chronic Kidney Disease care, LTC and NCDs care. Currently, there are 1,726,507 Family Volunteers trained (PHC Division's Database: FV)[72]. For the training on LTC, skills and knowledges on body hygiene, eating, drinking, communication, mental care, basic rehabilitation, prevention of bedsores, proper environment, supportive care for older people using nasogastric tube feeding, ventilator, or urinary catheter, etc will be provided. The Family Volunteer will provide health information of persons under care to VHVs, VHV-home doctors or the FCT for further medical assistance (Department of Health Service Support 2016).**

[71] Since those trained as ECVs are already working as VHVs, numbers may duplicate with numbers of VHVs.
[72] Numbers trained by categories (CKD: 451,377, LTC: 579,719, NCDs:1,227,311)

Appendix 3 Strategies in the 2nd National Plan

The 2nd National Plan on the Elderly (2002-2011), (The 1st revised of 2009 was approved by the Cabinet's resolutions on April 27, 2010)

5 strategies in the 2nd National Plan on the Elderly are:

a. Strategy 1: Preparation of the Population for their Quality Aging
b. Strategy 2: Promotion and Development of Well-being of Older people
c. Strategy 3: The Social Security/Protection for older people
d. Strategy 4: Administration to Develop the National Work on Older people and Personnel Involved in the Elderly Work
e. Strategy 5: Knowledge Support and Monitoring of the Implementation of NPE.

CLTC for older people was specified in the 'Strategy 3: The Social Security/Protection for Older people' under the measures 4.2 and 4.3.[73].

Item 4.2 Establish and develop the CLTC fully accessible to and usable by older people by emphasizing the home care model inclusive of health care and social services simultaneously which covers:

- a service that supports long-term care
- a nursing system
- treatments for significant chronic diseases such as hypertension, diabetes and cerebro-vascular disease
- community-based volunteers
- supporting caregivers to access knowledge and skill in the elderly care

Item 4.3 Encourage LAOs, religious entities, private entities, and the entities with public interests to take part in provision of welfare for older people emphasizing a community-based approach.

[73] Cited from http://www.dop.go.th/download/laws/law_th_20161107091458_1.pdf

Appendix 4 Elderly Questionnaire

CTOP's ELDERLY SURVEY FORM

【Source: CTOP Handbook / Eng. Version】

Questionnaire No. ☐☐-☐☐☐☐-☐☐
(11) Chiang Rai (22) Khon Kaen (33) Nonthaburi (44) Surat Thani

Date of interview: _____Interview start time: _____

Name of Interviewer: _____
Position: _____
Phone No: _____

Name of Informant: _____
Relationship with the Elderly: _____

//

I. GENERAL INFORMATION

1. Your Name
   ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other (Please specify: _____)
   First name: _____
   Last name: _____
   Citizenship ID Card No. ☐-☐☐☐☐-☐☐☐☐☐-☐☐-☐

2. Gender: ☐ Male ☐ Female

3. Birthdate (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

4. Religion: ☐ Buddhist ☐ Christian ☐ Muslim ☐ Other (pls.specify_____)

5. Marital Status: ☐ Married ☐ Bereaved ☐ Divorce ☐ Single
   ☐ Other (pls.specify_____)

6. Educational Background: ☐ Uneducated ☐ Lower elementary School
   ☐ Upper Secondary School ☐ Lower Secondary School
   ☐ High Vocational School / Associate Degree
   ☐ Bachelor's degree or higher education
   ☐ Other (pls.specify_____)

7. Literacy
   ☐ Can read and write
   ☐ Can read but can't write
   ☐ Can't read but can write my name
   ☐ Can't read and can't write

8. How many people do you live together excluding the elderly? (living for 6 months onwards)
   Persons living together___ persons + An elderly (yourself) = Total ___persons

   //

II. SOCIAL AND ECONOMIC VARIABLES

9. Your occupation at present
   ☐ Current government official ☐ Employee ☐ Farmer
   ☐ Self-employment ☐ Unemployed ☐ Other jobs (pls.specify_____)

10. Your occupation before 60 years old
    ☐ Government Official ☐ State Enterprise Official ☐ Employee ☐ Farmer ☐ Self-employment ☐ Unemployed ☐ Other jobs (pls.specify_____)

11. Your own average income per month (including allowance, pension, money from other family member, and so on)
    ☐ Lower than Bt500 ☐ Bt 500-Bt 1,000 ☐ Bt1,001-5,000
    ☐ Bt 5,001-Bt 10,000 ☐ Bt10,001-20,000 ☐ Bt 20,001-Bt 50,000
    ☐ More than Bt50,000

12. Ownership of your residence
    ☐ Owner ☐ Not Owner

13. The elderly is living alone
    ☐ Yes ☐ No

14. Is the elderly's housing condition at risk for accident or is it unsafe to the elderly
    ☐ Yes ☐ Stairs are unsteady and unsafe ☐ Floor has many levels ☐ Toilet is too far/slippery floor ☐ Not enough light ☐ Other (pls.specify_____)
    ☐ No

15. Who is your main caretakers?
    ☐ None ☐ Spouse ☐ Son ☐ Daughter ☐ Daughter in law
    ☐ Grandchild ☐ Neighbor ☐ Relatives ☐ Other (pls.specify_____)

16. Have you participated in any social group since 60 years old? (Multiple Choice)

Club/Group	Yes	No
16.1 The Elderly Club	☐	☐
16.2 Occupation group	☐	☐
16.3 Saving group	☐	☐
16.4 Fitness group	☐	☐
16.5 Funeral welfare group	☐	☐
16.6 Dharma praying group	☐	☐
16.7 Field trip group	☐	☐
16.8 Musical group	☐	☐
16.9 Local handicraft group	☐	☐
16.10 Other (pls.specify: 1)_____ 2)_____ 3)_____	☐	☐

17. In your daily life, how do you access news and information? (Multiple Choice)
☐ Book ☐ Newspaper ☐ Magazine ☐ Television ☐ Radio
☐ News broadcasting tower ☐ Conversation ☐ Seminar/meeting
☐ Public Health Office ☐ Volunteer ☐ Other (pls.specify_____)

18. Do you know about the grant-in-aid for elderly funeral 2,000 THB per persons?
☐ Yes ☐ No

19. Does the elderly acknowledge the information of the Elderly Act 2003?
☐ Yes ☐ No

//

III. DAILY ACTIVITIES

【As per ADL Barthel Index 】on the following topics

20. Feeding	21. Grooming	22. Transfer
23. Toilet use	24. Mobility	25. Dressing
26. Stairs	27. Bathing	28. Bowels
29. Bladder		

//

IV. HEALTH

30. Please tell us the followings.

Weight……. Kg	
Height…….. Cm	
Arm Cm	Span…….
Waist……..... Cm	

Remarks: Arm Span will use in case height cannot be measured.

31. Are you a registered disabled person?
☐ Yes ☐ No

32. In one year round up to the present, have you undergone the annual basic physical check (blood pressure, sugar blood, and so on)?
☐ Yes ☐ No

33. Have you been taken care by the public health personnel?
☐ Yes ☐ doctor ☐ nurse ☐ public clinic official
☐ No

34. Do you smoke?
☐ Yes ☐ No

35. Do you drink alcohol? (liquor, beer, etc.)
☐ Yes ☐ No

36. Do you eat raw food?
☐ Yes ☐ No

37. Exercising behavior

☐ I do not practice 'physical activity', and never think of starting it.
☐ I do not practice 'physical activity', but have intension to start it.
☐ I try to do 'physical activity', but not regularly.
☐ Yes. I practice 'physical activity' regularly.
'Regular' means at least 3 days a week and average 30 minutes per day.

38. Were you diagnosed as the following chronic diseases? (Multiple Choice)

1	Hypertension	☐ Yes ☐ No
2	Cerebrovascular Accident	☐ Yes ☐ No
3	Angina Pectoris, Myocardial Infraction	☐ Yes ☐ No
4	Paralysis	☐ Yes ☐ No
5	Diabetes	☐ Yes ☐ No
6	Asthma	☐ Yes ☐ No
7	Respiratory Disease except Asthma	☐ Yes ☐ No
8	Dementia	☐ Yes ☐ No
9	Depression	☐ Yes ☐ No
10	Other Mental Diseases	☐ Yes ☐ No
11	Malignant Neoplasms	☐ Yes ☐ No
12	Backache	☐ Yes ☐ No
13	Joint and Bone Disease (Arthropathia, Osteoporosis)	☐ Yes ☐ No
14	Oral Disease (Gingivitis, Periodontium Disease, Caries)	☐ Yes ☐ No
15	Eye Disease (Cataract, Glaucoma)	☐ Yes ☐ No
16	Others. Pls.specify……	☐ Yes ☐ No

39. Are you currently suffering from any of the following symptoms? (Multiple Choice)

1	Low Back Pain	☐ Yes ☐ No
2	Aching or Pain in Joints of Limb	☐ Yes ☐ No
3	Dimness of Sight	☐ Yes ☐ No
4	Stiff Shoulder	☐ Yes ☐ No
5	Constipation	☐ Yes ☐ No
6	Buzzing Ear	☐ Yes ☐ No
7	Palpitation	☐ Yes ☐ No
8	Insufficient Breath	☐ Yes ☐ No
9	Itching	☐ Yes ☐ No
10	Fatigue	☐ Yes ☐ No
11	Have a Desire to Urinate	☐ Yes ☐ No
12	Sleep Disturbance	☐ Yes ☐ No
13	Dizziness	☐ Yes ☐ No
14	Toothache	☐ Yes ☐ No
15	Heavy stomach feeling, heartburn	☐ Yes ☐ No
16	Others. Pls.specify……	☐ Yes ☐ No

40. Presentation of troubles in job or daily life resulting from getting things. (Informant only)

	Point
☐ Very often	=1
☐ Often	=2
☐ Sometimes	=3
☐ Rare or No	=4

41. Forgetfulness in getting worse during these 2 years. (Informant only)

	Point
☐ Very often	=1
☐ Often	=2
☐ Sometimes	=3
☐ Rare or No	=4

42. Able to answer today's date (Elderly only)
(Count the number of correct answers out of the following 4 items)

- Date of the week	☐ Can =1	☐ Cannot =0
- Date of the month	☐ Can =1	☐ Cannot =0
- Month	☐ Can =1	☐ Cannot =0
- Year	☐ Can =1	☐ Cannot =0

From 40-42, total…….points

43. Over the last 2 weeks, how often have you been bothered by any of the following problems?
(1) Little interesting or pleasure in doing things
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
(2) Feeling down, depressed, or hopeless

Appendix 5 CTOP: Resource Survey Questionnaire to project sites

【Source: Short-term expert's report, JICA】

1. Questionnaire **Tambon = Sub-district**

General information(Demographic)	
1.Population of Tambon	
2.Elderly population of Tambon	
3.Number of households in Tambon	
4.Number of recipients of monthly allowance in Tambon	
5.Annual expenditure of monthly allowance in Tambon	
6.Number of UC members in Tambon	
7.Area size of Tambon	
8.Number of hospitals in District	
9.Types of hospitals in District	
10. Number of hospitals in Tambon	
11.Types of hospitals in Tambon	
12.Number of community hospitals in Tambon	
13. Number of health centers in Tambon	
14. Number of multipurpose senior citizen centers in Tambon	

Social Resources			
-Health Sector			
	(i) Community Hospital	Is there a community hospital in your Tambon? YES/ NO **For the following questions, If there is a community hospital in your Tambon, please answer about the community hospital. If there is not, please answer about the nearest community hospital from your Tambon.	
		1.Number of doctors	
		2.Number of nurses	
		3.Number of other staff	
		4.Number of beds(IPD)	
		5.Number of patients(OPD)	
		6.Number of UC members in catchment area	
		7.Annual budget for P&P (Prevention & Promotion) in catchment area	
	(ii)Health Center in your Tambon	1. Number of nurses	
		2. Number of other staffs	
	(iii)Multipurpose senior citizen center	1. Number of staffs	
		2.Number of participants	

