LONG-TERM CARE

FOR DEPENDENT ELDERLY

IN THE NATIONAL HEALTH SECURITY SYSTEM

NHSO
National Health Security Office

GLOSSARY

ASSESSMENT USING THE BARTHEL ADL INDEX FOR ACTIVITIES IN DAILY LIVING

This is a tool used to classify persons as to whether they are eligible for long-term health under the UCS. The Index has a maximum score of 20; if a person scores 11 or less, that person is considered dependent.

DEPENDENT ELDERLY

There are two types of dependent elderly in the UCS: (1) Home-bound, which includes persons with some mobility in the household but need help for some daily activities; and (2) Bed-bound, which refers to those who are immobile and need assistance for movement or daily activities.

LONG-TERM CARE (LTC)

This refers to on-going care for dependent elderly, starting from the authentication of their eligibility, compiling information of those considered for LTC, collection of relevant personal information, arranging benefits according to the dependent groups, compensation disbursement, monitoring, and evaluation.

CARE MANAGER (CM)

The CM is the primary person responsible for managing and coordinating with a multidisciplinary team, the local government organization, and related entities, in order to provide LTC for dependent elderly according to the set of benefits. The CM health must be trained by relevant agencies using curricula of the Department of Health of the Ministry of Public Health, or equivalent.

CAREGIVER (CG)

This is a person who has completed at least 70 hours of training in accordance with the curriculum approved by the Subcommittee on LTC for Dependent Elderly, or other relevant subcommittee under the National Health Security

Committee. The CG provides direct care for dependent elderly including assisting with daily activities and ensures proper housing.

FAMILY CARE VOLUNTEER (FCV) FOR HOME-BOUND OR BED-BOUND ELDERLY

The FCV can be a family member age 15 years or older, who has received at least 18 hours of training in LTC for dependent elderly household members, and provides day-to-day care for the dependent elderly person. The FCV also provides information and awareness-raising for other members of the family.

VILLAGE HEALTH VOLUNTEER (VHV)

The VHV are selected from villagers in each community, and are trained according to the curriculum set by the Ministry of Public Health. The VHVs play an important role as a leader in health behavior change, public health news sharing, dissemination of knowledge, planning and coordinating public health development activities, and providing public health services such as health promotion, disease surveillance, prevention of disease, primary care, and other health assistance by using drugs and medical supplies in accordance with the scope prescribed by the Ministry of Public Health. The VHVs refer cases for rehabilitation, and organize health development activities for the people in their home village/community.

ELDERLY CARE VOLUNTEER (ECV)

These persons are recruited, trained and managed by the Ministry of Social Development and Human Security, and are volunteers who provide home-based care and maintain contact with all the elderly in the community. These volunteers conduct surveillance and issue warnings of unmet need. They support the provision of services and social welfare by assisting and improving the daily lives of the elderly in the following areas: physical health, mental health, intellectual and memory ability, economic status, social and habitat, and environmental conditions.

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1 INTRODUCTION

The rapid growth in the number of Thai aging citizens is leading to a formidable challenge for the public health sector. In 2018, the proportion of the Thai population aged 60 years or over was 18% of the total population in Thailand (about 11 million persons). That proportion represents a seven-fold increase from the level 50 years prior. Further, it is projected that, in the next 20 years, the proportion of Thai elderly will reach 30%.[1] The explosive increase in this segment of the population contributes to the country's epidemiological transition, where a pattern of predominately infectious diseases shifts to one with high prevalence of chronic non-communicable diseases (NCDs). Most NCDs require continuous care or treatment, and these conditions create the increasing number of elderly who depend on relatives and other members of the household for care. The 2013 Survey of Thai Elderly Health conducted by the Department of Health (DOH) of the Ministry of Public Health (MOPH), found that two out of five (41%) of the sample had hypertension, one out of five (18%) had diabetes, 6% had a disability, and 1% were bed-bound.[2] At the same time, the capacity of the average Thai household to care for dependent elderly is declining due

to the shrinking size of the family. In 1980, the average Thai household size was five members, and that decreased to only three persons by 2016. Further, the percent of elderly living alone increased from 6% in 2002 to 9% in 2014.[3] Another factor is that more women, the primary care-provider in traditional Thai households, are working outside the home.

In the past, health care and social support for the elderly in Thailand have been fragmented, lacked integration, were ad hoc and sporadic, and suffered from an ineffective fiscal mechanism. In addition, the hospital-based care system was still primarily geared toward acute care. Thus, there was neither an emphasis on care for NCD and chronic conditions or age-related disability, nor intermediate or long-term care (LTC) for dependent elderly.[4, 5]

For these reasons, it is imperative that Thailand must establish a cost-effective LTC system. Efficient LTC will reduce the financial burden of health care (treatment, medicines, in-patient care) for dependent members of the family,[5] and, in particular, the lower socio-economic status households. Those households already face difficulty in making ends meet, and if there are dependent members of the household, the burden to cover the family's expenses is even greater. Consequently, the family has no time to care for a dependent elderly member of the household, and the elderly person may be abandoned.[6] In addition, without a comprehensive LTC system, the government is confronted by the fiscal burden for dependent elderly's health care.

IN 2018, THE PROPORTION OF THE THAI POPULATION AGED 60 YEARS OR OVER WAS

18%

OF THE TOTAL POPULATION IN THAILAND

2

PRINCIPLES, STRATEGIC PLAN, AND RESPONSIBLE AGENCIES
OF THE LTC SYSTEM FOR DEPENDENT ELDERLY

2.1

PRINCIPLES OF LTC

The decline in health status with age and the deteriorating function of organs or illnesses (e.g., stroke, injury from accident, mental illness, dementia) are causing an increasing number of elderly to become dependent through one or more disabilities. These elderly face difficulty in accessing a health care provider, and their daily life is severely disrupted. Therefore, these people need more than just medical services. Instead, what is needed is a housing environment with a universal, elderly-friendly design, tailored economic support, and supportive family members to care for elderly dependent members.[5]

THESE DEPENDENT ELDERLY FACE DIFFICULTY IN ACCESSING A HEALTH CARE PROVIDER, AND THEIR DAILY LIFE IS SEVERELY DISRUPTED. THESE PEOPLE NEED MORE THAN JUST MEDICAL SERVICES.

