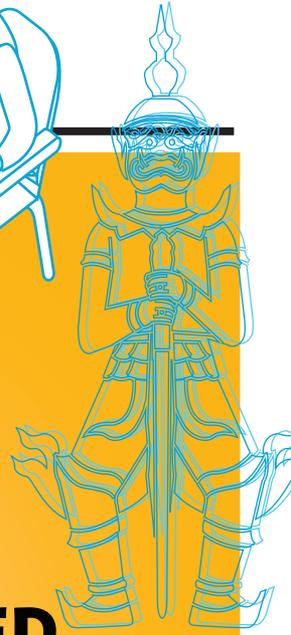


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LESSONS FROM THAILAND'S NATIONAL COMMUNITY-BASED LONG-TERM CARE PROGRAM FOR OLDER PERSONS



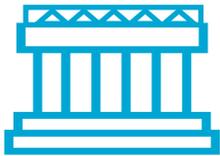
Thailand's population is aging and the proportion of the population with care needs is growing. The percentage of the population aged 65 and over is expected to increase from 9% in 2010 to 25% in 2040.

Thailand's current long-term care (LTC) system has emerged from a decade of work, including advocacy efforts, research studies, and pilot programs. In 2016, a community-based LTC pilot program was launched, with a target of 100,000 beneficiaries in 1,000 out of 7,255 subdistricts and it has since scaled up annually.

THAILAND

COMMUNITY-BASED LONG-TERM CARE SYSTEM

The community-based LTC program aims to offer coordinated care, with assessment, case management, and provision of in-home visits by home caregivers for 2–8 hours a week depending on the need and availability of care support. A range of medical services that depend on the needs of the beneficiary are listed in the benefits package.

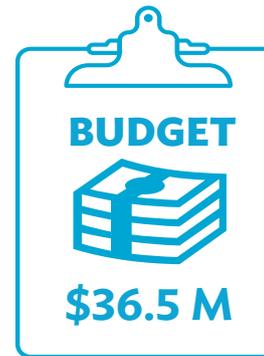
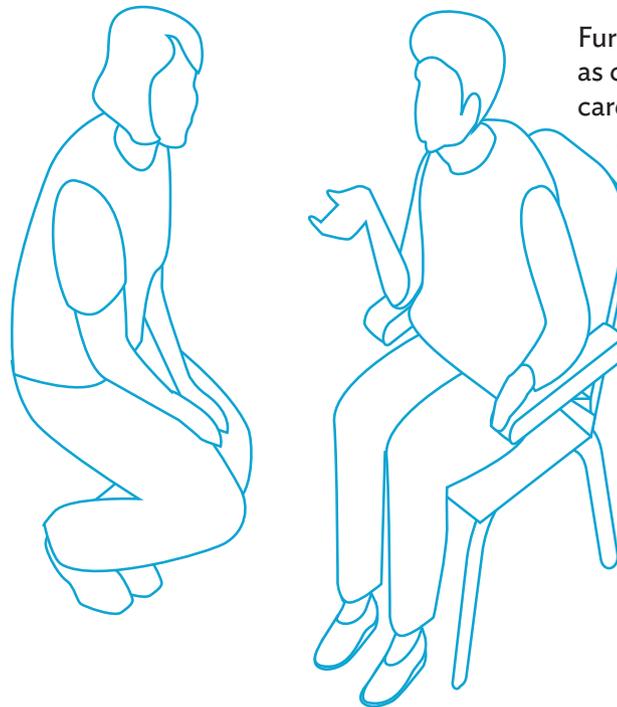


NATIONAL HEALTH SECURITY OFFICE

The National Health Security Office is currently responsible for the community-based LTC program for older people. It uses local administration organizations from the health and social services sectors to provide integrated services to beneficiaries, with support from the Ministry of Public Health.

CAREGIVERS

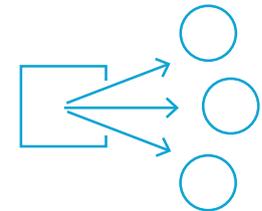
The program provides funding and training to part-time caregivers from the community, building on the country's long history of community volunteers, and has developed and trained a new role of care managers.



