

CASE-STUDY
THAILAND

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1 General background data

1.1 Preamble

Thailand is a developing country currently undergoing a rapid social and economic transition. In the last two decades of the 20th century, the economy has fluctuated considerably, with years of economic growth interrupted by the economic crisis of 1997. Social changes have accompanied these economic movements, with rapid urbanization and exposure to western culture being examples of two significant developments.

In recent years, there have also been important epidemiological and demographic changes in Thailand. The demographic transition includes an increasing number and proportion of elderly in Thailand's population. The segment of the population over 65 years of age – who will require increasing amounts of long-term health care – has grown over the last twenty years and is projected to increase from 5.2% in 2000 to 11.4% in 2025.

This ageing of the population has accompanied an epidemiological transition from 'diseases of poverty' to 'diseases of affluence' that has shifted the major health burden to that of a more chronic nature. These transitions indicate increased needs for long-term care.

In recent years, there have also been important changes in financing and service provision strategies for health care in Thailand. For example, resources devoted to health care have increased markedly in recent years. While national health expenditure has increased gradually, it has done so at a faster rate than that of the gross domestic product (GDP), rising from 3.5% to 6.3% to 6.2% in 1979, 1991, and 1998 respectively. Systemic changes include a new universal health insurance system, which aims to provide health care to the entire Thai population, and a move to decentralize resources and service provision responsibility.

With regard to provision of LTC, the family has traditionally occupied the dominant role in providing care for disabled and elderly relatives. There is no systematic data on how care is provided to those with long-term health needs.

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However, given what we know about the current health care system and about accessibility to health services and utilization rates in Thailand, it would be fair to assume that most of those in need of LTC are receiving such care from family members. Furthermore, residential care in Thailand is not very popular because the Thai culture stresses the importance of family care for the elderly.

We also know that, in hospitals and health care centres where holistic and continuous care is being provided, family members play a crucial role in assisting members of the health teams that provide care for their relatives. There are private foundations in Thailand that assist and empower family caregivers by providing tools, regular technical supervision, and ad hoc consultation.

The State has played a lesser role in LTC provision, on the assumption that families continue to take care of their own welfare needs and are independent of outside assistance. The poor, therefore, must rely on their own families to care for older relatives.

However, looking at the growing needs for long-term care as described previously, it appears that families will need assistance and supplementation from Government sources in order to provide sufficient care for the growing populations of disabled and elderly.

In this case-study, the demographic and epidemiological changes occurring in Thailand that will impact on the need for long-term care will be examined in more depth. Additionally, the health and social services systems in Thailand will be explored to better understand how long-term care can be melded with the current and future service infrastructure.

Presented on the following three pages are background data concerning Thailand, derived from international data bases.¹ These data include demography, vital statistics and epidemiology, economic data, and health

¹ For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); UNDP, Human Development Report 2001; US Government. The World Factbook 2002; WHO, World Health Report 2002; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002

1.2 Background data from international data bases

Demography (year 2000)	
Population (thousands)	62 806
Land area (sq km)	511 770
Population density (per sq km)	122
Population growth rate (% 2000–2005)	1
Urban population (%)	20
Ethnic groups (%)	
Thai	75
Chinese	14
Other	11
Religions (%)	
Buddhist	95
Muslim	3.8
Christian	0.5
Hindu	0.1
Other	0.6
Total adult literacy rate (% in 1997)	95
Age Structure (%):	
0–14	26.7
15–24	18.7
60+	8.1
65+	5.2
80+	0.6
Projections 65+ (%)	
2025	11.4
2050	21.1

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Demography (continued)

Sex ratio (males per female):

Total population	0.97
15–64	0.97
65+	0.78

Dependency Ratio:

Elderly dependency ratio in 2000 ²	8.9
Elderly dependency ratio in 2025	18.2
Parent support ratio in 2000 ³	5.7
Parent support ratio in 2025	8.8

Vital statistics and epidemiology

Crude birth rate (per 1000 population) (2000) 17.8

Crude death rate (per 1000 population) (2000) 6.2

Mortality under age 5 (per 1000 births) (2001)

males	38
females	31

Probability of dying between 15–59 (per 1000) (2001)

males	272
females	148

Maternal mortality rate (per 100 000 live births) (1995) 44

Total fertility rate (children born/woman) (2001) 2.0

² Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

³ Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.

