Development of the long-term care system in Thailand

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Abstract

Thailand is on the verge of becoming an ‘aged society,’ with 13% of its population aged 65 years and over. Under these circumstances, the Government of Thailand has developed a community-based long-term care (LTC) system on a pilot basis, taking advantage of local and external knowledge and resources.

Japan’s official development assistance for Thailand to develop an LTC system has contributed to the development of models regarding community-level integration of LTC, the development of specialised care and the rehabilitation capacity. This has led to the creation of Thailand’s own LTC model, which is being scaled up as pilot LTC programs.

However, there are policy concerns for Thailand in expanding standardised quality LTC across the country in the future: (1) There is a lack of regulations for private LTC providers in urban areas; and (2) financial resources will need to be secured as LTC expands nationwide.

Keywords： Thailand, Japan, ageing, universal coverage, long-term care

1. Introduction

Along with economic development and various health policy implementations, the life expectancy of Thai people has increased to 77.7% in 2020[1]. With its declining mortality rates, the proportion of the population aged 65 years and over stands at 13.0% in 2020, and only 1% remains to become an ‘aged society.’ The proportion is expected to increase to 19.6% by 2030 and 29.6% by 2050[2]. Thailand is required to urgently establish and strengthen a long-term care (LTC) system at the national level for the growing ageing population.

Some factors need to be considered when building an LTC system in the context of Thailand. First, ageing is taking place while rural areas, especially in its northeast provinces, remain relatively underdeveloped despite economic development. Second, financial resources for LTC may be limited, as the proportion of government health expenditure is already at 15% of overall government expenditure[3]. Third, there are a limited number of rehabilitation specialists. In Thailand, an LTC system needs to be configured to correspond to geographical, economic and human resource settings.

A community-based integrated LTC system is a solution to these constraints. It can improve the quality of LTC services focused on older adults with the integration of health and social services in collaboration with the support from local organisations and people, enabling ageing in place, which allows older adults to ‘maintain the relationships and community networks that can foster well-being’[4]. Thailand is currently developing such a system, building on its district health system consisting of multiple stakeholders and existing volunteer systems.

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In Japan, a long-term care insurance (LTCI) system was developed in the late 1990s. The system is centred on health and social service integration, home-based (except for those requiring intensive nursing care) and community-based care. Through the reforms in 2006 and onwards, it has further evolved toward a 'Community-based Integrated Care System (Chiiki-houkatsu-care).' With this historical background, Japan has been providing official development assistance in the field of LTC through the Japan International Cooperation Agency (JICA) to twelve Asian and Latin American countries and the Southeast Asia region[5]. In Thailand, JICA has executed three projects consecutively to develop care models for older adults since 2007.

The two countries are different, but both can benefit from bilateral technical cooperation in the field of LTC. Although there is a wide gap in social, service, and financial conditions between the two countries, they share some ageing policy concerns: (1) the size of households has been dwindling in both countries, although at different rates, weakening the role of family care; and (2) the need for LTC is expected to rise as the size of the older population increases, requiring both countries to develop and sustain LTC in response to the growing demand. In these aspects, policy measures implemented in Japan can be relevant in the context of Thailand, and there is also an opportunity for mutual learning for developing new community care designs for both countries.

However, there is a stark difference between the two countries. In Japan, most services are provided by the private sector, regulated by the LTCI Act, while in Thailand current pilot LTC programmes are funded by the government and concentrated on public service providers and volunteers, leaving the private sector substantially unregulated. There is a certain limitation to the ability of bilateral technical cooperation to immediately intervene in the issue where basic structures between the two countries differ.