Nursing homes and other assisted living facilities are an option for families to alleviate the burden of dependent elderly care but, in Thailand, most of these are privately owned and very costly. Regular expenses such as room, board, and general care cost around 15,000-26,000 baht/month, and additional services, such as rehabilitation and occupational therapy, cost around 1,000-4,000 baht/month. Clearly, the financial hurdle deprives most of the population from this kind of institutional care.

Given the physical constraints of the elderly to access to public health services and the high cost of nursing homes, community-based LTC has become increasingly important. In recent years, a policy movement has emerged to establish LTC for the elderly through multiple channels. These include the National Plans for Older Persons, National Elderly Assembly, and the National Health Assembly. The above information emphasizes the need for organizing community-based long-term care services, along with promoting and supporting localities as the main operating units. There are several strengths in the context of Thai society that are indigenous to the Thai culture and which support care for the elderly in the community settings, notably family ties and the value of inter-generational gratitude (*ga dtan yuu*). These cultural values motivate family members to care for the older persons in their families out of a sense of filial duty. Additionally, Thais have a deep sense of social capital, which leads to the success of community-based LTC services. This social capital includes volunteering, community savings funds, and the local administrative organization (LAO), becoming a conduit for integration and interconnectedness within the community.[5]

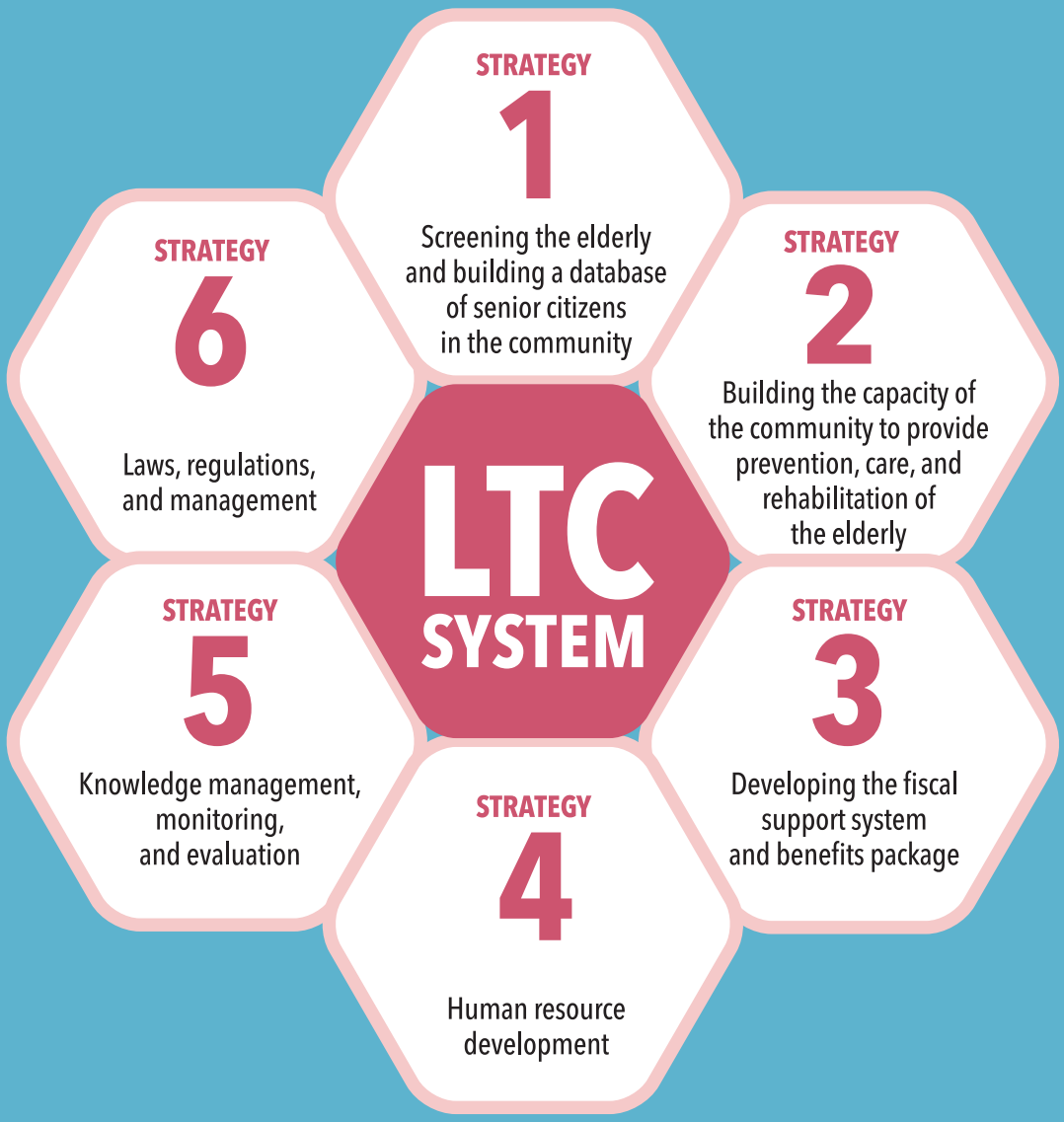
THE OBJECTIVE IS TO BUILD CAPACITY OF INDIVIDUALS, FAMILIES AND COMMUNITIES TO CARE FOR THEIR ELDERLY MEMBERS SO THAT THEY CAN