-Social sector			
Public sector	(iii)Provincial Welfare Office	1.Number of officers in Provincial Welfare Office	
		2. Number of staffs in charge of elderly issues	
Non-public sector	(iv)Temples	1. How many temples are there in your Tambon?	
		2. How many of the temples are doing activities for the elderly?	
	(v)Volunteers	1. Number of Health volunteers	
		2. Number of Elderly volunteers	
		3. Number of other volunteers	
	(vi)Elderly club	1.Number of Elderly Club	
		2.Number of members of Elderly Club	
	(vii) Fund related to the elderly	1.Types of fund (ex. One-Baht Fund) and its number of members	

TAO Capacity	
1. Number of staffs of TAO	
2.Number of representatives from villages	
3.Number of staff for Health sector	
4.Number of staff for Social sector	
5.Annual expenditure of TAO **(2006/2007)**	
6.Annual budget(revenue & expenditure) for activities related to Health and Social welfare for elderly people **(2006/2007)**	
7.Description of activities conducted in your Tambon for **Health** of the elderly (including the case where an activity is conducted in your Tambon and other Tambon)	
8.Description of activities conducted in your Tambon for **Social welfare** of the elderly (including the case where an activity is conducted in your Tambon and other Tambon)	

Appendix 6 SUGGESTIONS from CTOP Experiences

【Source: CTOP Handbook / Eng. Version】

KEY PLAYERS

Suggestions 1: Any kind of community based committee is set and run periodically, whose member consists of local residents, local officials, and related community organizations, and equal partnership among stakeholders is maintained at the committee.

Description: For the sake of continuity of the activity, community-based activities for older persons should be designed and implemented based on local people's participation with their "needs", "will", "decision", "action", and "responsibility". In addition, equal partnership has to be emphasized between resident participants and officials, among residents or organizations, respectively.

When equal partnership as above mentioned is built between community people, problems of people in need will be recognized as "problems of the community as a whole", and solving the problems will become the "target of the community as a whole", then participation and contribution into community based activities are promoted.

Therefore, places for dialogue between local residents, local officials and local related resources based on equal partnership are necessary, for discussing issues such as 'What kind of services and supports are necessary for solving the problems of the elderly at community", "What kind of roles need to be played by local authority and local residents.".

This is why it is desirable that a community based committee is established as "a place for dialogue" based on equal partnership, and that the committees is regularly held.

In the dialogue at the committee, it is not appropriate that the local authority try to lead the discussion towards a specific direction without properly listening to opinions of local residents, and it is not appropriate neither that one-sided criticisms, demands nor requests are emphasized from local resident side. In order to avoid such situations, it is thought to be effective to build some rules for community dialogue as followings.

- Set a limit for speaking time, so that as many participants as possible can speak
- Prohibit criticizing comments
- One of the local residents chairs the meeting, and local official attend the meeting as a citizen.

Suggestion 2: Local authority at tambon level has a leading and important role in the community. Local authority at tambon level has to initiate local action while acting as a coordinator and mediator among stakeholders.

Local authorities as tambon level are the administrative agencies which are the closest to local residents, and can best grasp the needs and conditions of residents. Taking into consideration the nation's political orientation for decentralization, they are expected to play more important roles for community-based activities for the elderly in the near future.

Local authorities at tambon level are expected to play leading roles when initiating local activities. They are expected to positively provide formal services for the elderly, or financially support these services. They are also expected to act as a coordinator and mediator among stakeholders for informal supports.

Suggestion 3: Involvement of a good external facilitator is set, and useful skills or tools are provided from them for the efficient and effective operation.

By involvement of good facilitators or academics from outside world and their introduction or useful skills and tools for efficient and effective operation and management of activities, participants of activities will be stimulated and recognize the importance of each process of cyclical management and appropriate methodologies for operation. This will make it more likely that participants will have successful experiences and stronger local ownership towards the activities.

PROJECT DESIGNING PROCESS

Suggestion 4: Community Dialogue is set for identifying needs of the elderly in the community, based on needs information grasped through questionnaire or interview survey.

Community-based activities for older persons should be based on needs of elderly people at community. The elderly needs are basically multifaceted, and it is elderly people themselves and local residents living very close to the elderly who understand best the needs of individual frail elderly.

However, it is not easy to grasp the entire picture of the elderly needs at community. For understanding the entire picture of the needs, it is necessary to share the information on different needs through dialogue between local people. And this dialogue should be based on needs information grasped through questionnaire or interview survey.

Concerning questionnaire, it is desirable that a questionnaire is designed based on a dialogue between local people. It might be very practical to customize the CTOP Elderly Questionnaire, according to specific situations of individual communities, instead of creating a totally new questionnaire.

In addition, it is idealistic that elderly people are classified according to their physical and mental conditions. In CTOP, a tool for elderly classification which is called 'Typology of the Aged with Illustration (TA)' has been introduced by a Japanese short-term expert. CTOP Questionnaire is linked to the TAI so that the results of TAI classification can be worked out by processing answers to CTOP Questionnaire through the programmed Excel sheet.

In any cases, it needs to be noted that we cannot decide what kind of activities will be actually carried out only by needs information. We also need to identify available resources in the community and determine what we actually will do by both of needs and resource information.

Suggestion 5: Resource Map (financial, human, and activities) is made for overall understanding of local situation by dialogue between formal and informal sector

The elderly needs are basically multifaceted, and in order to design appropriate countermeasures for these various needs, it is necessary to make best use of available resources at community. For this purpose, it is necessary to grasp what kinds of resources are available in which part of the community.

It is difficult to identify all the available resources by only the efforts of administrative agencies. Therefore, it is important to share the information on resources among local people through dialogue between local residents, local officials and related community resources. And it is also very important to share such information in a clearly visible way, by developing 'resource map'.

Leaders of activities need to see to it that the resource map is exposed to as many people as possible. and that it is updated in appropriate timings.

It needs to be noted that we cannot decide what kind of activities will be actually carried out only by resource information. We also need to identify needs of the elderly in the community and determine what we actually will do by both of needs and resource information.

Suggestions 6: The community plan for the elderly is made and endorsed by local committee of the activity consisting of local residents, local officials and related community resources.

Community based activities for older persons should be designed and implemented based on local people's participation with their "needs", "will", "decision", "action" and "responsibility".

Therefore, it is very important that needs and conditions of the elderly are shared through dialogue at the community based committee, which is based on equal partnership between local residents, local officials and related community resources, and that as a result, the goals of the community will be identified and endorsed in the form of the community plan.

All of local stakeholders are supposed to have strong responsibility and motivation to achieve for the goals which they themselves have identified, and are expected to work hard by co-operating each other for achieving the goals.

Suggestions 7: Documentation of design and operation of activity prepared is carried out.

In principle, it is desirable the cyclical management contains, 1) research or education training process, 2) planning process, 3) action, and 4) evaluation and improvement. And it is also desirable that the design and operation of the activity which are agreed between related stakeholders as a result of "planning process" are documented in the form of written manuals. Otherwise, it is like that the following "action" process will not be operated in an agreed manner.

PREFERABLE PROJECT DESIGN

Suggestions 8: Activities are covering multi-lateral domains of local institutions and services, or activities have integrated feature such as health and social welfare. Activities are also covering all of three different categories of the elderly, that is to say, independent elderly, dependent elderly and bedridden elderly.

Community-based activities for older persons should be based on needs of elderly people at community. The elderly's needs are basically multifaceted, therefore integrative approach is required for fulfilling these various needs.

Therefore, activities need to involve not only different administrative agencies and related organizations, but also as many local residents as possible, and need to target cross sectoral issues such as health and social welfare.

In addition, activities need to cover three different categories of elderly, that is to say, independent elderly, dependent elderly, and bed-ridden elderly. In activities for independent elderly, it is preferable that those elderly provide supports to others or play some positive roles, rather than that they receive supports from others, because playing positive roles in society is expected to contribute to the maintenance of their physical and mental health.

Suggestions 9: Integration of information: Information sharing system is established among stakeholders. There are several methods to share information, such as database or liaison and coordination system.

The elderly's needs are basically multifaceted, and for fulfilling these various needs, it is sometimes necessary to support an individual elderly by different stakeholders in different manners. In such cases, such elderly people can be better supported by sharing information on such elderly people among related stakeholders or appropriately transferring such information between related stakeholders.

As methods of sharing elderly information, there are several different ways, such as building a database by taking advantage of modern information technology, or conveying information by hand-written memos, or holding meetings for sharing information.

In any cases, appropriate cooperative relationship between related stakeholders need to exist as the basis of information sharing. Without such relationship, any system for information sharing will not work

appropriately.

Suggestions 10: Main activity has to be implemented periodically based on an annual plan

The cyclical management will motivate the participants and build up local ownership activities by repeating the cycle where operations of activities are improved by the 'trials and errors'

That is to say, the cyclical management is based on the assumption that activities are arbitrary repeatedly implemented. Activities should be designed as continuous and sustainable arrangement, not one time activities, because elderly support is a theme which needs to be tackled in the long term. It implies that the each part of activities has clear context that why it was planned.

For attracting as many participants as possible to activities which are repeatedly implemented, it is important to implement them according to a fixed plan, such as an annual plan of activities. When the contents, timings, locations of the activities are fixed in advance and wll announced, people who are interested in the activities can participated in them more easily by adjustment of their own schedule.

Under the cyclical management, gradual improvement of operations by repeated reviews in daily activities are greatly encouraged, but stakeholders can be confused if the basic design of activities is too often reviewed and modified. Major reviews which can result in modification of basic design of activities should be carried out after a certain period of repeated 'trial and errors'. Therefore, such major reviews should be carried once a year or so, and clearly scheduled in the annual plan of the activities.

Suggestions 11: The objective criteria for the selection of target group (screening) have to be set agreed and reviewed if necessary, by stakeholders.

If any objective criteria for selection of target group are not set based on agreement between stakeholders, target will be selected arbitrarily. It is highly likely that this kind of arbitrariness will increase the distrust of the activity among local residents, and damage the local ownership towards the activity, which is essential for community based activities.

Suggestions 12: Special activity in order to extend the network of potential human resources is set.

The primary activities for supporting elderly people at community are daily or regular activities for taking care of daily lives of the elderly and keeping them as healthy as possible, but if only these daily routine activities are implemented, it might result in fixation of participants of the activities.

It might be a good opportunity for expanding network of human resources, to have special events which the core members of the activities organize from time to time for publicizing the daily activities.

OPERATION (Empowerment and Encouragement of Player

Suggestions 13: Continuous skill training and opportunities for intercommunication with experts on variety of issues directly and indirectly related to their activity are provided.

The role played by informal support people such as volunteers is very important for supporting frail elderly people at community. In order for informal support people to better support frail elderly's life and to deal with difficult situations, supports for these informal support people from professional workers are necessary.

To be more concrete, it is important to provide periodical opportunities for training courses from various professions about various skills, and to build the relationship between informal support people and professional workers where informal support people can easily consult professional workers and ask them for advices when facing difficult situation. It is also desirable that professional workers build their own network so that a professional workers can consult with another more suitable professional worker for a difficult case brought by an **informal support persons, according to the necessity.**

Suggestions 14: Periodical opportunity for exchange of information or consultation of informal support people working in the community.

The role played by informal support people such as volunteers is very important for supporting frail elderly people at community.

In order for informal support people to better support frail elderly's life and to deal with difficult situations, it is desirable that opportunities for exchanging information and knowledge, and consult each other among informal support people are provided.