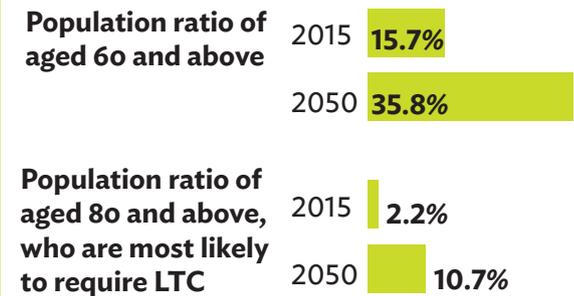
The budget for the community-based LTC program was B600 million (\$19 million) for 100,000 beneficiaries in 2016; the target for 2018 was B1,159 million (\$36.5 million) for 193,200 beneficiaries.

NEXT STEPS

The community-based program is just one element in an LTC system, selected by the government as an initial step in developing services for older people.



Further developing community-based care services such as community day care, respite care, and transitional care services would also help to ensure that care needs are met and reduce the workload on family carers.



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Japan
Fund for
Poverty
Reduction



From
the People of Japan



Ministry of Strategy
and Finance

This study was commissioned under the regional technical assistance for *Strengthening Developing Member Countries' Capacity in Elderly Care*, funded by the Japan Fund for Poverty Reduction and the Republic of Korea e-Asia and Knowledge Partnership Fund. Samrit Srithamrongsawat, director of the Health Insurance System Research Office, and Orajitt Bumrungrukulswat, former senior director of the Bureau of Community Health Service System of the National Health Security Office, did the peer review.

In this publication, "\$" refers to United States dollars and "B" for baht. On the back cover: Population aging in Asia and the Pacific creates an urgency to develop long-term care systems for older persons (ADB Photo).



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Aging in Thailand

Asia is undergoing one of the most profound demographic shifts in the world. By 2050, the number of people over the age of 65 is expected to exceed 1 billion. The Asian Development Bank (ADB) is supporting its developing member countries (DMCs) prepare for this in a variety of ways, such as raising awareness through examples from countries leading the way.

Thailand's public, community-based care program, financed primarily through social health insurance, is especially relevant to the DMCs in the region facing a growing need for care.

The population of Thailand is aging and the proportion of the population with care needs is growing. The percentage of the population aged 60 and over is expected to more than double from 15.7% in 2015 to 35.8% in

2050.¹ The proportion of those over the age of 80, who are most likely to require long-term care (LTC), will increase almost fivefold from 2.2% in 2015 to 10.7% (footnote 1). The country's fertility rate has dropped dramatically over the past 6 decades and migration has further reduced the availability of care support from adult children.

The country's health system has a reputation for quality, coverage, and affordability, and ranks highly among low- and middle-income countries. The Universal Coverage Scheme (UCS) introduced in 2001 covers the 75% of the population not covered by the two other health insurance schemes, i.e., the Social Security Scheme and Civil Servant Medical Benefit Scheme.² Local Health Funds (matching funds between UCS and local governments) established in

¹ United Nations, Department of Economic and Social Affairs, Population Division. 2019. *World Population Ageing 2019*. New York.

² P. Jongudomsuk et al. 2015. The Kingdom of Thailand Health System in Review. *Health Systems in Transition*. 5 (5). 2015. World Health Organization Asia Pacific Observatory on Health Systems and Policies.

2006 now cover 99.7% of the country. These are mechanisms through which national healthcare funding and locally raised funds are pooled and used for locally managed health care services to promote health, primary care, disease prevention, and rehabilitation services, as well as services for older adults and people with disability.

Thailand has a uniquely strong history of use of a volunteer cadre for health. The Village Health Volunteer program was established more than 4 decades ago to strengthen primary health care through health education and self-care support. The original intent was to support maternal child health, but the program's mandate has expanded to include noncommunicable disease prevention, screening for cervical cancer, and community health promotion campaigns.

In 2018, the Ministry of Public Health organized more than 1 million village health volunteers, each responsible for 60–80 people and working alongside 5–10 other volunteers to cover a whole community. In December 2018, Thailand showed a continued commitment to this program, investing funds to raise the monthly stipend from B600 (\$19) to B1,000 (\$31).



Thailand has a uniquely strong history of use of a volunteer cadre for health.

History of Long-Term Care System Development in Thailand

Thailand's current LTC system has emerged from a decade of work, including advocacy efforts, research studies, and pilot programs. The 2nd National Plan on Older Persons (2002–2021) and the Act on Older Persons (2003) laid the groundwork for LTC by recognizing the needs and rights of older people. In the first revision of the 2nd National Plan on Older Persons in 2007, LTC and support was specifically included.