AGE WITH DIGNITY

2.2

STRATEGIC PLAN FOR IMPLEMENTING A SYSTEM OF LTC FOR THE ELDERLY

The National Health Security Office (NHSO) developed the **"Strategic Plan for Implementing a System of Long-term Care for Dependent Elderly for the period of 2014-18".** The objective is to build capacity of individuals, families and communities to care for their elderly members so that they can age with dignity. The strategy calls for efficient linkages between the health and social services system, and the central focus is on those family members who are home-bound or bed-bound. The local medical facility provides health care knowledge and clinical care to the families. The philosophy behind this approach is to make use of the existing community assets and resources, including human resources including (e.g., Village Health Volunteers – VHV, Elderly Care Volunteers - ECV). There are Senior Citizens' Clubs in every community throughout the country, and the Local Administrative Organizations (LAO) play a major role in integrating support among the relevant services[5]. The Local health security fund, a collaboration of the NHSO and the LAO over the past decade, is the financial mechanism to support the LTC activities.[8]



STRATEGIC PLAN FOR IMPLEMENTING A SYSTEM OF LTC FOR THE ELDERLY

THE FOLLOWING DESCRIBES THE SIX COMPONENTS OF THE STRATEGIC PLAN FOR LTC OF DEPENDENT ELDERLY:

STRATEGY 1

Screening the elderly and building a database of senior citizens in the community: These steps are necessary to create an accurate picture of the number and health status of the elderly, and to identify those who are eligible for services under the benefits package. There is a set of elderly classification criteria for standardized screening for need of assistance. The next step is to train the VHV/ECV to conduct the screening and enumeration of elderly by needs status. This produces an accurate and up-to-date elderly database for planning LTC, social welfare, and related services for each group.[5]

STRATEGY 2

Building the capacity of the community to provide prevention, care, and rehabilitation of the elderly: This component calls for the linking of the community-based services with clinical care to provide a comprehensive LTC system and essential infrastructure for LTC for dependent elderly in the community. The system and infrastructure should include the following: 1) Service and system standardization of the facilities, including the Quality of Life Development Center, elderly day care center, respite care center, and community nursing home. The standards for human resources such as Care Giver (CG) and Care Manager (CM), and standards for services and a referral system among home, village, and health care facility are in place. 2) Outreach care for the elderly at home and in the community, and the establishment of a center for the development of quality of life and vocational activity (Senior Citizens Multipurpose Center).[5]

STRATEGY 3

Developing the fiscal support system and benefits package: This component of the plan aims to ensure a comprehensive package of services which meets the basic needs of the elderly with an appropriate and sustainable financial support system. Therefore, the integration of LTC budgets of the various related agencies is required.[5]

STRATEGY 4

Human resource development: The plan calls for ensuring an adequate number of trained personnel who meet the standards for quality LTC of the elderly. Therefore, the LAO, community, and the private sector should be encouraged to participate in the planning and management of human resources to serve the needs of the community. In addition, this requires a standard training curriculum for these personnel, the CM and CG in particular, and recruiting, training motivating human resources to deliver LTC in community and health facility.[5]

STRATEGY 5

Knowledge management, monitoring, and evaluation: This component calls for building a basic level of knowledge and compiling the relevant data and information to monitor the LTC services and assess outcomes. This includes developing the benefits package for prevention and care for dependent elderly, implementing a model of community-based services, managing the funds at various levels to ensure integrated services, promoting quality of care, and evaluating implementation of LTC.[5]

STRATEGY 6

Laws, regulations, and management: This component is implemented to create an enabling environment for all related agencies in the LTC system. This requires revising the Civil Servants Medical Benefits Scheme (CSMBS) to ensure coverage of community care, identifying the LAO as the main agency in overseeing LTC, and revising local regulations for fluent management, and, lastly, revising the existing LTC service, for example, by improving the quality control of private nursing-home and at-home care.[5]

2.3

KEY AGENCIES FOR EACH OF THE SIX STRATEGIC COMPONENTS

According to the strategic plan, there are several government agencies involved in the implementation. These include the following:

1) LAO (under the Ministry of Interior);
2) Ministry of Public Health (MOPH);
3) NHSO;
4) Ministry of Social Development and Human Security (MSDHS);
5) Ministry of Education (MOE);
6) Council of Public Health Professionals; and
7) Comptroller-General Department of the Ministry of Finance.

In addition, the Foundation of Thai Gerontology Research and Development Institute (TGRI), which collects and compiles research and information about Thai senior citizens, and other related non-government and private organizations, are key players in strategy implementation.[5]

These agencies and organizations are involved in all six components of the national strategy in accordance with their mission. The NHSO collaborates with the MOPH, MSDHS, and LAO to develop the benefits package for LTC of dependent elderly, and to design the financial mechanism to maximize access to standard quality services. The development of standards for services and personnel involved in community-based LTC is the responsibility of the MOPH, MSDHS, and LAO. In addition, the evaluation survey of older persons and creation of a senior citizens database is the responsibility of the LAO and Tambon Health Promotion Hospital (THPH) because of their proximity to the target population.[5] More detail on the responsibilities of the various agencies and organizations is provided in the appendix.

In addition to the community-based LTC for dependent elderly, agencies in the public, private, and Civil Society sectors assist in LTC in other ways. Article 11 of the 2003 Act on the Elderly stipulates that the elderly are to receive social protections and support, such as universal and equitable monthly cash subsidy, essential food/clothing/lodging, and elderly-friendly buildings and public infrastructures. This support should be funded by each agency's budget.[9] Table 1 summarizes the key agencies and responsibilities.

Table 1

ROLE OF GOVERNMENT AGENCIES IN LTC[9-11]

AGENCY	KEY RESPONSIBILITY
MSDHS	• House renovation for the elderly • Development of standards for elderly housing • Arrangement of day care for the elderly at Senior Citizens Clubs
Department of Local Administration, Ministry of Interior	• Sliding scale monthly cash subsidy for the elderly
Ministry of Labor	• Income security for old age
Office of Non-formal and Informal Education, Ministry of Education	• Training CG
Private sector	• Private nursing homes
Civil Society	• Community savings group • Senior Citizens Clubs

Box 1

LTC IN JAPAN: LESSONS FOR THAILAND

Japan has the highest proportion elderly population among countries in the world. In 2016, the proportion of the Japanese population age 65 years or older was almost 30 percent. At the current rate of growth, the time it will take for the elderly population of Japan to double in size is only 24 years, compared to 40 years in Germany and 115 years in France.[12]