2. Thailand's LTC policy measures

In Thailand, family care is recognised as an expression of filial piety. However, the size of households has been declining. Urban areas offer job opportunities for higher income generation, which leads to the migration of workers[6], resulting in smaller households. The rate of older adults aged 60 and older who co-reside with their children decreased from 77% in 1986 to just above 50% in 2017[7]. This is one of the reasons family caregivers are beginning to feel stressed and need respite care. A study in Nakhon Ratchasima Province showed that the prevalence of high caregiving burden was 41.7% of 314 subjects and that time constraints were a major cause of burden[8]. With diminishing household capacity, the form of caregiving is becoming more diversified than before. If family members live away from their parents, they may make home visits on weekends, make frequent calls, and/or send money. In addition, extended family members may take on the role of caring for older parents instead of their children[9].

The Government of Thailand has implemented policies regarding LTC that correspond to social and demographic changes. Initially, Thailand emphasised family care in the First National Long-term Plan for Older Persons (1982–2001), and in order to legally support that, the Senior Citizen Act was passed in 2003. In the same year, the Ministry of Social Development and Human Security (MSDHS) deployed elderly homecare volunteers in eight provinces, perhaps building on the earlier experience of another volunteer system in the health sector. Their role was to provide daily living support to older adults. This system was scaled up to the national level in 2005. As the Ministry of Public Health (MOPH) has fielded village health volunteers since 1997, some village health volunteers have been appointed as elderly home volunteers.

In 2007, the Second National Long-term Plan for Older Persons was revised to emphasise family care and the role of the community. In 2009, the second National Health Assembly, which works as a soft power to influence Thailand's health policy[10], was held to endorse the development of an LTC system and to define LTC. Later, the 12th National

Economic and Social Development Plan (2017–2021) embodied improvements in the LTC system and an age-friendly environment. In 2015, the National Health Security Office (NHSO), the purchaser of Universal Coverage Scheme (UCS) for the informal sector, allocated BT600 million to execute a community-based LTC pilot project[11]. In 2016, the NHSO funded the 'Development of a Public Health LTC System for Dependent Older People in LTC Subdistricts,' which provided care to 193,000 older people by 2018[12]. The fund is distributed to the newly established LTC fund at the Tambon level (administrative sub-divisions of provinces) and is co-financed and co-managed by the local administration office. The programme has introduced care management, deploying care managers who are mostly trained nurses from local-level government hospitals. It provides 70-hours of training to volunteers or paid community caregivers[13]. This is a major shift from conventional, on-the-spot support to management-based residential LTC. As of 2020, over 90% of sub-districts nationwide have met the criteria for LTC services set by the MOPH. The criteria include having care managers, care givers and/or elderly care volunteers and the condition in which local administration office and/or community employs a care management system and develops care plans[14].

3. Relevance of Japan's LTC policies in the context of Thailand

Japan's initial ageing policy was formed in the late 1970s. In 1973, medical services for people aged 70 and older were made free of charge, which accelerated the admission of older adults to hospitals. The weakness of social welfare services and support created a situation where many older people were admitted to existing hospitals for frailty and social reasons, not necessarily health problems, known as 'social admission'. There was a lack of specialised care for the increasing older population at that time. In addition, as Japan entered into a moderate economic growth period in the late 1970s, it was anticipated that the medical and social welfare costs for the increasing number of older persons would rise in the future[15]. The Government of Japan initially sought a solution in family care to contain LTC costs, taking advantage of the high multi-generational household rate at that time[16].

In 1990, the rate of the population aged 65 years and older was 11.9%, which is close to Thailand's current rate of 13.0%. The proportion of people aged 65 years and older who live in a multi-generation household was 46.7% in 1986, but this had declined to 35.5% by 1995 (the latest available rate is 10% for 2019)[17]. Family care created a serious burden on caregivers and gradually weakened as the social structure of multi-generational households shrank. In Thailand, the rate of co-residency with a child for people aged 60 and older was 76.9% in 1986, a much higher rate than that of Japan, but it also declined to 51.5% by 2017[18]. Although there is still a wide gap in household composition between the two countries, Thailand's declining trend poses a threat to the dependency on family caregivers, as in Japan.