In 2003, the Ministry of Social Development and Human Security established the Community Volunteer Caregivers for the Elderly project, now supervised by local administration organizations (LAOs). This project provided 18 hours of training for volunteers who provide social support for older people who are poor or live alone and who do not have informal carers. However, an evaluation of the project found that care provision through this program was inconsistent and inadequate, and focused on the LTC needs of those who had only mild or moderate difficulties with activities of daily life.

At around this time, the Senior Citizen's Council of Thailand, which represents approximately 30,000 community groups, also established a peer-to-peer care group for social visitation of older people. In some places, Local Health Funds were used to support civil society provision of health promotion and prevention, in addition to social care and social visitations at home. The funds also supported elderly care center in the community setting by local governments.

Recognizing the need to improve integration of health and social services, from 2007–2011, the Ministry of Social Development and Human Security and Ministry of Public Health worked with the Japan International Cooperation Agency on a technical cooperation project to coordinate the delivery of health and social services to older people. The project Community-Based Integrated Health Care and Social Welfare Services Model for Thai Older Persons was conducted in four districts from four regions of Thailand.

It targeted independent, homebound, and bed-bound older people with community-based care provided by trained volunteers and family members, and each region developed a draft model for integrated health and social services for older people. One key finding was that bed-bound older people require additional support from LTC professionals.

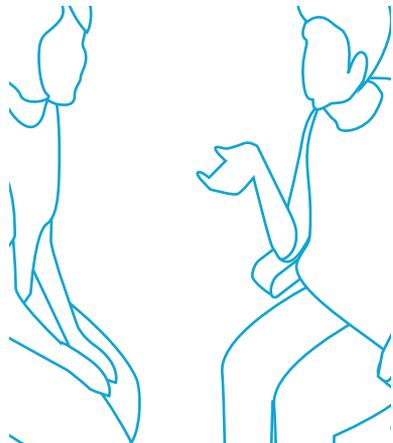
A national definition of LTC for older people was adopted by the Second National Health Assembly in 2009. Numerous other pilots contributed to the range of practical examples of how integrated health and social care could be delivered in Thailand, and evaluations of these models influenced the development of the current community-based LTC program, including its financing mechanism, service delivery system, and human resource management.

To date, there is no government body mandated to oversee the overall development of the LTC system in the country. Program implementation rely on the coordination between and among the various line ministries that are responsible for delivering care. Thailand's Act on Older Persons placed the promotion and protection of older people under the Ministry of Social Development and Human Security. However, this ministry alone cannot coordinate and deliver LTC: the Ministry of Public Health runs the majority of public health facilities, and the Ministry of the Interior is responsible for LAOs, who in turn are responsible for coordinating, developing and delivering services in their districts. The National Health Security Office is responsible for the UCS.

National Definition of Long-Term Care for Older People

Long-term care for older people refers to all dimensions of care, including social, health, economic, and environmental aspects. Older people who have difficulties due to chronic disease or disability and are partially or totally dependent on others for daily living activities need long-term care. It is provided by formal care personnel (professionals in health and social work) and informal carers (family members, friends, and neighbors) and may include care services provided by the family, community, or institution.

Source: Second National Health Assembly in 2009.



Each of these ministries has played a key role in early pilots for integrated LTC, which have laid the groundwork for the current program. Beyond these key ministries, there are others who may well have roles in the future LTC system, including the ministries for transport, education, and industry.

Similarly, there is still no specific legal framework or coordination mechanism for public, community-based LTC. Nevertheless, the government is proactively working toward an LTC. The 12th National Economic and Social Development Plan (2016–2021) includes policies and measures to mitigate the challenges of an aging society. These include improving the LTC system and creating age-friendly environments.³ The plan also initiated the Thailand 4.0 Development Agenda, the long-term strategic plan guiding the government's direction. Currently, the government has adopted several policies for its aging population based on these principles that the elderly should be supported to age at home within their family, supported by a community-based system of health care and social services; and that institutional care should only be the last resort for elderly care.

**Thailand's current LTC system
has emerged from a decade
of work, including advocacy
efforts, research studies,
and pilot programs.**

³ NESDB. 2017. *National Economic and Social Development Plan 12*. Bangkok: NESDB.

Thailand's Community-Based Long-Term Care Program

The community-based LTC program aims to improve the quality of life of bedridden and homebound older people through home-based care and support. It assigns responsibility for managing LTC to local governments, with the support of the district health system. The Local Health Fund is employed as a strategic mechanism to drive the development of this system.