In 1961, Japan achieved universal health coverage and, in 1973, Japan started providing free medical service to all citizens. In 1983, a co-pay system was introduced to cover some of the cost of care. The family size of Japanese people is declining and, thus, families do not have the capacity to take of the older family members. If an older family member needs hospital care, in some dire cases, families abandon elderly relatives after they are admitted to the hospital. This phenomenon is called "social admissions," thus increasing the cost of inpatient hospitalization. Japan has instituted a Long-Term Care Insurance system to help reduce family expenses, and integrate medical and social welfare services. Those eligible for LTC are divided into two groups: those age 65 years or older, and those age 40-64 years who have at least one of 16 age-related diseases/conditions.[12, 13]

The LTC insurance system covers care in the clinical setting, the community, and the home.[10] However, there is no compensation or support for the caregivers of the elderly in the family. Increasingly, family members are having to play a greater role at a time when LTC costs in nursing facilities are rising. Accordingly, the Japanese government is now trying to implement community-based LTC which integrates medical, nursing, and preventive care with support for everyday living for dependent elderly. This approach is seen as preferable to institutionalization, since older people can be cared for in a familiar environment. This also makes Japan's Long Term Care Fund more sustainable.[12]

The experience of providing LTC for the dependent elderly in Japan should be a very useful guide for Thailand. In addition, the Japan International Cooperation Agency (JICA) helped Thailand develop its own LTC system for dependent elderly that integrates medical services and social welfare through the CTOP, LTOP, and S-TOP Projects, as well as helped to develop a Care Manager training course.

3

STEPS IN IMPLEMENTING LTC FOR DEPENDENT ELDERLY

As a first measure, the NHSO provides benefits for persons age 60 years or older who are dependent, or home-bound/bed-bound, and are eligible under the Universal Coverage scheme (UCS). It was recommended that the LTC benefit covers others as well.[14] Accordingly, in FY 2020, the NHSO expanded LTC coverage for all persons who are home-bound/bed-bound and all elderly with a government-sponsored insurance scheme (including the CSMBS and Social Security Scheme).[15]

The three main agencies which oversee LTC for dependent elderly are: (1) LAO; (2) Service provider, including THPH and health centers of the MOPH, and Centers for Quality of Life Development for the elderly and disabled of the LAO; and (3) NHSO. These three agencies' responsibilities are in accordance with Strategy 2 of the Strategic Plan for Implementing a System of LTC for the Elderly (2014-18) in specific rehabilitation services and support for community-based care. The LTC program is used as a key mechanism for linking data across related agencies.[5, 16]

The first step in implementing LTC for dependent elderly is to appoint a "Sub-committee for Support LTC for Dependent Elderly" comprised of the following individuals: (1) Chief Executive Officer of the LAO; (2) representative of the local Health Security Office; (3) Director of the local hospital; (4) District Health Officer; (5) Chief of the Primary Care Unit; (6) Care Manager; (7) Care Giver; and (8) Chief Administrator of the LAO or appointed staff.

Once the subcommittee is established, the following steps should be implemented:

1

The local service provider conducts a survey and assessment of older persons to identify the dependent elderly (i.e., home-bound/bed-bound) using a standard assessment, the Barthel ADL Index, and then records the data in the LTC program.

2

The LAO inspects and confirms the screened cases in the LTC program.

3

The service provider develops a care plan (CP) and submits the project to the LAO. The subcommittee reviews and approves the CP, then the relevant entities formulate an agreement to provide LTC services.

4

The NHSO inspects and compiles the data entered into the LTC program to allocate a budget for the planned services.

5

The NHSO transfers budgets for the LTC services in two parts: One is for service provider, and the other is for the LAO by paying to the local Health Security Fund.

6

The Care Manager (CM) and Care Giver (CG) deliver LTC as per the care plan (CP).