Suggestions 15: User friendly manual for volunteers or participants is prepared for easier commitment of them.

The role played by informal support people such as volunteers is very important for supporting frail elderly people at community. In order for general local residents to participate in activities easily, some important elements of the activities such as 'Whatr needs to be done?', 'Why is the activity necessary' need to be explained in plain language. For this purpose, it is important to prepare manuals which are easy to understand for local residents. It is desirable that manuals are jointly developed by some experts such as academics as well as local residents who will use them in reality.

Suggestions 16: Start with feasible action. It helps to motivate participants by successful experience.

In order to make a community based activity more sustainable, it is important that participants have successful experiences at an early stage of the activity. No matter how meaningful an activity is, it cannot last long if participants do not feel that it is going well. 'Successful experience' is a key word for realizing sustainable community based activities.

One of good way to have successful experiences at any stage is to start from something feasible. By having successful experiences, participants will have self-confidence and better team-spirits, and it will be much easier for them to move on to the following more difficult stage.

Examples of 'something feasible' are activities which have been successfully carried out in other areas. Therefore, it is important to study good practices of other areas when starting community based activities for the elderly.

Suggestions 17: Opportunity to fostering 'pride' of participants by joining to national competition or activity or positive media exposure.

When activity is something you can be proud of, it will attract stronger commitment of bigger number of people. 'Pride' is a keyword for building a strong local ownership towards a community based activity.

For example, participants of an activity will be proud of it, if the activity participates in national competition of activities and obtain a prize. And an exposure to mass media will also foster the pride in the activity among its participants. Leaders of activities need to devise methods for building up prides of participants in their activities.

SELF-EVALUATION AND IMPROVEMENT

Suggestions 18: Activity is reviewed among stakeholders after each activity and shared as a written document. Tips from operational experiences are also recorded.

The key process of cyclical management is the process of "evaluation and improvement", however, it will be difficult to appropriately evaluate the actions without written records of "how the actions are actually operated". Taking into consideration the limited capacity of our memory, it is the most dependable way to have a review meeting right after every occasion of action and share the results of the review discussion in the form or written record.

Review record of each action can be immediately utilized for better operation of the following action, and accumulated review records will be useful materials for review of the activity design.

Apart from the findings through review meeting, you can sometimes find out tips or knacks for improving the operation of the activity, in the process of the operation. Even when these tips or knacks are thought to be too trivial to discuss at meetings or committees, by recording them in the form of document, they will become useful information for successor, newcomers, and even already participating colleagues of the activity.

Activities for the elderly are expected to continue for a long period. Accumulating small findings steadily will make a big difference in the future.

Suggestions 19: Opportunity for presentation on their activity to external is set.

Opportunity of making presentation on your own activity towards external people is a good occasion for better understanding the strength and weakness of your activity.

And opportunity for providing information on your activity to the outside world is also a good occasion for getting information on good practices of other areas, and this can result in improvement of your own activity.

Suggestions 20: Periodical opportunity to learn about good practices in other sites is set.

In CTOP type activities, by cyclical management, opportunities for recognizing strength and weakness of the activities are richly provided. And it is effective to learn from practices of other areas in order to improve the weakness of the activities.

One of effective method of learning from other areas' good practice is "study tour". It is very important that key persons of the activity participate in the tour and participants observe the activities of good practices with clear sense of purpose. Study tour is supposed to be very good occasion for strengthening team spirits among participants of the activity.

Appendix 7 CTOP's CHECK-LIST of Self-Evaluation

【Source: CTOP Handbook / Eng. Version】

No	Suggestions
I. Key Players	
1	Any community-based committee is set and run periodically, whose member consist of local residents, local officials, and related community organizations, and related community organizations, and equal partnership among stakeholders is maintained at the committee.
2	Local authority at tambon level has a leading and important role in the community. Local authority at tambon level has to initiate local action while acting as a coordinator and mediator among stakeholders.
3	Involvement of a good external facilitator is set, and useful skills or tools are provided from them for the efficient and effective operation
II. Project Designing Process	
4	Community Dialogue is set for identifying needs of the elderly in the community, based on needs information grasped through questionnaire or interview survey.
5	Resource Map (financial, human, and activities) is made for overall understanding on local situation by dialogue between formal and informal sector.
6	The community plan for the elderly is made and endorsed by local committee of the activity consisting of local residents, local officials and related community resources.
7	Documentation of design and operation of activities is carried out
III. Preferable Project Design	
8	Activity is covering multilateral domains of local institutions, and services of activities have integrated feature such as health and social welfare. Activities are also covering all three different categories of the elderly, that is to say, independent elderly, dependent elderly and bedridden elderly.
9	Integration of information: Information sharing system is established among stakeholders. There are several method to share information, such as database or liaison and coordination system.
10	Main activity has to be implemented periodically based on an annual plan
11	The objective criteria for the selection of target group (screening) has to be set agreed, and reviewed if necessary, by stakeholders.
12	Special activity in order to extend the network of potential human resources is set.
IV. Operation (Empowerment and Encouragement of Players)	
13	Continuous skill training and opportunities for intercommunication with experts on variety of issues directly and indirectly related to their activities, are provided.
14	Periodical opportunity for exchange of information or consultation of volunteers working in the community.
15	User friendly manual for volunteers or participants is prepared for easier commitment of them.
16	Start with feasible action. It helps to motivate participants by successful experience.
17	Opportunity to fostering "pride" of participants by joining to national competition of activity, or positive media exposure.
IV. Operation (Empowerment and Encouragement of Players)	
18	Activity is reviewed among stakeholder after each activity and shared as a written document.
19	Periodical opportunity for a presentation on their activity to external is set.
20	Periodical opportunity to learn about good practices in other sites.

Appendix 8 CTOP 4 MODELS

【Source: CTOP's Project Document】

Chiang Rai Site

Model: "Modification of Behavior in High-Risk Group of Older People with Hypertension"

Major problem: Hypertension

Major functional body: Khuntan Community Hospital / ECVs / Chiang Rai Provincial Social Development and Human Security Office (PSDHS)

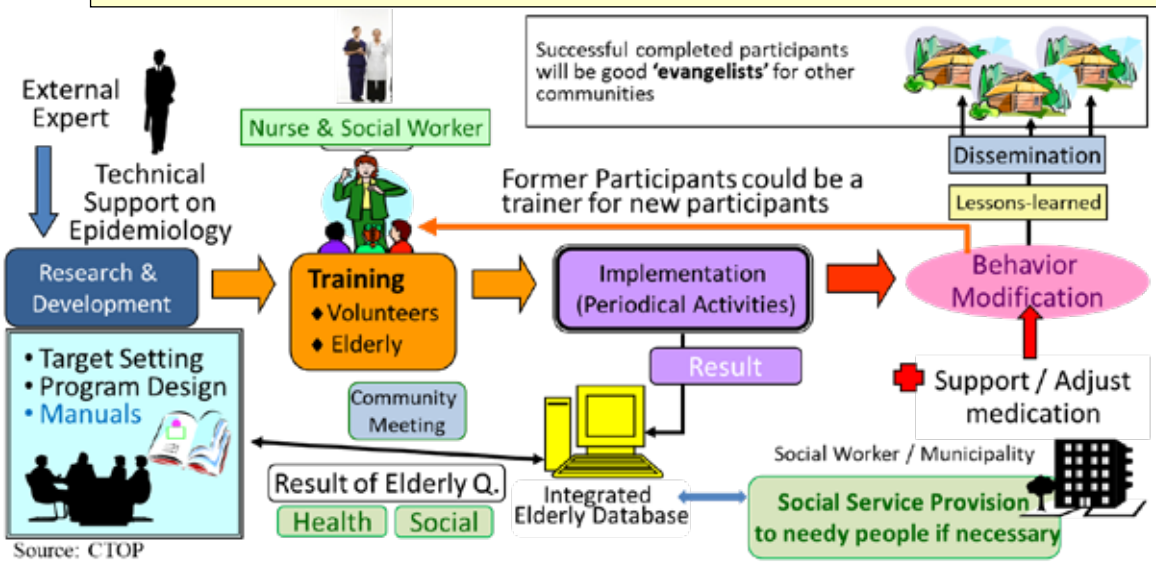
Activities: a. health checks to older people with high-risk of hypertension, b. knowledge on exercise, nutrition and proper medication, c. training to volunteers to be more knowledgeable for hypertension prevention, etc.

Significance and Highlights: (1) Hypertension is the most prevalent chronic disease in most areas and the approach and manuals developed can be utilized. (2) Older people participation since the beginning of the model development has led to inclusion in disease prevention by older people after gaining the knowledge on behavior modification.

Figure 23: Yanghom (Chiang Rai) Model

Yanghom (CR): Management of Behavior Modification Project

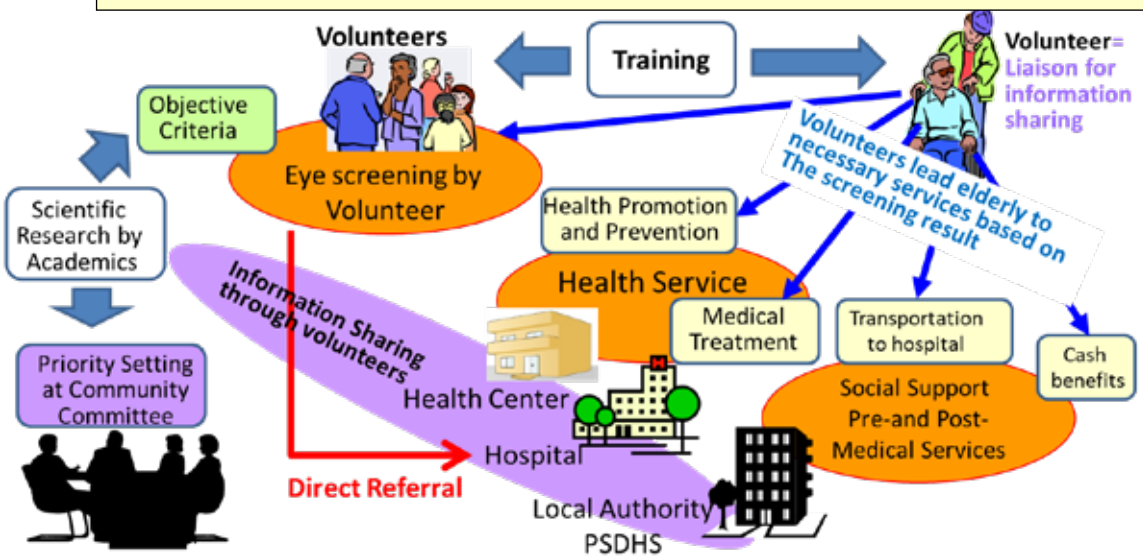
The behavior modification is a typical intervention approach in health sector. In Chiang Rai, however, CTOP covers **wider needs of the elderly by the participation from health and social sectors,** and through elderly database. The behavior modification requires continuous and positive participation of participants and volunteers, **who are motivated through the cycle of actions and revisions**. The project also has the idea that participants can be **providers as model elderly, as well as recipients**. In addition, **user-friendly manuals were developed by academic support**, which is crucial to enable local people to easily understand the activity and facilitates their positive participation.