The pilot of this program was designed to test the theories that this approach will lead to greater cooperation and involvement in communities for LTC, mobilize more resources to support the development of the care system, and lead to better coordination and integration of health and social services. The project pilot began in 2016 with a target of 100,000 beneficiaries in 1,000 out of 7,255 subdistricts and has scaled up annually.

The project pilot began in 2016 with a target of 100,000 beneficiaries in 1,000 out of 7,255 subdistricts and has scaled up annually.

Governance and Coordination

The National Health Security Office is currently responsible for the community-based LTC program for older people. It works with LAOs, which are the key responsible organizations in managing the system with the support of district health system.

The Local Health Fund (LHF), a matching fund between UCS and LGs, is employed as strategic mechanism in driving the development of community-based LTC system.

Care is provided by the families of older adults, supplemented by help from a community caregiver under the supervision of the care manager.

Care managers in this scheme are specially trained nurses, physiotherapists, or social

workers. They assess the eligibility of older persons and prepare a care plan.

The National Health Security Office and LAOs then transfer money into the Local Health Fund for financing the scheme.

The pilot evaluation determined that the LAOs are the appropriate agencies to manage older person care.

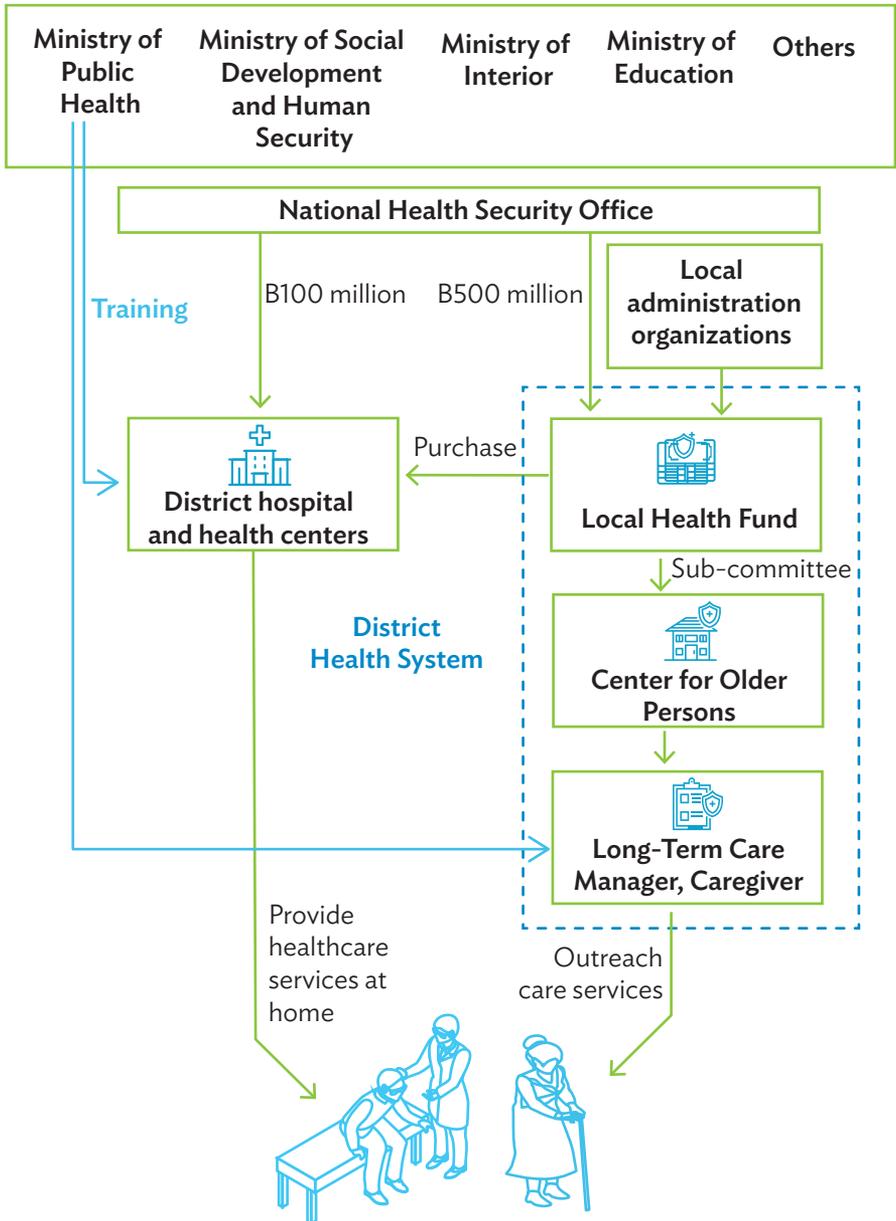
LAOs are encouraged to establish Centres for Older People, which will provide a range of services such as day care, home-based care, and case management. However, until these centers are widespread and operational, in the transition period it is predominantly Ministry of Public Health-run facilities that perform this role.