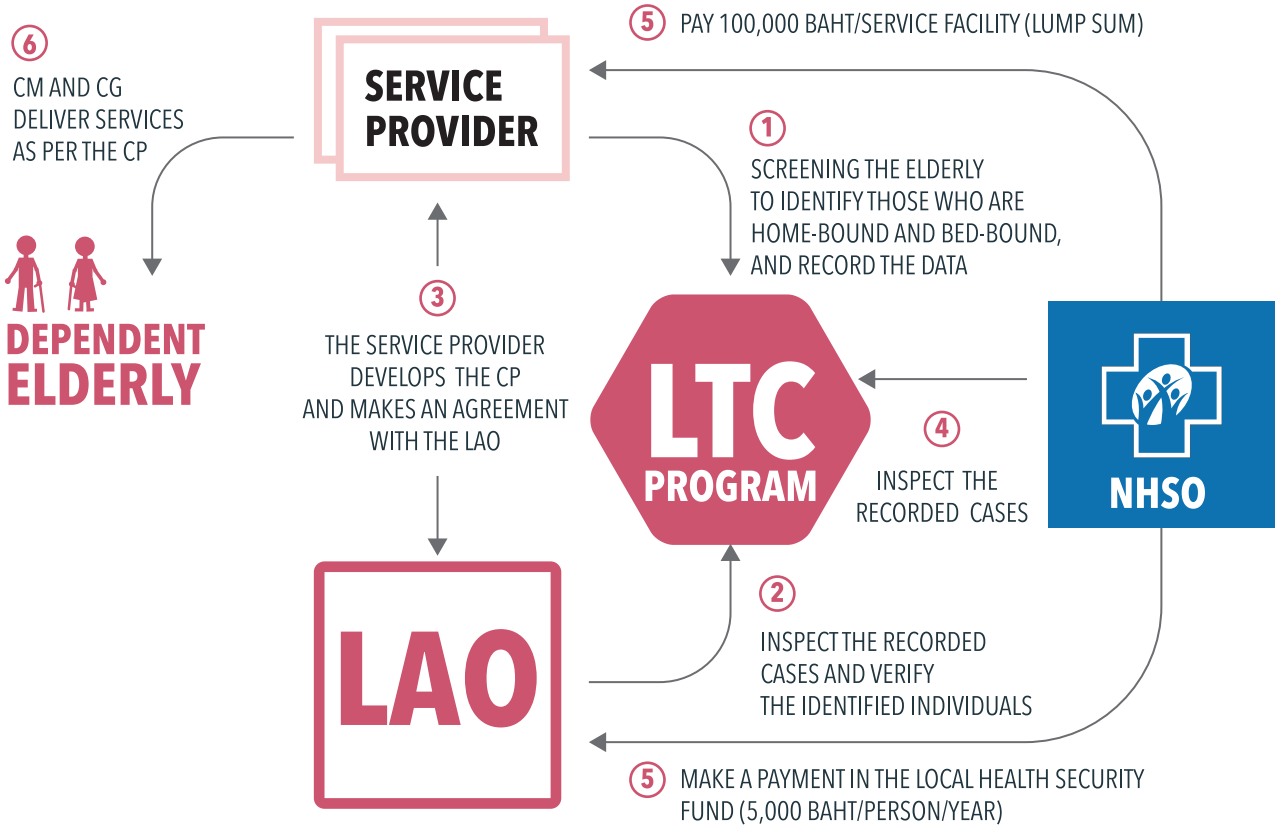


FIGURE 1
STEPS IN IMPLEMENTING LTC FOR DEPENDENT ELDERLY

Then nine months after implementing the services according to the CP, the service provider conducts an assessment of the elderly who are home-bound or bed-bound using the Barthel ADL Index as a measure of the outcomes of the LTC. The results of the assessment are then recorded in the LTC program as a basis for requesting additional budget for on-going LTC. In addition, after one year of completing the care, the service provider reports the outcomes to the National Health Security Board.[16]

In 2016, there was a total of 1,752 LAOs participating in the community-based LTC initiative, and that number steadily increased. By 2019, there was a total of 6,003 LTC providers in 7,852 LAOs (76% of the total LAOs in the country).[17, 18]

BY 2019,
THERE WAS A TOTAL OF

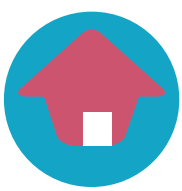
6,003

LTC PROVIDERS IN
7,852 LAOS

3.1

OLDER PERSONS ELIGIBLE FOR LTC

There are two types of dependent elderly who are eligible to receive the community-based LTC: (1) Those who are home-bound but are able to move around the house by themselves. These persons need assistance for some daily activities. Thus, the goal of the LTC is to help rehabilitate these individuals and help them prevent injury or further debilitating illness in the hope that they can be quasi-independent for as long as possible, while reducing the care burden on other members of the household; and (2) Those who are bed-bound. In these cases, there is a constant need for someone to be in the home, at least for part of the day, to help the person with essential daily activities. The goal of LTC for this group is also for rehabilitation and prevention of injury, further disability or complications of their NCD/condition, and to help them live their daily life as normally as possible.[19, 20]



HOME-BOUND ELDERLY

BED-BOUND ELDERLY

The NHSO further classifies the home-bound and bed-bound into four sub-groups based on assessment using the Barthel ADL Index as follows:[19]

GROUP 1

Ability to somewhat move independently, but may need help with eating and toileting

GROUP 3

Cannot independently move and need help with eating and toileting; or with a severe illness

GROUP 4

The same as Group 3 and at the end-stage of life

GROUP 2

The same as Group 1 plus who also have a cognitive disability

3.2

BENEFITS PACKAGE

The benefits package for LTC of dependent elderly covers home-based care or community-based care, and clinical devices and equipment. The benefits may vary slightly from person to person based on individual needs, frequency of required services, etc. The following table summarizes the components and cost of the benefits packages.

Table 1

BENEFITS PACKAGE FOR LTC OF DEPENDENT ELDERLY

Type	GROUP 1	GROUP 2	GROUP 3	GROUP 4
Assessment and establishing the Care Plan by the CM or health personnel	Annual			
Health services by public health staff including counseling, basic nursing care training for caregiver, rehabilitation, nutrition, pharmaceuticals, and other related areas based on the needs of the dependent elderly	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 by the CG for health and housing	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 by the LAO, service center, or private sector	Clinical device or equipment to assist movement or functioning of the dependent elderly			
Evaluate and adjust the CP by the CM or public health personnel	At least once every 6 months	At least once every 3 months	At least once every 3 months	At least once a month
Payment Compensation (lump sum baht/person/year)	Not over 4,000	3,000-6,000	4,000-8,000	5,000-10,000

Source: Handbook on Support for Management of Long-term Health Care for Dependent Elderly under the National Health Security System, NHSO (2016)

3.3

PERSONNEL IN THE LTC SYSTEM

CARE MANAGER (CM)

The Care Manager (CM) is the key person in the LTC by overseeing the care of the dependent elderly, and coordinating with external health and clinical services covered in the benefits package. The CM sets up the care plan (CP) for consideration by the Sub-committee, and arranges budget support from the Local Health Security Fund according to the CP. The CM helps select the Care Giver (CG) who is assigned to homes with dependent elderly, and coordinates with the multi-disciplinary team in the LAO and relevant health partners to ensure implementation of the CP. One CM can adequately oversee 5 to 10 CG who work together to care for 35-40 dependent elderly. Those who are eligible for the CM position is someone with training in medicine, nursing, and/or public health, has experience in care for elderly persons, and has been trained in the CM training curriculum of the LTC program of the Department of Health (DOH) (or equivalent).[19]

CAREGIVER (CG)

The Care Giver is someone who has been trained in a curriculum approved by the NHSO. The CG should have completed 70 hours of training in the requisite subjects. The role of the CG is to help the dependent elderly to perform daily essential activities, ensure that the housing situation is safe for the elderly, help prepare meals, and refer the elderly person in case of emergency. The CG is supervised by the CM.[20] If the CG successfully completes 120 hours of the Elderly Care Curriculum, then they are qualified to be professional care giver.[19, 21]

FAMILY CARE VOLUNTEER (FCV)