Against the background of both social admissions that plunged older adults into unnecessary institutional medical care, which resulted in care that was not people-centred, and the weakening capacity of family caregivers, the LTCI was enacted in 1997 after intensive multi-stakeholder discussions over three years and implemented in 2000 after thorough preparations and coordination between the central and local governments. The main pillars of the LTCI were initially developed in 1994 by the 'Study Group for Long-Term Care and Support for Independence,' set up by the Ministry of Health and Welfare. The principle was to support older adults' independence, enabling them to maintain independence and quality of life[19]. To realise this principle, the following directions were included in the group's report: (1) the concept of free choice, whereby older people can choose service providers on their own rather than receiving services decided by the government; (2) home-based or residential care to enjoy life at home and in a familiar neighbourhood; (3) integration of health and social welfare services, expansion of services by promoting private service providers and enhancing their quality through competition; (4) specialised support to identify older people's needs and connect them to services, based on the concept of care management, which includes needs assessment and care plans. ('Care manager'

was proposed later by 'Council for Health and Social Welfare for Older Adults' in 1995); and (5) establishment of social insurance that provides mutual benefit based on social solidarity[20]. Later, it was decided that the local government should be designated as the insurer because the needs and service levels vary depending on the local situation.

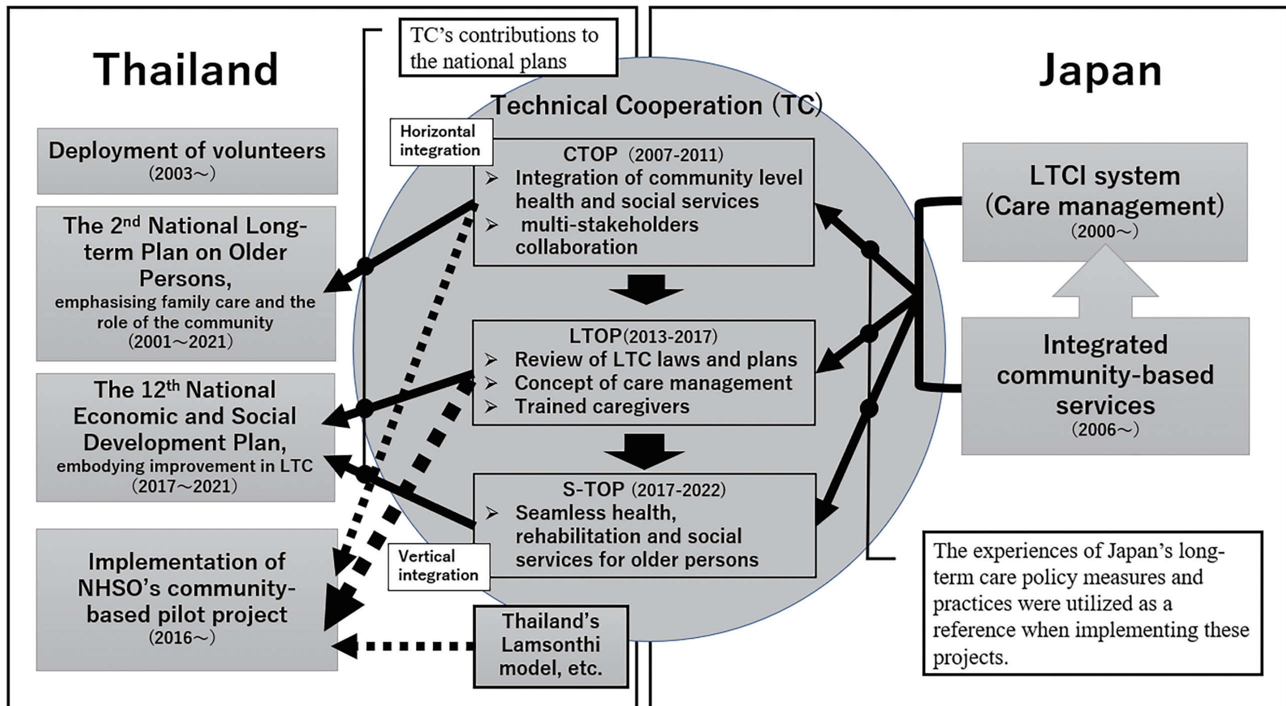
Several reforms have taken place since the establishment of the LTCI in 2000. To control the rising cost of LTC, two policy measures were implemented through an LTCI Act amendment in 2006: (1) hospital beds under the LTCI system were abolished; (2) some LTC services were redefined to emphasise community-based prevention for those with moderate frailty, and groups requiring assistance were re-categorised accordingly[21].