Khon Kean Site
Model: "Eye and Dental Screening"
Major problem: Vison and Teeth
Major functional body: Namphong Community Hospital and ECVs
Activities: a. eye and teeth health checks to all older people in Sa-ard Sub-district, b. preliminary screening by ECVs, c. referral to medical institutes, d. provision of eyeglasses or dentures
Significance and Highlights: (1) With the support from a Japanese ophthalmologist, Prof.Masao Matsubara of Tokyo Women's Medical University, the concept of receiving cataract removal operation for **prevention of decline and promoting quality of life**, rather than just to save vision, was built. (Identifying eye vision for prevention of falling, which might lead to necessity of LTC)

Figure 24: Sa-ard (Khon Kaen) Model

Sa-ard (Khon Kaen): Comprehensive Community Care System
In Comprehensive Community Care System for Eye Patients, **volunteers lead the elderly to various necessary services, based on the result of the eye screenings.** This screening is also carried out by trained volunteers, **according to objective criteria which was developed based on a scientific research.** The following pathway is also structured based on this research, and **patients who need urgent treatment are directly referred to hospital,** without going to a health center. **Different service providers can share the individual information on elderly because volunteers function as liaison persons.** This project has been initiated by the decision of community committee which prioritized eye problem based on the scientific research.



Source: CTOP

Nonthaburi Site
Model: "Rehabilitation Center"
Major problem: Physical ability of older people discharge from hospitals
Major functional body: Bangsithong TAO (later upgraded to be a municipality) / ECVs / Bangsithong THPH
Activities: Tailored rehabilitation plan for each older person coming to the rehabilitation center
Significance and Highlights: (1) Rehabilitation as a strategy to enable older people to continue living at home and preventing bed-ridden, (2) The most prominent model of integration of health and social services, with cooperation of the local authority, TPHP, community hospital, rehabilitation institute, temples, and communities (elderly club and ECVs) (3) The leading area in having the local authority to be a main player in providing LTC services to older people.

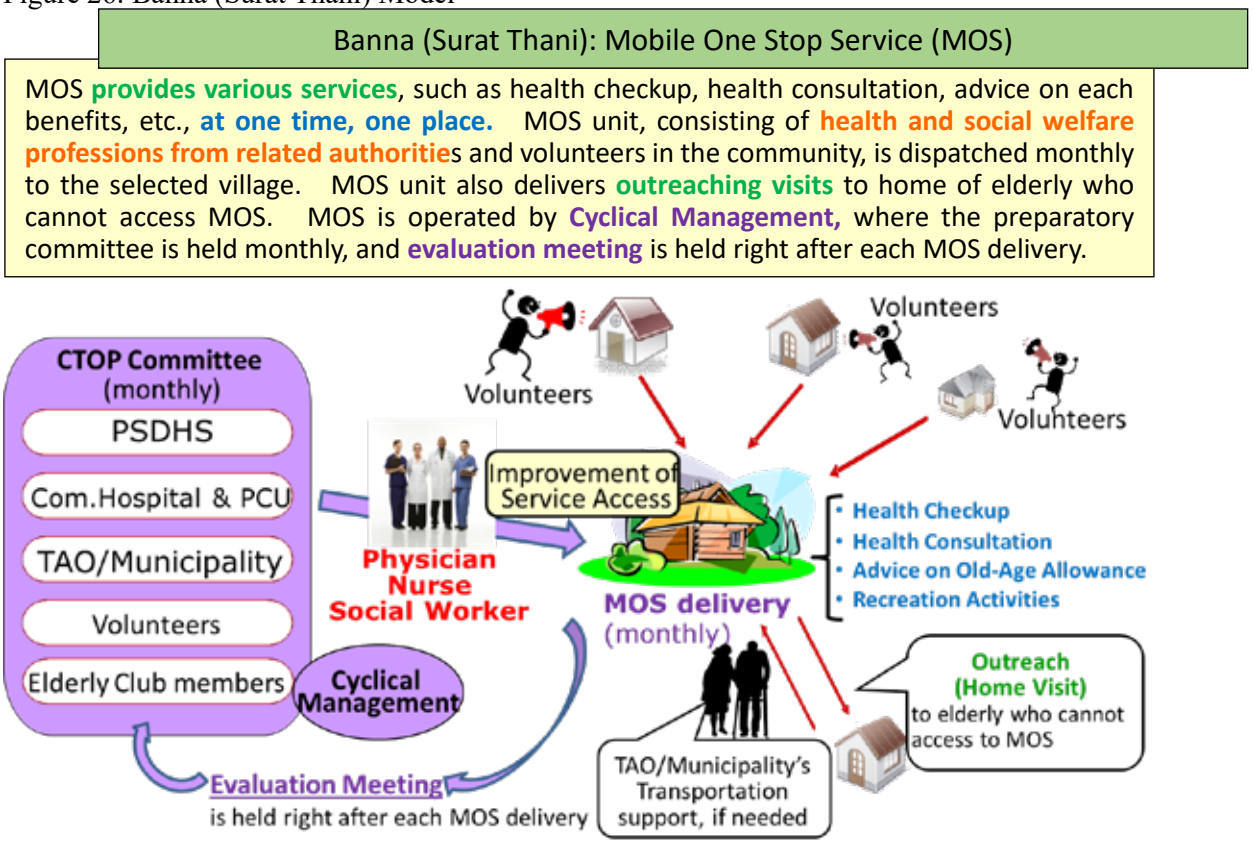
Figure 25: Bangsithong (Nonthaburi) Model

Bangsithong (Nonthaburi): TAO owned Rehabilitation Center
Rehabilitation Center is a kind of multi-purpose center which provides **various services for elderly with different needs & conditions**. **Volunteer workers at the center are technically supported by a network of high skill professions.** Center is operated by **Administrative Committee where elderly club members play important roles.** That's why the operation of the center is based on the **real local ownership.**

Source: CTOP

Surat Thani Site
Model: "Mobile One-Stop Service (MOS)"
Major problem: Poor public transportation
Major functional body: Bannaderm Community Hospital / Banna municipality **Activities:** Health check and welfare consultation by multi-disciplinary team
Significance and Highlights: (1) Changing governmental attitudes from sitting back and waiting for the patients to a proactive approach, (2) Reviewing activities by all stakeholders right after the mobile service (once a month) for further improvement (PDCA).

Figure 26: Banna (Surat Thani) Model



Source: CTOP

Appendix 9 Responsibilities of Municipalities and TAO

【Source: Unofficial Translation of each Act】

Municipalities Act (1999)

Section 50: Compulsory mandates of Sub-district Municipalities are as follows.

1) Maintain orderliness among the people
2) Create and maintain walkways and waterways.
3) Keep clean of the roads, walkways, and public place
4) Prevent and stop contagious diseases
5) Provide fire extinguish devices
6) Provide education for the people
7) Encourage the development of women, children, older people, and the disabled
8) Maintain arts, tradition, local wisdom, and local culture
9) Others as designated by law to be mandates of municipalities

Section 51: Optional responsibilities that Sub-district Municipalities may take charge are as follows

1) Provide clean water or water irrigation.
2) Provide slaughterhouse
3) Provide markets, boat, and ferry piers
4) Provide cemeteries and crematoriums
5) Encourage people's employment and earning
6) Provide and maintain places for protection and care of people with illness
7) Provide and maintain electricity or other means of illumination
8) Provide and maintain water drainage system

Tambon Council and Tambon Administrative Authority Act (1994)

Section 67: It is the duty of the Tambon Administrative Authority to do the following in its territory:

1) Create and maintain walkways and waterways
2) Keep clean of the roads, waterways, walkways, and public place; and also provide garbage and night soil services
3) Prevent and stop communicable diseases
4) Provide public disaster relief
5) Promote education, religion, and culture
6) Encourage the development of women, children, older people, and the disabled
7) Protect, look after, and maintain natural resources, and the environment
8) Maintain arts, tradition, local wisdom, and local culture
9) Perform other duties as entrusted by the service with a budget allocation, or personnel when necessary and as appropriate

Section 68: Tambon Administrative Authority may do the following business in its territory:

1) Provide water for consumption and agriculture
2) Provide and maintain electricity or other means of illumination
3) Provide and maintain water drainage system
4) Provide and maintain meeting places, sports, recreation, and public parks
5) Provide and promote farmer's groups and cooperative business
6) Promote family industries
7) Maintain and promote occupation
8) Protect, look after, and maintain properties

Determining Plans and Process of Decentralization to Local Government Organization Act (1999)

The Municipality, and Tambon Administrative Organization have power to systematize the public services for the benefit of local communities as follows

1) Establish local self-development plan
2) Provide and maintain land route, water route, and water drainage
3) Provide and control of market, wharf, pier, and parking
4) Public utility and other constructions
5) Public assistance
6) Promote, train, and carry-on occupations
7) Commerce and investment support
8) Promote tourism
9) Provide education for the people
10) Encourage the development of women, children, older people, and the disabled
11) Maintain arts, tradition, local wisdom, and local culture
12) Improve the slum areas and arrange for housing
13) Provide and maintain the recreational areas
14) Enhance athletic sports
15) Enhance democracy equality, rights, and freedom of people
16) Enhance the participation of people in development of local organizations
17) Keep clean and keep the city in perfect order
18) Waste management system including wastewater
19) Public health, family sanitation, and healthcare
20) Provide cemeteries and crematoriums
21) Control of livestock farming
22) Provide and control of animal slaughter
23) Security measures, public order, sanitary, theatre, and other public places
24) Provide, maintain, and benefit taking from forestry, land, natural resources, and environment
25) City plan
26) Transportation and traffic engineering
27) Preserve public places
28) Control structure
29) Prevent and alleviate of public dangers
30) The public order, promote, and support the prevention and security measures of life and properties
31) Other activities for the benefit of local communities announced by the Committee

Appendix 10 NHA's Resolution on LTC

【Source: Unofficial translation from NHA (2010)】

In the resolution of the 2nd National Health Assembly (NHA) held on 18 December 2009 on LTC, mandates of local authorities and relevant ministries were assigned as follows.

In the NHA's resolution, **LAOs** were assigned to,
- coordinate at local level to establish an LTC development committee for dependent older people,
- develop elderly database,
- promote establishment of daycare centers and/or rehabilitation centers,
- nurture community volunteers for dependent older people, and
- encourage elderly club to participate in the process of development of community plan for LTC

In the NHA's resolution, **MSDHS, in collaboration with MOI, MOPH, Ministry of Education (MOE), Ministry of Culture (MOC), Ministry of Labor (MOL), Ministry of Transport (MOT), Ministry of Agriculture and Cooperatives (MOAC)** were assigned to,
- consider increasing Old Age Allowance (OAA) for dependent older people,
- increase skills and knowledge of elderly clubs or volunteers,
- improve skills and knowledge of non-professional workforces, i.e. family care givers, elderly club members
- support budgets and knowledges to local authorities to ensure LTC services for dependent older people are well-provided,
- nurture care managers who will manage LTC services,
- support Primary Care Units (PCU) to provide health care services, rehabilitation services and mobility services to older people residing at home,
- support LAOs to be able to provide health care to older people
- support LAOs to be able to nurture human resources for elderly care,
- support budgets to LAOs to ensure LTC services for dependent older people are well-provided,
- support LAOs to allocate and manage budget for LTC,
- promote registration of nursing homes with responsible agency to ensure standardized services
- promote Social Welfare Development Center for Older Persons under MSDHS to provide standard LTC services and act as a learning center for local authorities, and
- study any impacts that may happen to dependent older people

In the NHA's resolution, **MOE in collaboration with MOPH and LAOs** were assigned to,
- nurture professionals, i.e. physiotherapist, occupational therapist, community practical nurse, geriatric nurse, geriatric physician, social workers, psychologist and etc, and
- to promote educational institutions at all levels to initiate the course on elderly care

In the NHA's resolution, **MOPH in collaboration with Thailand Nursing and Midwifery Council, MSDHS and MOI** were assigned to,
- develop national LTC standards and mechanism for dependent older people with participation by community and local authorities and supervise such standard

Appendix 11 Action Plan to promote LTC for Older People and Implementation Results