Household members who are age 15 years or older can be trained as family caregivers for dependent elderly in the household. The training course is 18 hours, and successful trainers are classified as Family Care Volunteers (FCV). Their role is to provide simple, essential care, and assistance for dependent elderly, and share knowledge on basic care-giving with other members of the household. The FCV promotes health development in the household, and links with the network of VHV. There should be at least one FCV in each eligible household.[21, 23]

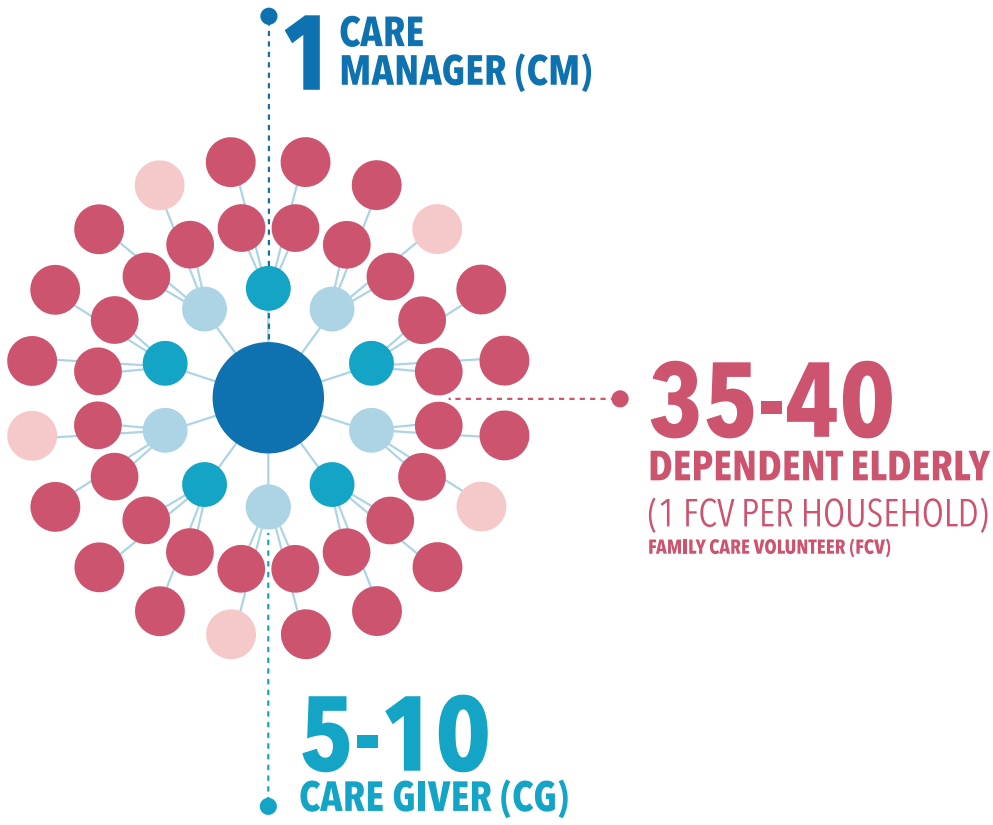


FIGURE 2
RATIO OF CARE GIVER (CG) TO CARE MANAGER (CM) TO DEPENDENT ELDERLY

THERE WAS APPROXIMATELY

ONE CAREGIVER

FOR EVERY THREE DEPENDENT ELDERLY INDIVIDUAL

Data from the 2019 Annual Report of the Department of Health (DOH) of the MOPH indicates that, during FY 2016-18, there was a total of CMs of 2,714, 4,139, and 5,990, respectively, who successfully completed training, yielding a cumulative total of 12,843 CMs. During the same period, the MOPH produced 27,696, 22,450, and 27,707 CGs, respectively, yielding a total of 77,853 CGs. The total number of dependent elderly enumerated during 2016-2018 was 180,821. Those totals indicate that there was approximately one CG for every three dependent elderly individuals. [22]

3.4

BUDGET ALLOCATION

The NHSO sets the budget for LTC services for the home-bound/ bed-bound cases. The budget is divided into the following:

1

Budget for the service facility (including the contracting unit for primary care (CUP), primary care unit (PCU), and service facility; and

2

Budget for the Local Health Security Fund.

For budget allocation to the service facility, the NHSO makes lump sum payments of 100,000 baht to the service facility of the participating LAO in the LTC program for dependent elderly to set up the system of services, conduct screening of local residents who are eligible for LTC, and develop the CP. Additional funds are allocated based on the number of home-bound/ bed-bound cases with an approved CP. The LAO, together with the local health facility, need to conduct an assessment of dependency of the elderly using the Barthel ADL Index to classify eligible elderly in the community. Next, the CM prepares the CP and submits it for review and approval by the Sub-committee. After approval, the NHSO issues additional budget to the service facility according to the number of dependent elderly.[19, 20]

The NHSO provides funds for the LAO through the Local Health Security Fund on a per capita basis at 5,000 baht/person/year according to the number of home-bound/bed-bound cases. That amount is expected to cover the basic LTC for one dependent elderly during the year according to the benefits package and compensation for the CG.[19, 20]