Coverage

The current target population for this program depends on age (over 60 years) and degree of frailty:

- Group 1: Can partially move, may have eating or elimination disorder, no cognitive disorder
- Group 2: Has cognitive disorder
- Group 3: Not able to move, may have some eating or elimination disorder, or severe disease
- Group 4: Not able to move, may have some eating or elimination disorder, or severe disease with considered serious illness or in palliative care

Coordination of Agencies Working on Long-Term Care



Source: *An Evaluation of Community-based Long-Term Care Implementation in Thailand*. Presentation at the National Consultation for Thailand. Samrit Srithamrongsawat, Paibul Surlyawongpaisal, Vijj Kaseamsup, Department of Community Medicine, Faculty of Medicine Ramathibodi Hospital, Mahidol University. September 2017.

Coverage Expansion Plan

The roll out of the community care plan across Thailand was ambitious, aiming to achieve national coverage in only 3 years. However by 2018, 5,639 out of 7,776 LAOs were implementing the program.

The main issue for incomplete roll out was the constraints of financial regulations on local governments.

This was due to the decentralization law that states that local governments can fund only what is specifically included in that law, which makes provisions for new programs a challenge.

The pilot evaluation determined that the LAOs are the appropriate agencies to manage older person care.

Table 1: Number of Community-Based Long-Term Care Program Beneficiaries, 2016–2018

Year	Budget (\$ million)	Benefited older persons				Implementing	
		Target	Receiving long-term care budget	New registered	Registered (from previous year)	Accumulation	Local Administration Organizations
2016	18.33	100,000	80,826	80,826	-	80,826	1,752
2017	27.51	150,000	100,015	94,552	5,463	175,378	2,522
2018	35.42	193,200	132,053	35,785	96,268	211,163	1,365
Total							5,639

Notes:

1. Accumulation are the accumulation of new registered older persons in each year.
2. Number of older persons receiving long-term care budget in 2018 was only 132,053 while data from Department of Public health website was 143,567 persons (9% were those with palliative care).
3. Data from only implementing areas and Universal Coverage Scheme members.

Source: National Health Security Office data as of 14 September 2018.

Services

Thailand is starting with a relatively modest program in terms of beneficiary eligibility and degree of benefits.

The target beneficiaries are bedridden and homebound older people. The program aims to provide assessment, case management, and provision of in-home visits by home caregivers for 2–8 hours a week depending on the need and availability of care support. A range of medical services are listed in the benefits package, which depend on the needs of the beneficiary. These services are broadly grouped into three categories: care management, social care, and health care.

Care management includes care assessment, development of a care plan, case conferences, and monitoring and evaluation. The pilot evaluation found that conducting case

conferences with related stakeholders for care planning resulted in better integration and coordination of services, but was time-consuming.

Social care services include support for activities of daily living and instrumental activities of daily living, transportation, social support, legal support, improvements to home environment, and economic support including provision of assistive devices. Health care services include treatment, nursing, medicine, rehabilitation services such as physical therapy and occupational therapy, palliative care, provision of medical equipment, and falls prevention.

Although this is the list of services to be provided, as yet there has been no evaluation to confirm if this is the list of benefits that are actually provided in all sub districts.

Quality Management

Initially there was no overall management information system in place. Plans to develop an online database to support implementation and monitoring and evaluation were approved in 2019. Of the two key performance indicators,

the first—the percentage of dependent elderly people accessing the LTC services—is being monitored, but the second—the number of elderly with an improved activities of daily living score—is not.

Integration and Coordination

The community-based LTC program aims to offer coordinated care bringing together health and social care. The evaluation of the pilot found that only 2 of 24 study areas had successfully provided integrated and coordinated people-centered care, providing a full range of

services from homecare, home modification, and managing and supporting informal carers. Generally, there was a division between health care and social care services and there were challenges with information sharing between various providers.