【Source: NHSO (2014), pp.10-11】

Table 10: Action Plan to promote LTC for Older People

Action Plan 1) Promotion and support of LTC at local community		
1.1)	Promote local authorities to have care assessment process for older people needing LTC	Institute of Geriatric Medicine, Department of Medical Services, MOPH developed 'Geriatric screening formats' and trained 389 (5% of total) local authorities (2012)
1.2)	Promote and support family care services (counselling, temporary care services, day care service, care devices center)	Department of Health, MOPH implemented Pilot Project on Sub-districts LTC Services (861 sub-districts participated in 2012)
1.3)	Training course for family caregivers and volunteers	Bureau of Health Promotion, Department of Health, MOPH developed 70-hour and 420 hours caregiver training curricula (2014) [74] MSDHS trained CGs and ECVs
1.4)	Promote social value of caregivers	Best ECVs award (228 persons in 2012)
Action Plan 2) Role of National Government on LTC		
2.1)	Set definition, criteria and assessment procedure of older people who need LTC	Definition, criteria and criteria for assessing ADL, mental health and cognitive impairment was developed by MOPH in 2012
2.2)	Set standards for operation and human resource management for residential home and nursing home	MSDHS developed the Standard on Elderly Home (2012) Issues: no standard for nursing home
2.3)	Establish day care centers or temporary care centers in governmental homes	4 THPHs, MOPH set up Day Care Centers (2012)[75] MSDHS set up day care centers in 12 Government's Elderly Homes (Social Welfare Development Center)
2.4)	Establish information center gathering data of older people who needs LTC	-
2.5)	Promote R&D and/or policy development on; -home nursing services -home-based and community services -Day hospital & intermediate care -Nursing care at hospital	Research by MOPH and The Foundation of Thai Gerontology Research and Development Institute (TGRI) on LTC care and services Issues: No research and cost analysis on services package for LTC and daycare services
2.6)	Promote and develop home health care	-
2.7)	Develop human resource on LTC	Same as 1.3)

[74] The 420-hr-guideline can be downloaded from https://tinyurl.com/yd3p4yuw and 70-hour-guideline can be downloaded from http://online.pubhtml5.com/ogkq/rxzr/#p=1

[75] BaanKhone/Uttaradit Province, Talaysap/Chumphon Province, Bukrasang/Burirum Province, Laembua/Nakorn Pathom Province

Action Plan 3) Financial and Fiscal Support		
3.1)	Financial support to the family with older people who need LTC	-
3.2)	Providing tax incentive scheme for private or NPO type nursing home	-
3.3)	Financial support for the house maintenance or reform for LTC purpose	MSDHS supported budget for house renovation (2000 cases in 2012) Ministry of Interior supported house renovation budget for older people needing LTC (2011)

Appendix 12 Concrete action plan under each strategy and responsible

【Source: NHSO (2014), pp.25-30】

Table 11: List of Actions under LTC Strategic Plan 2014-2018

Strategy	Action Plan	In-charge
1: Screening older people and developing a database	1.1 Develop an older people screening format and develop criteria/standard to categorize older people based on necessity in receiving LTC services (2014) 1.2 Train Village Health Volunteers (VHVs) and Elderly Care Volunteers (ECVs) on screening (2014) 1.3 Conduct screening survey (2014-2018) 1.4 Develop older people database to plan for necessary LTC services and welfares (2014-2018, 60%→100% in 4 years)	- NHSO, MOPH, MSDHS - THPH, LAO - ECV, LAO - THPH, LAO
2. Building capacity of community (Develop service system)	2.1 Develop service standards and service supporting system (2014) 2.2 Provide elderly home-care services by THPHs (2014-2018) 2.3 Set up Elderly Quality of Life Development and Career Promotion Center at sub-district level (2014-2018) 2.4 Establish day care centers at sub-district level (2014-2018) ** Plan for respite care and nursing home was suspended.*	- MOPH, MSDHS, LAO - THPH, LAO - MSDHS - LAO
3. Developing Fiscal support system and benefit package	3.1 Develop LTC Benefit Package for the dependent older people (2014-2018) 3.2 Design fiscal support system and service payment system (2014-2015) 3.3 Provide recommendation on budget integration by relevant agencies (2014-2018) 3.4 Extend coverage of Rehabilitation Fund for Disabled (2014-2018)	- NHSO, MOPH, MSDHS, LAO - NHSO, MSDHS, DLA - NHSO, MSDHS, DLA - LAO, NHSO
4. Human resource development	4.1 Support local authorities, community, and private sectors to plan and manage workforces for LTC (2014-2018) 4.2 Develop curricula and conduct training for care manager (2014-2018) 4.3 Develop curricula and conduct training for caregivers (2014-2018) 4.4 Support the employment of LTC workforces in community (VHVs, ECVs, CMs, and CGs), THPHs (professional nurse, clinical psychologist, and traditional doctor), and hospitals at community and provincial level (family physician, physical therapist,	- LAO, Private Sector - MOPH - MOPH, MSDHS - MOPH, NHSO, LAO, MOE

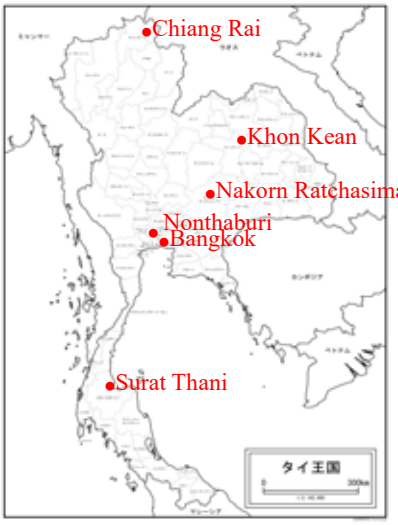
Strategy	Action Plan	In-charge
	occupational therapist, geriatric physician, geriatric nurse, etc.) (2014-2018)	
5. Knowledge Management, M&E	5.1 Study and develop benefit packages for frail prevention and care of dependent older people (2014-2018)	- NHSO
	5.2 Study and develop service practices for community-based LTC and fund management system at sub-district level (2014-2015)	- NHSO
	5.3 Study service payment system (2014-2015)	- NHSO
	5.4 Study LTC financing (2014)	- TGRI
	5.5 Study and develop evaluation system of LTC (2014-2018)	- TGRI
6. Law, regulations, and management	6.1 Revise regulation to ensure all dependent older people, including civil servants, can utilize community services (2014)	- CGD
	6.2 Designate local authorities to be a main service provider in providing LTC and revise regulations of local authorities in relation with LTC services (2014)	- DLA
	6.3 Review laws and regulation regarding LTC, i.e. standards for private nursing care, standards on services for home-based LTC, etc. (2014)	- HSS, MSDHS

NHSO: National Health Security Office, MOPH: Ministry of Public Health, MSDHS: Ministry of Social Development and Human Security, THPH: Tambon Health Promotion Hospital, LAO: Local Administrative Organization, DLA: Department of Local Administration (Ministry of Interior), TGRI: The Foundation of Thai Gerontology Research and Development Institute, CGD: The Comptroller General's Department (Ministry of Finance), HSS: Department of Health Service Support (MOPH)

Appendix 13 LTOP's Site Charateristics

Project: **LTOP**
Period: January 2013 – August 2017
Target: Direct beneficiaries: central and local government officers/service providers engaged in LTC services for older people
Indirect beneficiaries: The frail older people in 6 pilot sites

LTOP Characteristics in each Pilot Site



- **The same sites as CTOP**

I. Chiang Rai
Main Player: Khuntan Community Hospital / CGs
In charge by: Department of Medical Services, MOPH
Daycare Center: Operated once a week. Later closed since being in a remote location that was not convenient for both service providers and users.
CM/CG trained in LTOP: 7/24
No. of Older people taken care in LTOP: 53
JOCV: 2 PTs (2015/09-2017/9 and 2017/9-2019/9)
GPP: Ambulance, Emergency-response medical equipment
Characteristics: Pilot site in the North covering large area of 134.8 km^3, with 727 households. Some households locate far from others and some in remote or mountainous area as in the following photos. This made home visit by CGs become difficult when transportation budget could not be provided. Besides, being the area with agriculture as a major occupation, family caretakers could not take the elderlies to the daycare center during cropping seasons and resulted in no users in some periods.

Images of the area near Khuntan Community Hospital and Yanghom Municipality

Source: Google map

II. Khon Kaen
Main Player: Namphong Community Hospital / Sa-ard Municipality / CGs
In charge by: Office of the Permanent Secretary
Daycare Center: Small Day Care Center operated by the Municipality before getting support from the GGP in the 2015.
CM/CG trained in LTOP: 6/13
No. of Older people taken care in LTOP: 46
JOCV: **2 PTs (2015/9-2017/9 and 2017/9-2019/9)**
GPP: The project for building the daycare center for the frail older people and other vulnerable people in Saard, Nam Phong, Khon Kaen (2015)

Characteristics: Pilot Site in the North-east covering the area of 82 km^3. Home visits are easier than the Yanghom area, with 2,469 households located in the area. "Namphong Model[76]", the LTC model for dependent elderlies and the disables, was initiated, with nurses at Namphong Community Hospital, members of Sa-ard Municipality, and CGs working as a team in providing care services. Namphong model has 3 teams of CGs. Team A takes care of bed-ridden elderlies, Team B takes care of home-bound elderlies, and Team C takes cares of elderlies visiting the Day Care Center, which has approximately 5 visitors a day. Namphong Hospital also has its own way of nurturing nurses, by providing scholarships to nursing college's students, who have domiciles in Namphong area. Study visits to Namphong Hospital will be made monthly during their studies, and jobs will be offered after their graduation. Theses scholarship grantees will provide services in the hospitals 3 days a week and conduct home visits in their residence area, with the family care team 2 days a week.

Image of the Daycare Center (GGP)

Source: isaranews

Image of area near Sa-ard Municipality

Source: Google Map

III. Nonthaburi

Main Player: Bangsithong Sub-district Municipality / Bangsithong THPH / CGs, with strong support from PPHO

In charge by: Department of Health

Daycare Center: 2 centers during the Project > extended to 42 centers as of April 2021.

CM/CG trained in LTOP: 13/56

No. of Older people taken care in LTOP: 45

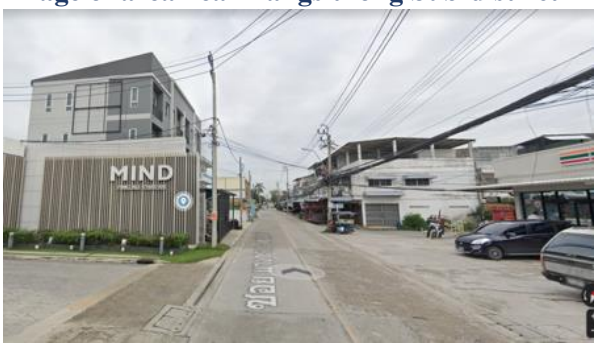
JOCV: 1 PT (2016/3-2018/3)

GPP: The project for providing a wheelchair lift car for the elderly and other vulnerable people in Nonthaburi (2016)

Characteristics: Pilot site in the Central part. Vicinity area of Bangkok covering the area of 58 km^3 with 3,867 households. Majority of population are civil servants, with higher income than the national average income. 'Bangsithong Model' consists of 3 major practices, a. Home Visit based on Care Plan for bed-bound and home-bound elderlies, b. Rehabilitation at 2 Rehabilitation Centers for home-bound elderlies, and c. activities by the Elderly Club for independent elderlies. CGs in this site work with voluntary mind and have not received compensation from the LTC fund until date (as of April 2021). Bangsithong is also a learning site for other provinces and countries, with the former sub-administrative chief of Bangsithong (currently Administrative Chief at Sainoi Municipality) as a trainer.