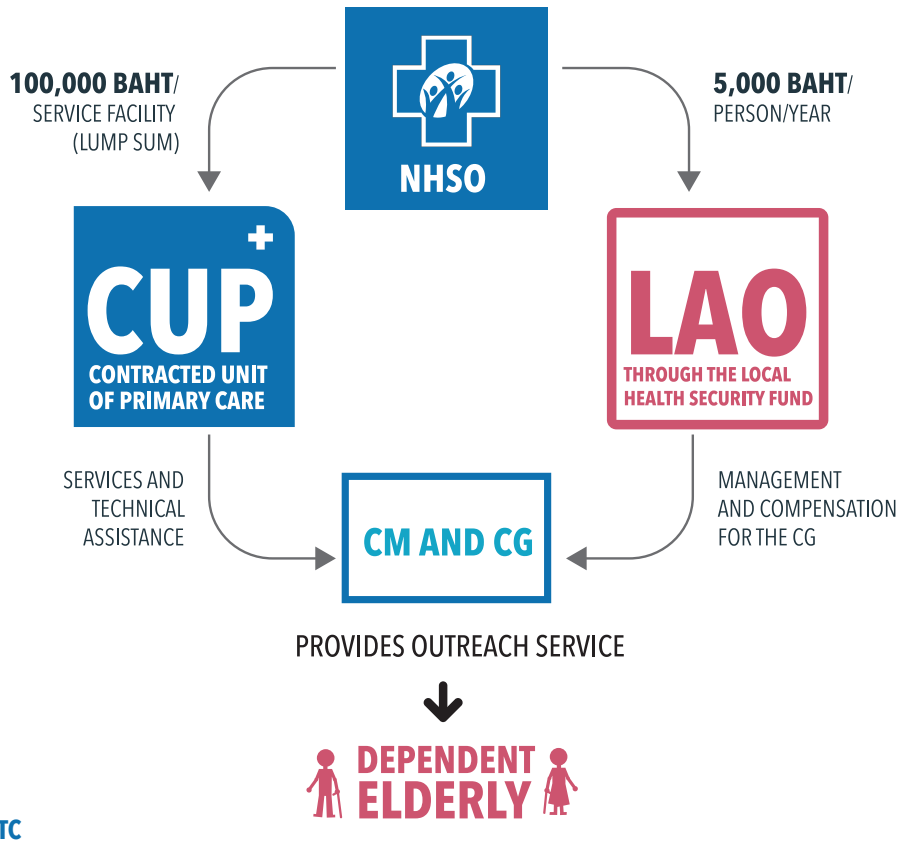


FIGURE 3
ALLOCATION OF BUDGET
OF HEALTH SERVICES FOR LTC

3.5

LTC PROGRAM

The NHSO has applied information technology to the LTC system by creating a computerized database for use in recording data on LTC services at every level in the system. This includes checking the insurance scheme of the elderly, inputting data of older persons who are eligible to receive LTC, and recording details of the CP, CM and CG of each elderly person. The database includes the benefits package for the four categories of dependent elderly, reimbursements for services rendered, and care outcomes. This database should help service providers and LAO to assess progress in LTC management, and enable monitoring of beneficiary status.[19] In addition, the data in the database can be used for overall monitoring and evaluation of the LTC management and system.

4

MONITORING AND EVALUATION (M&E) OF IMPLEMENTATION

The MOPH and NHSO work together to conduct M&E of the LTC system at the central, regional, and local levels on a quarterly and yearly basis. There are two main components of the M&E. The first component is to monitor the records to verify the number of dependent elderly by location, and track the budget allocated for LTC services and budget in the Local Health Security Fund. The second component is to monitor quality of services at the health facilities and in the management of LAO according to KPI.[19]

In 2016, the NHSO commissioned the Health Systems Research Institute (HSRI) to evaluate the LTC program. The evaluation included an assessment of the capacity of the LAO in implementing LTC for the elderly, and an assessment of the management system, including budget and financing mechanism and costs of the activities of the LTC system in practice. That evaluative study by HSRI exposed some shortcomings of implementation of the LTC system, and pointed to areas which need improvement.[19, 24]

THE MOPH AND NHSO WORK TOGETHER TO CONDUCT M&E OF THE LTC SYSTEM AT THE CENTRAL, REGIONAL, AND LOCAL LEVELS ON A QUARTERLY AND YEARLY BASIS

5

PROBLEMS, OBSTACLES AND PLANS FOR FUTURE IMPLEMENTATION

The LTC system of the NHSO is still in an early stage of implementation. Thus, it still faces several challenges. The following highlights some priority areas that need to be addressed:

5.1

Some LAOs are not yet ready to manage LTC. According to data in 2019, a total of 6,003 LAOs were participating in the LTC initiative out of a national total of 7,852 LAOs, or about 76%. Thus, 24 percent, or 1,849 LAOs, were not yet ready to implement LTC.[17, 18] At the same time, there is no clear strategic plan for building capacity of the locality to successfully implement the LTC services in a self-sustaining way.[23]

5.2

There are differences of opinion between the NHSO and MOPH about the concept of volunteerism and contracted work of the CG, and this has caused confusion and inconsistency in hiring CG. For example, the official announcement, issued by the MOPH, indicates a compensation rate for CG in the amount of 300 baht/month. This has led to the understanding that the CG is a contracted hire, and that the CG are expected to be paid for their work. However, the guidelines for compensation differ in interpretation and practice and, in some cases, there is no payment or delayed payment for services rendered by the CG.[24]

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5.3

It is not always easy to recruit persons eligible to assume the full-time position of CG. This is especially true in the case where the CG is viewed as a "volunteer" and, thus, there is less interest in applying. If a person was to take on the full-time CG role, then most would have to leave whatever occupation they were employed in. In addition, after training, some CG are not able to implement the required tasks because they may not be have the necessary skills.[23]

The NHSO plans to alter the LTC budget allocation by transferring the whole budget to the LAO instead of splitting into 2 channels. That way, the LAO will be able to manage budget more efficiently and systematically. For the renumeration payment to CG, the NHSO is aware of the shortcomings, and is trying to clarify and streamline the system of payments to the CG. The NHSO has submitted a proposal to the Cabinet to approve LAO to use budget from the Local Health Security Fund to pay the CG in their area of administration. There is also a plan to upgrade the CG position to a more formal status by providing an additional 50 hours of training for those CG who have completed 70 hours of training to become a full-time assignment (8 hours/day and 5 days/week). The LAO would be the contracting agency to hire and pay the CG, and monitor their performance.

6

SUMMARY

As Thailand continues to become an increasingly aged society, a major epidemiological transition is occurring, from a predominate pattern of infectious disease to NCD and other chronic conditions. This epidemiological change will significantly increase the burden of care for older persons, and the duration an individual will require care as life expectancy of the population lengthens. At the same time, the capacity of the typical Thai household to care for older members of the family is decreasing due to demographic and socio-economic factors. Average household size is shrinking, while more working-age women are taking jobs outside the household. That leaves many families with no one at home during the day to care for dependent elderly members. Clearly, Thailand will have to rapidly develop a comprehensive, expandable, and sustainable LTC system to cope with the demographic tsunami of older persons that is starting to flood the country. An efficient LTC system can help reduce the burden on the family for LTC of its aging members. In addition, community-based care is a more efficient mechanism to provide LTC as compared to institutional-based care.