Human Resources

The program provides funding and training for two categories of workforce for LTC: caregivers and care managers. Service coverage is limited to 2–8 hours of home visits a week. Therefore, family carers continue to provide the majority of care work for beneficiaries. Care planning

and case coordination meetings often include other service providers such as government health staff including nurses, doctors, physical and occupational therapists, village health volunteers, and social welfare staff including local government staff.

Caregivers

The caregivers take a 70-hour training course covering population aging, the rights of older people and the role of caregivers, common diseases, critical conditions, first aid, care for those with condition-specific challenges, drug administration, health promotion for older people, and local health wisdom, mental health and self-care, home environment and recreation, work practice, and testing and evaluation.

By 2018, 44,000 caregivers were engaged in the program, providing support for activities of daily life, monitoring changes in behavior or health status of beneficiary and communicating with appropriate relatives and others, health promotion including home environment safety and sanitation, cooking meals, referrals, data collection, and reporting to care manager.

The decision to use paid or volunteer caregivers in this program has been an area of debate. The pilot evaluation found that 75% of the participating districts used volunteer caregivers and 25% used paid caregivers. Many of them, whether paid or unpaid, had experience as village health volunteers. The Ministry of Public Health and others have raised concerns about the impact on volunteers feeling inequitably treated if other caregivers are paid for the same work.

The National Health Security Office, meanwhile, argues that paid caregiving is a more equitable and sustainable approach to increasing the LTC workforce. The evaluation of the pilot found that while all of the caregivers received the same level of training and had the same job responsibilities, the paid caregivers outperformed the volunteer caregivers in the first 3 years of this program in all main areas of care provision.

Care managers

Care managers conduct assessments to determine eligibility of possible beneficiaries and identify their care needs. Care managers prepare individual care plans through a multidisciplinary team meeting and develop weekly plans, which are regularly reviewed. They develop the capacity of the team and manage and monitor the performance of 5–10 caregivers.

Care managers also undergo 70 hours of training on aging, older people's rights, the

role of a care manager and basic care management, assessment and intake, understanding care delivery, practice sessions, study visits and actual practice in health facilities in the community, and testing.

Currently, as most LAOs do not yet have strong centers for older people through which to recruit and manage care managers, most care managers are nurses from community health promotion hospitals managed by the Ministry of Public Health.

Financing

Funding for the program comes from the UCS managed by the National Health Security Office. In its first year, the central government provided B600 million (\$19 million) through the National Health Security Office to support this project. Of this, B500 million (\$16 million) went to the Local Health Funds to support care provision at home and the remainder went to the District Hospitals and Health Centers for human capacity building, including care management, and volunteer caregiver training.

Case coordination is covered by the program's budget

but services provided by health professionals and social workers are not. Therefore, the scope of services received relies on the functioning of the health and social welfare systems. Financing of the UCS is itself a keenly debated topic as the scheme is 100% tax financed without a cost-sharing mechanism. Measures for increasing UCS efficiency and cost containment, as well as identifying new sources of finance and ways to increase tax are under consideration. Initial studies on the feasibility of LTC insurance are in process.

Cost of Services

The budget allocated for community-based LTC is increasing year by year. In 2016 the budget was B600 million (\$19 million) for 100,000 beneficiaries; the target for 2018 was B1,159 million (\$36.5 million) for 193,200 beneficiaries. Table 2 details the budget categories by group.

The generosity and coverage of the program depends on negotiations with the government. The original plan was to provide families

with support for half of the care needs of those with activities of daily living scores below 11 and a budget of approximately B30,000 (\$947) per person per year. However, the government decided to start the project on a smaller scale, and approved a limit of only B6,000 (\$189) per person per year. Later, other elements of care provision may be added and invested in and eligibility and benefit packages can be expanded.

Table 2: Categories of Groups Eligible for Benefit Packages

Group	Budget
Group 1: Being able to partially move, having some eating or elimination disorder, no cognitive disorder	< \$122.26
Group 2: Having cognitive disorder	\$91.70–\$183.40
Group 3: Not able to move, having some eating or elimination disorder or severe diseases	\$122.26–\$244.53
Group 4: Serious illness or palliative condition	\$152.83–\$305.66

Source: Ministry of Health. 2018. Financial Practice Guidelines about budget receiving, money collection and payment of health service fees for caring for the dependent elderly and public health service fees from local health insurance funds or areas of service units under the Ministry of Public Health (unofficial translation). Bangkok.
<https://apps.hpc.go.th/dl/web/upFile/2018/12-5004-20181227151546/3d4686ca1d477d384f709a3fd672a7c9.pdf>

Funding for the community-based LTC program comes from the UCS managed by the National Health Security Office.