[76] Note: Information of Namphong Model from isaranews on 30 July 2018 (https://www.isranews.org/thaireform/thaireform-documentary/68205-care.html)

Image of area near Bangsithong Sub-district Municipality and older people survey



Source: Google Map

Source: Bangsithong Municipality

IV. Surat Thani

Main Player: Bannadoem Hospital / Banna Sub-district Municipality / CGs, with support from Suansaranrom Mental Hospital
In charge by: Department of Mental Health
Daycare Center: At a CG's house in the first few years / Established just before termination of LTOP, by using the 1st floor of the old building of Banna Municipality as a place for exercise, massage, mental training, etc.
CM/CG trained in LTOP: 8/6
No. of Older people taken care in LTOP: 33
JOCV: 2PTs (2014/10-2016/10 and 2016/9-2018/9)
GPP: The Project for Providing a Wheelchair lift car for the Elderly and Other vulnerable people in Banna Sub district in Suratthani Province (2017)
Characteristics: Banna Sub-district has two local authorities; Banna Sub-district Municipality and Banna Tambon Administrative Office. Banna Sub-district municipality covers the area of 4.08 km^3, with 1,262 households located in the area. Household size is large (4.8 prsn/hh), with higher income than the country average. In this pilot site, close coordination among Bannadoem Hospital, Banna Municipality, and CGs can be observed. Bannadoem hospital sends doctors/nurses/PT to station at the daycare center two days/week. C/Ps from this area who went to Training in Japan is obliged to perform elderly care either in the hospital or in the daycare center. Home visits were conducted by CGs, most of which are owners of plantation and work with voluntary mind, without needing any compensation in earlier days. Now, most CGs work with pay by LTC fund or by the LAO's budget.

Image of Municipal area of Banna Sub-district and Bannadoem Hospital

V. Nakorn Ratchasima

Main Players: Joho Community Health Center under affiliation of Maharaj Hospital, Joho Sub-district Municipality

In charge by: Department of Medical Services

Day Care Center: Located next to the Community Health Center / Operated before LTOP, mainly for recreation

CM/CG trained in LTOP: 7/27

No. of Older people taken care in LTOP: 34

JOCV: 1 PT (2015/9-2017/9)

GPP: n/a

Characteristics: Pilot site in the lower North-eastern part. Big city located in central part of Nakhon Ratchasima, covering the area of 9.50 km^3 with 8,382 households. Joho Community Health Center, with supports from Maharaj Hospital, is well-equipped with medical human resources. Besides, traveling to the daycare center, which locates next to Joho Community Health Center, is convenient. On the other hand, unlike rural areas, home-visits by CGs were difficult since most household did not trust persons whom they did not know and did not allow CGs to enter their houses. Not being able to visit older people, sometimes care services could not be provided as planned.

Image of Joho Sub-district Municipality and Joho Community Health Center

VI. Bangkok

Main Players: Public Health Center 4-Dindaeng

In charge by: Department of Health

Day Care Center: A room in the Public Health Center 4, where VHVs would conduct activities for older people.

CM/CG trained in LTOP: 8/13

No. of Older people taken care in LTOP: 20

JOCV: n/a

GPP: n/a

Characteristics: The pilot site is located at Bangkok Metropolitan, the capital city of Thailand. In this pilot site, major activities are home visits and rehabilitation. Home visits are conducted by CGs of Public Health Center 4, and rehabilitation is conducted at the Dindeang Elderly Service Center managed by the Social Development Department, BMA.

Images of Public Health Center 4 and Dindaeng Elderly Service Center

Source: Photos from Website

Appendix 14 POLICY RECOMMENDATIONS

【Source: JICA LTOP】

POLICY PROPOSAL TO THE THAI GOVERNMENT FOR THE ELDERLY LONG-TERM CARE

In this policy proposal, the drafting committee adopted the WHO Health System Framework which consists of 6 components (service delivery, workforce, information, technology, financing, and leadership and governance) with the addition of community participation, as the concepts based on which the policy recommendation on long-term care for the elderly to the Thai government was developed. Based on WHO good health service system, this policy recommendation considers accessibility, coverage, quality, safety, efficiency, responsiveness to the real needs of service user and sustainability of the long-term care system for the elderly.

In the Thai context, there are several strong points in managing long-term care for the elderly: 1) In the Thai society, people still help each other. Family and community are very strong and have potential to provide care to their elderly member. 2) Thailand has village health volunteer and other volunteer systems spreading over the country. Therefore, this policy recommendation tries to maintain this strong characteristics by encouraging family and community to help themselves first. To Begin with the elderly, they should prepare themselves to enter into the old age. Then, people in the community should help each other before seeking helping hand from the formal sector provided by government to prevent critical financial problem. Elderly should be supported to live happily with the family based on family conditions. Family and community should act as a main player to taking care of the elderly.

I. Service Delivery

1.1 Establish a family member support system to enable them to bear family caregiver duties to take care of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound). It is for improvement of the quality of life of the elderly and family caregivers.

1.1.1 Establish a family member development system to enable them to perform family caregiver duties. Health service provider and local authority will be assigned to take responsibility for this.

1.1.2 Establish an education and care practicing system and communication media (leaflet, VDO, and online media) for taking care of the elderly. This system should be easily accessible to family caregiver.

1.2 Provide care services to the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/homebound) as a community care to cover all sub-district in Thailand.

1.2.1 Survey the number, types and situation of the elderly, and perform preliminary screening of their health. Set up the group of the elderly based on long-term care needs in the responsible area.

1.2.2 Set up care management system which consists of

1) Preparing care plan by care manager in response to the care need of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/homebound), and their family by considering suitability, efficiency and standards. Care plan should be developed for the individual under the agreement between service provider and service receiver. It must get approval from the 'Tambon committee …….. (Name of the committee will be designed later)

2) Assigning the caregiver who has been trained under the standard curriculum certified by the Ministry of Public Health, to provide care services to the frail elderly (dependent/ bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) based on the care plan.

3) Multidisciplinary team or family care team which is comprised of medical doctor, dentist, pharmacist, registered nurse, physical therapist, care manager, social worker and personnel in other related disciplines cooperating to provide long-term care to the elderly based on the care plan.

4) Appropriate social and environmental management including house improvement to avoid harms which may occur to the elderly.

1.1.3 Provide services at home based on the care plan prepared by care manager. Services will be comprised of;

1) functional training,

2) psychological support,

3) body assessment and vital sign check,

4) take care of personal hygiene,

5) take care of environmental hygiene of the house (not included in the house condition improvement)

6) provide individual consultation to family member to take care of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/homebound),

7) daily living assistance for the elderly needing special food and having no one to take care,

8) oral health and hygiene care services,

9) take care of nutrition, and

10) Thai traditional massage service.

1.1.4 Establish Tambon Day Care Center which local authority is responsible for managing and operating for providing services based on the care plan. Services provided at the day care center will be comprised of;

1) physical rehabilitation by muscle exercise and walk practicing,

2) Thai traditional medicine and alternative medicine, such as Thai traditional massage, herbal steam and hot herbal press to care and cure the elderly, and

3) recreation activities service.

1.1.5 Transportation service to/from Tambon Day Care Center and home of the elderly.

1.1.6 Transportation service from/to home and nearby hospital to receive service when the elderly;

1) has an appointment, and

2) needs emergency care or need referral to another health service provider

1.3 Provide respite care services based on the care plan for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) to reduce the burden of family which has difficulties to take care of their elderly member or the elderly living alone. This service will be comprised of;

1.3.1 Home respite care service for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/homebound) by caregivers, and

1.3.2 Respite care service at the tambon day care center for the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

1.4 Related government organizations support the elderly to have sufficient and suitable tools and devices by;

4.1 Setting up a center which lends (or rents) suitable daily living assisting tools and devices to the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

4.2 Providing tools and devices for physical rehabilitation at the hospital, and

4.3 Providing tools and devices for physical rehabilitation at the tambon day care center.

II. Workforce

Set up clear roles, number of manpower, necessary skills, and qualification of personnel to provide care to the elderly as follows:

2.1 Care manager has the following duties:

2.1.1 Act as the main responsible person to manage care services to the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

2.1.2 Assess the situation of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound). Prepare care plan and submit to 'Tambon committee …….' for approval.

2.1.3 Assign and advise caregiver to provide services to the elderly based on care plan, and monitor and evaluate long-term care services provided.

2.1.4 Coordinate among concerned organizations for the activities to be provided as planned. Supervise, monitor and evaluate to put the work plan into action.

2.1.5 Revise and adjust individual care plans when necessary.

2.1.6 Suitable ratio of elderlies per care manager:

1) Part-time care manager: 10-15 frail elderlies per 1 care manger.

2) Full-time care manager: 30-50 frail elderlies per 1 care manger.

2.1.7 Necessary skills: health knowledge, communication and coordination skill, social work skill.

2.1.8 Qualification: Bachelor degree and completion of training under the care manager development curriculum certified by Ministry of Public Health.

2.1.9 Should understand very well the community which they have to work with. It will enable them to cooperate with other organizations to strengthen community to provide long-term care services to the elderly.

At the initial period, the staff of MOPH or staff of local authority should be assigned for care manager position. Payment for this position should be based on government budget related to the personnel. The suitable number of manpower varies based on the need of each area. Full-time equivalent (FTE) can be adopted as a framework to estimate the manpower necessary to cover the number of the elderly needing long-term care in the area.

2.2 Caregiver has the following duties: (Emphasizing duties to provide health care and social care more than domestic helper duties)

2.2.1 Provide services assigned by care manager according to the care plan to the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) at home.

2.2.2 Provide services to the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) at tambon day care center.

2.2.3 Provide short time respite care for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) at home.

2.2.4 One caregiver responds to 5-10 the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound). This number is based on the result of the survey of LTOP project from 6 pilot sites. On average, care giver's monthly working hours per client was 16.8 hours (See Table 3.2 in appendix), which included the time for providing services at the daycare center, for traveling, for recording information into different forms, for reporting, and for participating in the care conference. If full time caregiver works 8 hours per day and 22 days per month or 176 hours per month, they should be able to provide care services to 10 elderlies at a maximum.

2.2.5 Necessary skills: Skills to communicate with the elderly and their family member, skills to guide the elderly for exercising and doing daily activities, basic medical checkup skills and health care skills, skills and knowledge to take care on personal hygiene, and Thai traditional massage knowledge and skills for those working in the area where such services are provided to the elderly.

2.2.6 Qualification: Completion of the secondary school and the training under the caregiver development curriculum certified by Ministry of Public Health.

2.2.7 In order to prevent volunteering system in Thailand from getting damaged by introducing payment to caregivers, we propose to develop caregivers from volunteer in the community. Hiring them as a permanent staff is not necessary. Payment can be based on the opportunity cost or workload. They have to work in their own community only.

2.3 Volunteer has the following duties:

2.3.1 Home visit for preliminary health screening and moral support to the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

2.3.2 Provide suitable health-related advice.

2.3.3 Suitable ratio is one volunteer per 10-15 households.

2.4 Family care team has the following duties:

2.4.1 Provide integrated care services in the form of multidisciplinary team at home to the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) which is set in the care plan.

4.4.2 Provide suitable consultation to care manager on care plan preparation and improvement.

4.4.3 Follow-up medical situation of the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) in the community and refer them to suitable service units when necessary.

4.4 Suitable ratio of family care team in the district level is 3 medical doctors per 30,000 population (adopted from principle of family care cluster).

2.5. Social worker and/or Community development officer has the following duties:

2.2.5.1 Help the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) in social welfare aspects, such as elderly allowance, house improvement for suitable living environment for the elderly and other social supports.

2.5.2 Suitable ratio of social worker/community development officer is 1-2 per one sub-district.

2.6. Family caregiver

2.6.1 Family caregiver is a family member that has duty to take care on daily activities and other activities of their older family member based on the care plan.