Starting in 2016, Thailand launched a system of LTC for dependent elderly under the UCS, and that has been extended to cover the beneficiaries under the CSMBS and Social Security Scheme. Thus, there is a unified LTC service package across government health insurance systems, and this creates equitable access to LTC for all dependent elderly. These advancements are the result of advocacy through the National Plans for Older Persons, National Elderly Assembly, and the National Health Assembly. A key strategy of the system is the devolution of LTC to become a community-based program with support from the LAO as the principal management agency. This strategy hinges on the confidence that the Thai traditional value for caring for senior members of the family is still strong and present in most villages and communities. There is the belief that the majority of Thai communities have the indigenous socio-cultural assets to embrace such a system of LTC, with support from their own LAO and Tambon Health Fund.

Three key agencies managing the LTC system are the MOPH, LAO, and NHSO, who have set up and rolled out a national LTC program. The MOPH has the role of overseeing the health and medical components of the LTC, and providing technical assistance and quality control to ensure standard service. The LAO manages the LTC system at the local level, and provides oversight of the Local Health Security Fund and service providers. The NHSO has the role of providing financial support and setting up the LTC management mechanism. In addition to the three principal agencies, there are other participating agencies in the public, private, and Civil Society sectors which support the livelihood of Thai elderly in their area of responsibility.

Nevertheless, this national LTC system for dependent elderly is still in its infancy and, thus, it can be expected that there will be more adjustments and streamlining needed to maximize efficiency of services and budgeting. All the participating LAO need to build capacity so that there is a uniform, minimum level of competency to oversee and manage the LTC service in their area of jurisdiction. As noted, the NHSO, MOPH, and LAO have to reach a common understanding about the role and compensation for such key personnel as the CM and CG. Ideally, in the future, these positions will be full-time so that LTC is consistent and uninterrupted. In addition, regularizing these positions in the community will make it easier to recruit and retain individuals when vacancies occur. Importantly, compensation for the CG positions needs to be attractive enough so that they will be willing to leave their current job to take on the role of care provider for dependent elderly. Since the vision is of a decentralized system, it will be up to the LAO to ensure that the LTC program is cost-effective and sustainable at the local level.

APPENDIX

Table A. 1

STRATEGY	RESPONSIBLE AGENCY
STRATEGY 1 **SCREENING OF THE ELDERLY AND CREATING A DATABASE THE ELDERLY IN THE COMMUNITY**	
Development of an evaluation form, criteria, and standards for classifying the elderly by level of dependence	• NHSO • LAO • MSDHS
Training of VHV and ECV to screen the elderly in the community	• THPH • LAO
Conduct an assessment of the elderly according to the criteria and standards	• ECV • LAO
Create a database of the elderly in the community	• THPH • LAO
STRATEGY 2 **DEVELOP SERVICES IN THE COMMUNITY FOR PREVENTION, CARE AND REHABILITATION OF THE ELDERLY**	
Develop standards and service support system (service provider, personnel, and services)	• MOPH • MSDHS • LAO
Conduct outreach care and services at home and in the community	• THPH
Create an infrastructure for LTC for dependent elderly in the community	• Community hospital • LAO • MSDHS
Deliver case-specific rehabilitation and support for dependent elderly within their home community	• LAO • NHSO • MOPH
STRATEGY 3 **DEVELOP A FISCAL SUPPORT SYSTEM AND BENEFITS PACKAGE**	
Develop a benefits package for LTC	• NHSO • MOPH • MSDHS • LAO

STRATEGY	RESPONSIBLE AGENCY
Design a fiscal system and model of payment for LTC services	• NHSO • MSDHS • Department of Local Administration
Develop a model of services and integrated budgeting	• NHSO • MSDHS • Department of Local Administration
Expand coverage of the Provincial Fund for Rehabilitation of the Disabled	• LAO • NHSO
STRATEGY 4 **HUMAN RESOURCES DEVELOPMENT**	
Provide in-service education opportunities or training to retain personnel in the local service centers and communities	• LAO • Private sector
Develop a curriculum and training for Care Manager (CM)	• MOPH
Develop a curriculum and training for Caregiver (CG)	• MSDHS • MOPH
Recruit CM at the sub-district (Tambon) level	• LAO
Recruit CG who have been trained according to standards/criteria at the Tambon level	• LAO • MSDHS
Add one registered nurse position, specialized in LTC, in each THPH, and one position for a physiotherapist in each district hospital	• MOPH • NHSO • LAO
Support the production of occupational therapist and geriatric nurse	• MOPH • NHSO • LAO • MOE • Health Professional Council

STRATEGY	RESPONSIBLE AGENCY
STRATEGY 5 **KNOWLEDGE MANAGEMENT, MONITORING, AND EVALUATION**	
Develop a model of services and management of the Local Health Security Fund	• NHSO
Develop a model of compensation payment to motivate provision of services and to ensure quality of services with financial sustainability	• NHSO
Conduct research on the fiscal support system for LTC	• TGRI
Conduct studies and evaluation of the implementation of LTC	• TGRI
STRATEGY 6 **LAWS, PROCEDURES, REGULATIONS, AND MANAGEMENT**	
Revise procedures for medical welfare for government civil servants to cover essential health care needs in the community	• Comptroller General Department
Define the role of the local agencies to oversee and manage LTC, and improve laws/regulations at the locality to facilitate implementation	• Department of Local Administration
Review related laws about LTC, such as standards and quality control for private nursing home	• MOPH • MSDHS

Source: Strategic Plan for Implementing the System of LTC for Dependent Elderly: 2014-2018, NHSO

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LONG-TERM CARE FOR DEPENDENT ELDERLY IN THE NATIONAL HEALTH SECURITY SYSTEM

Project on Knowledge Management, Lesson Learnt Reflection, and Dissemination of National Health Security Office (NHSO)

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