However, initial community-based prevention was not necessarily successful. A priority was placed on high-risk older people who were supposed to be guided to community intervention programmes after screening. However, the participation rate for that screening was low due to physical, environmental and other barriers[22]. In 2015, a community-based population strategy was introduced to approach all people and mobilise community activities, such as the creation of gathering places, to reduce disability incidences. This strategy seems successful as the number of gathering places has been on the rise[23].

Thailand, with its falling rate of multi-generational households and increasing burden on family caregivers, has chosen community-based LTC care as a solution by utilising community resources under limited service, human, and financial resource conditions. This is the same reason Japan instituted the current LTCI system. Therefore, the policies and practices that evolved in Japan concerning home-based and residential care, integration of health and social welfare services and community-based approach with local government at its centre, can be relevant if they are translated into Thailand's conditions. Thailand has made its own efforts to integrate health and social welfare services provided separately by the MOPH and MSDHS. For example, Lamsonthi Hospital in Lopburi Province developed an LTC system that included care management, the deployment of multidisciplinary care teams and collaboration with community stakeholders. However, no standard community-based care for older adults has been developed as of 2013[24]. Such local models are vital for developing a system that suits country-specific conditions. At the same time, the national standards of care management and integrated community LTC, already applied nationwide in Japan, can add value to developing Thailand's LTC system.

4. Technical cooperation from Japan for Thailand's LTC

One of the characteristics of Japan's technical cooperation is to utilize Japan's policy measures and practices as a reference to strengthen the institutions of developing countries, and develop models tailored to country and community-specific conditions. Japan has provided technical cooperation through JICA in the field of LTC for Thailand since 2007, as shown in figure 1.



Source: The figure was drawn by the authors.

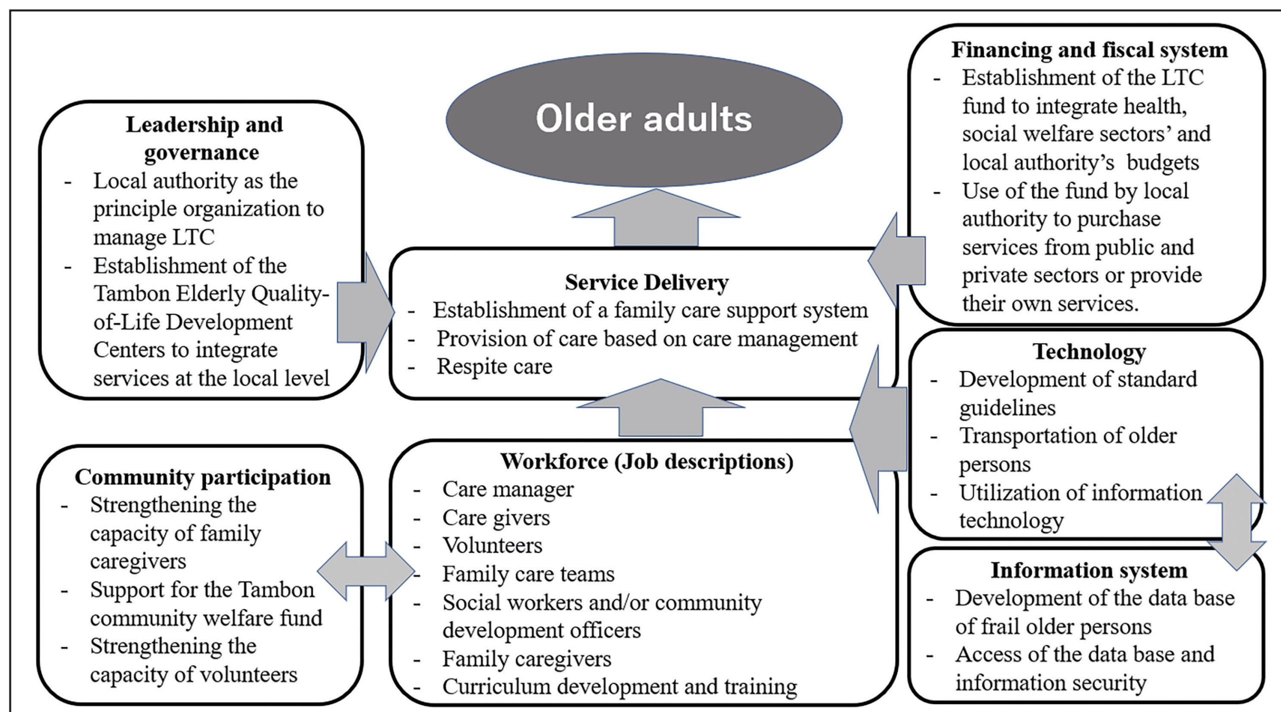
Figure 1. Japan's technical cooperation for Thailand