2.6.2 A support system should be developed to enable family caregivers to take care of the elderly effectively.

2.6.3 A support system should be developed to provide family caregivers with relief from tension to take care of the elderly and enable them to have a better quality of life.

2.7 Curriculum development and training;

2.7.1 Development of care manager development plan and conducting the training should be assigned to public health colleges, nursing colleges, and educational institutes of which curricula are certified by MOPH.

2.7.2 Development of caregiver development plan and conducting the training should be assigned to training institutes and educational institutes of which curricula are certified by MOPH.

III. Information System

3.1 Establish the database of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) in the district level which integrates civil registration database, health data and other necessary related information. It should be set as a minimum data set operated under the standard security system to protect information and personal rights.

3.2 Concerned persons in the district or in the sub-district level are able to access to the data under the standard security system to protect information and personal rights.

3.3 Minimum information contained in the data set will be comprised of;

3.3.1 personal information such as name, address, marital status and education,

3.3.2 family information such as number of family member and main family caregiver,

3.3.3 economic information such as income, health scheme and occupation,

3.3.4 health status information (general information, vital sign, Activity Daily Living (ADL), Typology Assessment Illustration (TAI)), congenital disease, health service access information, health screening and geriatric syndrome

3.3.5 social information such as membership of a group or club, channels to access the information and group participation, and

3.3.6 the location of persons needing assistance for preparation to help them when they have emergency need.

IV. Technology

4.1 Standard guidelines should be set to provide care in the community to the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) as a manual for care managers, caregivers, family caregivers, volunteers and family care teams. The duty to develop the manuals should be assigned to Older Person Bureau of Health Department and Institute of Geriatric Medicine of Medical Service Department.

4.2 Support to develop suitable vehicles to transport the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

4.3 Support to develop information technology such as mobile phone application to;

4.3.1 develop knowledge of family caregivers and other people, and

4.3.2 advertise and promote public to use EMS 1669 application developed by the National Institute for Emergency Medicine when an emergency help is necessary.

V. Financing and Fiscal System

5.1 Set up long-term care fund which integrates the health-related budget (NHSO), the social welfare related budget (MSDHS), the quality of life development budget (local authority) to provide services for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound). Local authority will be assigned to manage the fund under the mechanism of Tambon committee…….. Issue or improve rules and regulations to allow local authority to operate the fund suitably.

5.2 Use the financing mechanism to support local authority to buy services from government service units, private service units, or to provide services by themselves for long-term care for the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

5.3 The budget allocated for committee……. (of local authority) should clearly specify all related expenditures as follows:

5.3.1 Personnel expenditures: care manager, health personnel, social worker, and caregiver.

5.3.2 Service expenditures: care plan preparation, home visit, home service activities, service provided at daycare center, expenditure to manage elderly care center, expenditure for transporting elderly to/from daycare center, expenditure for consumable goods and medical tools.

5.3.3 The budget for committee ……. will be monitored and evaluated.

5.4 Information from the survey of LTOP project in Section 4 and appendix can be used to estimate the budget. For example, caregiver should be paid based on hourly workload shown in the care plan. On average one caregiver had 25 working hours per month (part-time caregiver) (See Table 3.2 in appendix). It included working time at the daycare center and time for traveling. According to the information from the cost survey, the average hourly wage of paid care workers in the pilot project sites was 54 Baht (See Table 5.5 in appendix). If the care cost of caregiver is assumed 30-60 Baht per hour, government is expected to spend the budget about 1,400 – 2,800 million Baht per year to hire caregivers.

5.5 Tambon committee ……. has the duty to make yearly budget report proposals to the local authority administrative board and committee in the district and provincial level.

VI. Leadership and Governance

6.1 Government authorizes local authority to absolutely act as the principle organization to manage the long-term care service system for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) by integrating their activities with government organizations' activities in the local area, such as MOPH, MSDHS, and other related organizations. These organizations should support long-term care operation where suitable.

6.2 Establish the committee at the national level (subcommittee to promote long-term care for the elderly) to classify the types of the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) and develop standard benefit package which meets the need efficiently.

6.3 Establish elderly committees in the district and provincial level which is comprised of related government organizations (MOPH, MSDHS in the provincial level, MOI, NSHO, etc.), civil sector, and private sector to monitor and audit the operation of the local authority and concerned organizations in the area, such as MOPH, MSDHS in the provincial level and report to the elderly committee at the national level.

6.4 Government assigns MSDHS as the secretariat of the National Committee on the Elderly to enact the law or improve the regulations related to human resources management, fiscal management, fund ……. management and other related management aspects to support local authority to manage elderly long-term care system.

6.5 Establish a system to receive complaints and suggestions from the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) and their relatives which is operated by the elderly committee in the district and provincial level.

6.6 Strengthen the tambon elderly quality of life development center which integrates missions of Ministry of Public Health, Ministry of Social Development and Human Security, local authority, Ministry of Education and other related organizations in cooperation with the community to promote and prevent people from becoming the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound). It includes occupational promotion as well.

VII. Community Participation

7.1 Strengthen the capacity of family caregivers for the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound) to share their experiences and have peer supports via the mechanism of elderly quality of life development center.

7.2 Support to have 'Tambon…. Community Welfare Fund' to provide social welfare or purchase and sell consumable goods for the daily living, such as diapers and gloves for the frail elderly (dependent/bed-bound) and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

7.3 Support and develop the capacity of volunteering clubs, elderly clubs, and children and youth council to perform their roles to taking care of the frail elderly (dependent/bed-bound), and the elderly who has limitation to perform their daily activities (partial dependent/ homebound).

VIII. Other Suggestion

8.1 Cooperate with international to develop, create or seek program to prevent geriatric syndrome in the community.

Appendix 15 Care Plan Format introduced by LTOP

Care Plan								
Name			**Address**				**Developed on**	
DOB **Age** **yrs**			**Tel.No.**				**TAI=** **ADL=**	
Intention of the Older Person and family			**Care Concept**				**Remarks**	
Issues needing resolution (Needs)			**Goal**					
Details		**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Major Activities**
	6:00								
	8:00								
	10:00								
	12:00								
	14:00								
	16:00								
	18:00								
	20:00								
	22:00								
Developed by_____					**I have agreed with this Care plan_____ dd/mm/yy _____**				

Appendix 16 Care Manager Training Curriculum Index[77]

【Source: unofficial translation of the index of the Guideline for Care Manager Training: Department of Health 2015】

Lesson 1: Aging Society and Issues
- Current situation of aging population
- Necessity of elderly care

Lesson 2: Care Management Concept
- Definition and introduction to care management
- Concept of care management
- Respecting Human rights
- Quality of life Enhancement

Lesson 3: Steps of Practices of Care Management
- Steps of practices of care management
- Knowledge on reflection

Lesson 4: Application of Social Resources for Care Management
- Application of social resources for care management
- Application of social resources to meet with physical, mental and social needs

Lesson 5: Interview Techniques in the Care Management System
- Listening skills and how to enhance communication skills
- Body language techniques

Lesson 6: Identifying Target Group and Grasping Situation
- Identifying target groups and grasping situation
- Screening the target groups and their special identity

Lesson 7: Intake Work
- Intake work
- Intake and reality

Lesson 8: Understanding Assessment
- Assessment in the care management system

Lesson 9: Assessment utilizing International Classification of Functioning, Disabilities, and Health (ICF)
- Assessment utilizing International Classification of Functioning, Disabilities, and Health (ICF)
- ICD and ICF
- Concept on multi-functioning

Lesson 10: Typology of Aged with Illustration: TAI
- TAI
- Classification of older people in Thailand
- Screening for older people needing LTC

Lesson 11: Practice: Case Study

Lesson 12: Understanding of Issues in Living and Steps of Assistance
- Understanding of issues in living
- Goal of living
- Assistance to meet the goal
- Developing weekly plan
- Care conference and how to organize a care conference
- Monitoring and how to monitor

[77] The CM Guideline can be downloaded from https://tinyurl.com/cvakkvk

Lesson 13: Practice from Case Study
Lesson 14: Rights of Older People based on the Constitution / Labor Act
- 2007 Constitution
- The Act on the Elderly 2003

Lesson 15: Roles and Ethics of the Care Manager
- Roles and ethics of the Care Manager
- Ethics of the Care Manager

Lesson 16: Study Visit and On-the-Job Training in service facilities and communities
Lesson 17: Assessment and Evaluation

Appendix 17 Steps needed in utilizing the LTC Fund

- Service units (district community hospitals / THPHs) screen older people under universal health care coverage (UC) and categorize older people who have ADL score of 11 or lower into 4 groups. The 4 groups eligible of LTC services under NHSO are, Group 1: Ability to somewhat move independently, but may need help with eating and toileting, Group 2: The same as Group 1 with cognitive disability, Group 3: Cannot independently move and need help with eating and toileting; or with a severe illness, and Group 4: The same as Group 3 and at the end-stage of life.

Table 12: Benefits package of each group

BENEFIT	Group1	Group2	Group3	Group4
HEALTH SERVICES	At least once a month	At least once a month	At least once a month	At least twice a month
HOME-BASED OR COMMUNITY BASED CARE	At least twice a month	At least once a week	At least once a week	At least twice a week
PROCURE CLINICAL DEVICES AND EQUIPMENT	Clinical device or equipment to assist movement or functioning of the dependent older people			
PAYMENT COMPENSATION (LUMP SUM BAHT/PERSON/YEAR	Not over 4,000	3,000-6,000	4,000-8,000	5,000-10,000

SOURCE: Royal Gazette (2016.4)

The Service units then send the data with Identification (ID) numbers of older people needing care to regional NHSO and then NHSO at central level. When NHSO inspected the recorded case, it will make a payment of 5,000 Baht/person/year to the LTC Fund.

- Service units[78] (district community hospitals/THPHs), Service Facilities[79] (PPHO, DPHO, Healthcare section in LAOs), or Community Center for Elderly's Quality of Life Development submit project details and service proposals to LTC sub-committee. A **Care Plan** developed by a **CM** needs to be attached.
- LTC Sub-committee reviewed the project details, service proposals and Care Plan and informed the result to LAOs
- LAOs contracted with the approved agencies and provide budgets as agreed by the LTC sub-committee
- LTC sub-committee monitors and evaluates as per the care plan, with supervision by MOPH, LAOs and NHSO.

[78] Service Unit: service facilities registered under the National Health Security Act B.E.2545 (2002)

[79] Service Facilities according to the National Health Security Act mean health facilities of the public sector, the private sector and the Thai Red Cross Society, facilities in service of the art of healing, and other health facilities as additionally prescribed by the Board.

LTC Sub-committee

【Source: Royal Gazette 2018.10】

Section 18: LHSF Committee shall establish a sub-committee to support LTC services to dependent elderlies. The sub-committee comprise of:

(1) Head of the local authority or the person designate d by the head	President
(2) 2 representatives from LHSF committee	Member
(3) Head of service unit or Representative	Member
(4) Head of District Public Health Office or Representative	Member
(5) Head of Primary Care Unit	Member
(6) Care Manager	Member
(7) Care Giver	Member
(8) Chief Administrative Officer of local authority	Member
(9) Other staff assigned by the head of the local authority	Member and Secretariat

Section 19: Responsibilities of the sub-committee are, approval of Service units, Service Facilities, or Community Center for Elderly's Quality of Life Development Community Center for QOL's project proposal, individual care plan, and budget according to the care plan

Appendix 18 Ministry of Interior's Regulation on Community Care Giver

【Source: Unofficial Translation of the MOI's Regulation in the Royal Gazette 2019】

Ministry of Interior's Regulation on
Local Authority's Community Care Giver and Disbursement
B.E.2562

It is deemed appropriate to have the Ministry of Interior's regulation on Local Authority's Community Care Giver and Disbursement B.E.2562.