Next Steps for Long-Term Care in Thailand

The community-based LTC program is being revised and expanded based on continuing learning and research. The formative evaluation of the pilot program referenced throughout this briefing was conducted in 2017 after the first year of implementation to assess how well the Local Health Funds performed, the scope and coverage of services, the care process and human resource management, and the policy implementation process and supporting system.

The key findings from the initial evaluation of the community-based LTC pilot program conducted after the first year of implementation were:

- The Local Health Fund is an appropriate mechanism for managing community-based LTC as it can generate cooperation across sectors.
- In practice, there were challenges integrating home health care and social services, and health care services are provided in a more systematic way and more regularly than that of social care services.

The service provided least often was social care for instrumental activities of daily living, economic support, and legal support.

- Unclear financial regulation of the National Health Security Office and local governments delayed and limited the implementation of the project.

Guidelines for the program were revised in 2019. These guidelines also specify the inclusion in the program of those under the age of 60 and of those outside the UCS of any age who meet the other eligibility requirements. The inclusion of these additional beneficiaries is to be financed by the Local Health Funds.

Further expansion of the program will require progress across the key elements of care systems, including improvements to human resources and workforce management, case management, and integration of health and social services. It will also require revisions to the legal framework and governance structures for better coordination.

Fiscal sustainability of the UCS mechanism for financing LTC is an ongoing concern. Projections show clearly that new financing sources, local taxes, or tax transfers are needed. Several attempts to estimate the future costs of LTC have been undertaken in Thailand.

One projection estimated that universal coverage for community-based LTC for only those with severe dependency would cost about 0.16%–0.22% of gross domestic product and 0.6%–1.1% of government revenue. Investing in LTC system development may contribute to gross domestic product through the impact on workforce participation, particularly by women and older people, as well as through services, assistive devices and other care products.

An improved actuarial model is needed for LTC services, including all sources of finance and covering community-based and residential LTC, both public and private.

Improvements in other systems, including health and social protection, are also needed to support the country's aim for LTC, as well as efforts to create age-friendly communities and a supportive environment.

Further expansion of the LTC program will require progress across the key elements of care systems, including improvements to human resources and workforce management, case management, and integration of health and social services.

Key Takeaways from Thailand's Long-Term Care Program

PRIORITIZATION OF COMMUNITY-BASED CARE

Thailand has placed a strong emphasis on the concept of “aging in place,” which means supporting older people to age successfully in their homes and communities. Aligned with this priority, and given the country’s fast pace of aging, strong public health system, level of economic development and social norms, Thailand has piloted a nationwide rollout of its integrated community-based home care program, which covers both health and social requirements of LTC.

DEVELOPMENT OF A CONTINUUM OF CARE

The community-based home care program is an important component to develop a continuum of care services for older people. This continuum can be strengthened by the future development of additional community-based care services such as community day care, respite care, and transitional care.

MOBILIZATION OF COMMUNITY CAREGIVERS

Building on the established system of volunteer village health workers, the community-based LTC pilot program recruited both paid and volunteer care givers from the local community. The evaluation of the pilot program highlighted the more consistent quality of services delivered by paid care givers over volunteer care givers, which has important implications for ensuring consistency in care for vulnerable adults.

ALLOCATION OF FUNDS FOR LTC

Thailand has financed the current community-based LTC program through general tax revenue, pooled under the UCS. This provides a minimum benefit package to the population covered by UCS. How to supplement these funds from other sources to provide more comprehensive services and expand coverage is currently being explored.

EMPHASIS ON LOCAL GOVERNANCE

In Thailand, LAOs have been deemed the appropriate body for oversight of LTC at the sub-district level since this allows for local adaptations and coordination. However, this may increase the risk of uneven quality and access to care among locations and thus will require monitoring and potential remedial actions.

IMPORTANCE OF MULTI-SECTORAL COORDINATION

The National Health Security Office led the implementation of the community-based LTC program with coordinated inputs from the Ministries of Public Health, Social Development and Human Security, and Education and Interior, highlighting the need for multi-sectoral coordination for successful LTC programs.



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