The first project, called 'CTOP' (Project on the Development of a Community-based Integrated Health Care and Social Welfare Service Model for Older Persons), commenced in 2007, in order to concretise the policies upheld in the Second National Long-Term Plan. It aimed to develop models to integrate health and social welfare services at the community level and implement pilot sub-projects at four sites, namely, Yang Hom in the Province of Chiang Rai, Sa-Ard in the Province of Khon Kaen, Bang Si Thong in the Province of Nonthaburti and Ban Na in the Province of Surat-Thani, to explore multi-stakeholder collaboration methods and the integration of services in divergent economic and geographic environments. A PDCA cycle was applied at the pilot sites. It entailed identification of needs, project design based on needs analysis, decision-making at a community committee, multi-stakeholders' participation in activities, a review process and coordination, and empowered local governments and increased local stakeholders' participation[25]. The lessons from these pilot sites were extracted and compiled into recommendations entitled 'Universal Lessons', focusing on local ownership, a needs-based integration approach and cyclical management.

During the late 2000s and early 2010s, LTC models were developed at different locations, such as Lamsonthi in the Province of Lopburi and Bang-Si Thong in the Province of Nonthaburi[26]. CTOP was one of these models. Its distinctive feature was that it extracted lessons from four different sites, aiming for wider applications at the beginning of the project.

Through the implementation of CTOP, the project stakeholders recognised that there was a need for more systematic LTC based on standardised assessment and specialised care to ease the burden of family caregivers. To fill this gap, a new project called 'LTOP' (Project on Long-term Care Service Development for Frail Elderly and Other Vulnerable People) was launched in 2013 and carried out until 2017. The LTOP is intended to provide technical support to the government of Thailand in shaping its LTC policies, utilising the knowledge acquired through the implementation of the care management system in Japan. It developed a service model based on the concept of care management and created programmes to train caregivers and care managers. Building on the trials in six pilot sub-projects and policy discussions on the LTC system between Thai and Japanese experts, LTOP produced policy recommendations on LTC,

building on the WHO's health system framework, an overview of which is shown in figure 2. The findings of LTOP were applied to MOPH's own pilot projects launched in 2013 in provinces that established a care management system for community-based LTC. Together with other Thai initiatives, these efforts led to the establishment of the LTC Fund in 2015 and the implementation of Thailand's pilot LTC project that was put into operation in 2016[27]. The LTC Fund was built on the financial system developed by NHSO, service models evolved by Lamsonthi Hospital and LTOP, and the care manager and caregiver training framework formulated by LTOP[28].