According to the Section 67 (7) of the Municipality Act B.E.2496, amended by the Municipality Act (No.4) B.E.2505, Section 69 and 77 of the Municipality Act B.E. 2496, Section 5, 85(10) and Section 88 of Tambon Council and Tambon Administrative Authority Act B.E.2537, and Section 6, Section 74(9) and Section 76 of Provincial Administrative Organization Act B.E.2540, the Minister of Interior issued the regulation as follows.

Section 1 This regulation is called 'The Ministry of Interior's Regulation on Local Authority's Community care giver and Disbursement B.E.2562'

Section 2 This regulation shall become effective as from the day following the date of its promulgation in the Royal Thai Government Gazette

Section 3 In this regulation,

'Local Authority' means municipality, Tambon Administrative Organiztaion and Provincial Administrative Organization

'Local Authority Management' means Mayor, Chief Executive of the Tambon Administrative Organization, and Chief Executive of the Provincial Administrative Organization

'Dependent Older Person' means an older person who cannot completely help oneself and in a dependent situation, as assessed by the criteria set by the National Committee on the Elderly

'Community Care Giver (CCG)' means the person not being a local authority staff, who was trained in the course of MOI on LTC of dependent older people. S/he shall assist the local authority in providing care to dependent older people, without being bound to labor protection Act, Labor Relation Act, and Social Insurance Act.

'Care for Independent Older People' means home-based and community-based care services for dependent older people, which cover basic health care, rehabilitation, physical therapy according to the type of services designated by the Ministry of Health. The services also include suggestion and assistance which are not the nurse care.

Section 4 Care for dependent older people, compensation rate, compensation payment to the CCG shall be according to the criteria, condition and rate set forth by the MOI.

In specifying the criteria, method, condition, compensation rate, and compensation payment in the previous paragraph, the MOI may consult with the Department of Older Persons, Department of Health, Department of Medical Service, National Health Security Office, or Decentralization committee.

Section 5 CCG who is entitled to receive the compensation for the time used in providing services and care to dependent elderlies, shall be the CCG residing in the local authority and is notified by the local authority management to provide such services.

The compensation in the previous paragraph shall be the rate in accordance with the Section 4. The budget shall be in the category of 'compensation', in the type of 'persons working for governmental agencies and benefiting local authorities'. Consideration on financial situation of the authority, appropriateness, and necessity shall be made.

Section 6Local authority may provide training course on care services for dependent older people, or may collaborate with other local authorities or other agencies to provide training to community people having intention to be CCGs. It may also provide retraining course to CCG, as being designated by the MOI.

Fee needed for training in the previous paragraph shall be in accordance with MOI's regulation on training fee for local authorities' staff.

Section 7Disbursement and evidences in the Section 5 and 6, shall be in accordance with the MOI's regulation on receiving money, disbursement, money deposit, money keeping, and expense audit of local authorities.

Section 8The Permanent Secretary of MOI shall be in charge of this regulation and have authority in interpreting, or questioning of fact to any problems occurred, and designating measures or practices to be in accordance with this regulation.

Appendix 19 The Notification on 20 Sept 18/Responsible Agencies prior to this Notification

Notification of the Prime Minister's Office 2018 on 'Designation of agencies responsible for protection, promotion, and support the elderlies in accordance with the Act on the Elderly B.E.2546 (No3)

【Source: Royal Gazette 2019.8】

In the NCE's Meeting No.3/2561 on 5 July 2018, the Committee has agreed to add the rights of older people in the Section 11(13) of the Act of the Elderly B.E. 2546, by designating responsible agencies for protection, promotion, and older people support in order to provide LTC to dependent elderlies.

To ensure the protection, promotion, and older people support be in more appropriate and more effective manners, the Prime Minister's Office has issued a notification in accordance with the second paragraph of the Section 11 of the Act on the Elderly B.E.2546, and the Section 24 of the Act on the Elderly B.E.2546 amended by the Act on the Elderly (No.3) B.E.2560 as follows.

No.1 To added no.21 in the table attached to Notification of the Prime Minister's Office on Designation of agencies responsible for protection, promotion, and older people support in accordance with the Act on the Elderly B.E.2003 and 2010 as in the table attached with this notification.

No.2 This notification shall become effective as from the day following the date of its promulgation in the Royal Thai Government Gazette.

20 September 2018

General Prayuth Chan-ocha

Prime Minister

Table 13: Designation of agencies responsible for protection, promotion, and elderly support

No.	Rights of older people in being protected, promoted, and supported	Responsible Agencies
21	LTC for dependent elderlies in accordance with the Section 11(13)	Ministry of Social Development and Human Security Ministry of Interior Ministry of Labor Ministry of Education Ministry of Public Health National Health Security Office Local Authorities

Responsible Agencies prior to the Notification on 20 Sept 2018

【Source: Royal Gazette 2010.1, Unofficial Translation of the Table attached to the notification on designation of the Prime Minister's Office 2010 on Designation of agencies responsible for protection, promotion, and support the elderlies in accordance with the Act on the Elderly B.E.2546】

Table 14: Designation of agencies responsible for protection, promotion, and older people support

No.	Rights of older people in being protected, promoted, and supported	Responsible Agencies
1	Medical and public health services with priority for better convenience in accordance with the Section 11(1)	Agencies providing medical services in the affiliation of: - Ministry of Defense - Ministry of Education - Ministry of Public Health - Royal Thai Police - Bangkok Metropolitan - Public enterprises
2	Education in accordance with the Section 11(2)	-Agencies providing education in the affiliation of Ministry of Education
3	Religion in accordance with the Section 11(2)	-Department of Religious Affairs, Ministry of Culture -Office of National Buddhism
4	Information benefiting older people's living in accordance with the Section 11(2)	Agencies providing useful information for older people's living -Ministry of Social Development and Human Security -Ministry of Public Health -Local Authorities
5	Older people's occupation or vocational training as deemed appropriate in accordance with the Section 11(3)	Agencies providing services related to occupation or vocational training in the affiliation of: - Ministry of Labor - Ministry of Education - Ministry of Interior - Local Authorities
6	Self-improvement, social participation, or gathering in the form of networks	Agencies providing the said services in the affiliation of: - Ministry of Interior - Ministry of Social Development and Human Security - Ministry of Culture - Local Authorities
7	Facilitating for convenience and safety in buildings or places in accordance with the Section 11(5)	- Department of Public Works and Town & Country Planning - Bangkok Metropolitan - Pattaya City
8	Facilitation for convenience and safety while using vehicles in accordance with the Section 11(5)	Agencies providing the said services in the affiliation of: - Ministry of Transport - Bangkok Metropolitan
9	Facilitation for convenience and safety in other public services in accordance with the Section 11(5)	Agencies providing the said services in the affiliation of Ministry of Social Development and Human Security

Appendix 19: The Notification on 20 Sept 18/Responsible Agencies prior to this Notification

No.	Rights of older people in being protected, promoted, and supported	Responsible Agencies
10	Assistance on transportation fee as deemed appropriate in accordance with the Section 11(6)	Agencies responsible in transportation in the affiliation of: - Ministry of Transport - Bangkok Metropolitan - Public Enterprises
11	Waiving for entrance fee of the public places in accordance with the Section 11(7)	Agencies in affiliation of ministries, departments, local authorities, and public enterprises taking entrances fees
12	Assistance to elderlies being maltreated, illegally exploited, or abandoned in accordance with the Section 11(8)	Agencies responsible for the said services in the affiliation of: - Ministry of Social Development and Human Security - Ministry of Interior - Ministry of Justice - Office of the Attorney General - Royal Thai Police - Local authorities having elderly home in their area.
13	Suggestion, consultation, or assistance on legal issues in accordance with the Section 11(9)	Agencies responsible for the said services in the affiliation of: - Ministry of Justice - Office of the Attorney General - Royal Thai Police
14	Suggestion, consultation, or assistance on family issues in accordance with the Section 11(9)	Agencies providing the said services in the affiliation of Ministry of Social Development and Human Security
15	Provision of habitation, food, clothes as deemed necessary in accordance with the Section 11(10)	Agencies providing the said services in the affiliation of Ministry of Social Development and Human Security
16	Monthly Distribution of Old Age Allowance rightly and covering all target persons in accordance with the Section 11(11)	Agencies responsible for the said service in the affiliation of local authorities
17	Assistance to organize funeral in accordance with the Section 11(12)	Agencies providing the said services in the affiliation of Ministry of Social Development and Human Security
18	Traveling services or activities as announced by the NCE, in accordance with the Section 11(13)	Agencies providing the said services in the affiliation of: - Ministry of Tourism and Sports - Public Enterprises
19	Facilitation related to museum, archeological site, national archives; Implementation of religious, art, and cultural activities as announced by the NCE, in accordance with the Section 11(13)	Agencies providing the said services in the affiliation of Ministry of Culture
20	PR to let elderlies know their rights as announced by the NCE, in accordance with the Section 11(13)	*Office* of *Promotion* and *Protection* of *Chil dren*, *Youth*, the Elderly and *Vulnerable* Groups, Ministry of Social Development and Human Security

Appendix 20 Major Agencies and their mandates on Elderly Care

Table 15: Major Agencies and Mandates

Major Agencies	Major Mandates on Elderly Care
National Committee on the Elderly (NCE) (Inter-sector committee chaired by the Prime Minister, established by the Elderly Act 2003)	-Focal authority for policies, principal plan, guideline and framework development for supporting older people (i.e. National Long-Term Plans for Older Persons) -Regulations involving the administration of the Elderly Fund -Recommendations and observations to the cabinet and annual report on situation of older people in Thailand
National Health Commission (NHC) (Commission established by the National Health Act 2007)	-Recommendations to the Cabinet on health policies and strategies following the National Health Assembly (NHA)'s resolutions
Ministry of Social Development and Human Security -Division of Strategy and Plan -Division of Older Persons Welfare Promotion and Rights Protection -Division of Older Fund Administration	-Secretariat office of the NCE -Policy, plan, and regulation with regards to social assistance and older people rights' protection - Social Welfare Development Centers for Older Persons (Elderly home) - Social assistance and welfare for underprivileged older persons (temporary financial assistance of B500 for abused older people; B2000x3 times a year for older people with domestic problems; B2000 for funeral support) - Standards for nonprofessional care providers, and standards for the buildings and the environments of LTC facilities - Elderly Fund
Ministry of Public Health -Permanent Secretary Office -Department of Health -Department of Medical Services -Department of Health Service Support	-Policy, plan, and regulation with regards to health care and health care providers - Regional Health Office, Provincial Public Health Office, District Public Health Office - Healthcare / Health prevention and promotion to older people / Training Care Manager and Care Givers / Care Management system for CLTC - Hospitals at regional, provincial, district, and sub-district level / Elderly Clinic / Medical professions -Registration of institutions providing medical and nursing services / Regulation for LTC institutions under the Health Establishment Act/ Standards for LTC services
National Health Security Office	- Universal Coverage Scheme (UCS) - Local Health Security Fund (LHSF)[80] / LTC Fund
Ministry of Interior - Department of Local Administration (76 Local Administrative Organizations (LAO), Bangkok Metropolitan Administration, Pattaya City)	- Old Age Allowance (OAA) and Disability Allowance payment - 13 Public Elderly Homes (operated by Provincial Administrative Organization under the Ministry of Interior) - 11 Service centers for the Elderly - As of Aug 2018, no mandate on elderly care.

[80] LHSF was initiated by the NHSO to increase awareness and involvement of local governments and communities in health promotion and prevention activities. NHSO financed 45 Baht per capita to the LHSF and Local Authorities Organizations (LAOs) are obliged to match the budget of 10%, 20%, or 30% to the fund, according to fiscal capacity. However, participation to the fund is on the voluntary basis.