Source: The figure was drawn by the authors based on LTOP's policy recommendations[29]

Figure 2. Policy recommendations produced by LTOP

Following LTOP, another project called 'S-TOP' (the Project on Seamless Health and Social Services Provision for Elderly People, 2017–2022) tested models aimed at strengthening the seamless transition of older adults between health services and living support by increasing the capacity of rehabilitation. A series of the bilateral technical cooperation based on Japan's policy measures and practices has had a certain effect in demonstrating needs-based LTC service integration models and developing a care management system for Thailand's own pilot projects, which are rapidly spreading to the national level.

The technical cooperation provided also an opportunity for the Japanese side to learn how informal actors such as volunteers and monks who are close to those needing care could contribute to LTC. For instance, a care manager from Japan who had worked as JICA's short-term expert has begun to invite a monk to their conference meeting for some clients back in Japan.

5. Remaining system constraints in Thailand

The stark differences between the two countries in terms of the LTC systems are as follows: (1) in Japan, LTC is provided mostly by private service providers, while in Thailand, most pilot projects have been run by government and

community organisations, not including the private sector; and (2) Japan's social insurance system, which is financed 50% by premium and another 50% by central and local government subsidies, was introduced and strengthened the LTC financial base, while in Thailand, the current pilot LTC is co-financed by tax-based resources from the UCS and local governments.

In Japan, the LTC system attaches great importance to ensuring older adults' choice of LTC through competition among private LTC providers, which are regulated through the LTCI Act. Unlike Japan, much of the public LTC depends on local volunteers in Thailand. Building on this foundation, Thailand's current pilot programmes trained 44,000 community caregivers as of 2018, including health and/or elderly care volunteers. The system is realistic and has merit in deploying caregivers who are deeply rooted and devoted to the local community. However, the surge of private LTC providers, which fills the demand gap in urban areas where community networks are weaker, is left outside of the system. In Bangkok, older people who need care go to either hospitals or rapidly increasing small-scale informal providers. Because there is no national standard except for those related to LTC facilities, the quality of these informal providers' LTC varies, and some of these offer LTC of poor quality[30]. It is pointed out that in relation to private LTC providers, 'state regulation is largely absent or ineffectual' and that 'this is due to the fragmentation of responsibilities across different agencies'[31]. JICA's previous projects have not addressed this issue.

Although a similar social insurance system to that of Japan would make it possible to broaden the financial base for LTC, it may not be immediately applicable to Thailand. A complex premium collection mechanism is required to establish such a system. In the case of Japan, it was decided that the premium would be collected through the existing premium collection mechanism of social health insurance for working-age populations and by deducting the premium from the pension benefit for older adults before LTCI was implemented[32]. On the contrary, given that 75% of its total population was in the informal sector, the Government of Thailand made UCS tax-funded[33] (and avoided premium collections) in order to achieve universal health coverage in a relatively short period of time. In the case of Thailand, establishing an LTCI system might require reconsidering much wider structures encompassing health and social welfare institutions. This would demand a big political debate, going beyond the technical spheres. Therefore, the path for Thailand in the foreseeable future would be to continue to secure financial resources for LTC from the current tax-based system, and in this case, the country may need to begin inter-ministerial discussions involving the Ministry of Finance, MOPH and MSDHS as a first step to further scale up LTC to the national level.

6. Conclusion

Japan's bilateral technical cooperation in the field of LTC, employing its policy measures and practices together with the Lamsonthi and other local-level pilot programme initiatives, has developed an integrated community approach and care management for Thailand to institute a community-based LTC system that fits its geographical, economic and human resource conditions. The approach is made from the mixing of the local knowledge and the knowledge gained from Japan's policy practices. Subsequently, it has contributed to the creation of the pilot projects, which are being implemented by the Government of Thailand.

With the government projects covering most of the sub-districts, Thailand would face at least two standing issues: one is the absence of regulations for the private LTC providers, which has permitted the existence of varied qualities of LTC in urban areas and between rural and urban areas; and the other is the financial space for the increasing demand for LTC. Thailand will need to make further strides in the future to regulate the private sector and ensure future LTC finance to expand standardised, quality LTC across government, private actors, and the country.

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