Vital statistics and epidemiology (continued)

<i>Estimated number of adults living with HIV/AIDS</i> (2001)	650 000
<i>HIV/AIDS adult prevalence rate</i> (%)	1.8
<i>Estimated number of children living with HIV/AIDS</i> (2001)	21 000
<i>Estimated number of deaths due to AIDS</i> (2001)	55 000
<i>Life expectancy at birth</i> (years) (2001)	
Total Population	68.9
Male	65.7
Female	72.2
<i>Life expectancy at 60</i> (years) (2000)	
Total Population	19.0
Male	17.0
Female	20.0
<i>Healthy life expectancy (HALE) at birth</i> (years) (2001)	
Total Population	58.6
Male	56.4
Female	60.8
<i>Healthy life expectancy (HALE) at 60</i> (years) (2001)	
Total Population	12.3
Male	12.0
Female	12.6

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<i>Economic data (year 2000)</i>	
<i>GDP – composition by sector (%)</i>	
Agriculture	13
Industry	40
Services	47
<i>Gross National Income (GNI) (\$PPP)⁴</i>	384 billion
<i>GNI – per capita (\$PPP)</i>	6320
<i>GNI – per capita (US\$)</i>	2000
<i>GDP growth (annual %) (1999–2000)</i>	4.3
<i>Labour force participation (%)</i>	
Male	65.3
Female	56.0
<i>Health expenditure (year 2000)</i>	
<i>% of GDP</i>	3.7
<i>Health expenditure per capita (\$PPP⁴)</i>	228
<i>Health expenditure per capita (US\$)</i>	71

⁴PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.

2 General health care and social service system

2.1 Basic income maintenance programmes

2.1.1 Income support/subsistence allowance for people with disabilities

Registered disabled people who are poor, unemployed, and incapable of earning, are entitled to a 500 baht monthly subsistence allowance. The allowance is also expected to enable people with disabilities to live with their families without needing care from the Department of Public Welfare (DPW) services. In 2000, there were 15 000 persons receiving the allowance contributing to a budget of 90 million baht.

2.1.2 Income support/subsistence allowance for the elderly

Since 1993, the Department of Public Welfare has provided income support or subsistence allowances to poor elderly people living in rural areas. This policy provides cash support for elderly people who are poor, without relatives, or abandoned, and living in villages where support centres for such people are established. The amount of such allowances is very small – approximately 200–300 baht a month. Each village has a committee which decides on the selection of recipients for the allowance. In 1998, there were 318 000 recipients nationwide.

2.1.3 Welfare assistance for families

Cash assistance up to 2000 baht is provided to distressed families, whose breadwinner has died or disappeared, is chronically ill, imprisoned, disabled or unable to take care of the family for any other reason. Assistance is also provided to persons affected by HIV/AIDS (patient or family caregiver).

2.1.4 Welfare assistance for AIDS patients

The DPW provides primary family assistance and a lifelong monthly allowance (500 baht per person) to patients unable to earn their living, and who have been neglected by other people in society.

2.1.5 Cash grants for HIV-infected women

An amount of 5000 baht is provided to HIV-infected women and women affected by AIDS, for self-treatment. This cash grant is provided to those both in and outside institutional care. In 1999, grants in the amount of six million baht have been allocated to women in need.

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2.1.6 Workmen's compensation

The Social Security Scheme and the Workmen's Compensation Scheme provide monetary compensation to eligible workers covered within the two schemes, for loss of certain body parts and consequent inability to work. Such compensation is made available through the premium paid by workers enrolled in the scheme. At present there are only about five million people enrolled in the system, and there are still bureaucratic problems related to disability compensation.

2.1.7 Interest-free loans for small enterprise investment

Interest-free loans for people with disabilities wanting to become self-employed or expand their businesses, are provided from the Rehabilitation Fund. A maximum of 20 000 baht per person is set for the loan with no interest. The maximum period of repayment is five years. In 1999, 77.31 million baht has been lent to 4050 disabled people.

The DPW has also supported rehabilitation projects for disabled people operated by governmental and nongovernmental organizations. In 1999, DPW provided 5.78 million baht of financial support to 51 projects.

3 Organizational structure of decision-making

3.1 Major stakeholders

The Ministry of Public Health (MOPH) is the major provider of public health services and provides about 90% of those services. Long-term care services, on the other hand, are provided by both the Ministry of Public Health and the Ministry of Social Welfare. There is no separate division for these services. Governmental agencies, besides the MOPH, which carry out health-related activities include: the Bureau of University Affairs, the Ministry of Industry, the Ministry of Defence, the Ministry of the Interior, and the Government Pharmaceutical Organization.

The Department of Public Welfare (DPW) is the major government agency responsible for providing social welfare to the Thai people. The DPW was established in 1940 under the administration of the Ministry of Interior, and in 1993 was transferred to the Ministry of Labour and Social Welfare. The Department deals mainly with the welfare of unemployed persons, children and youth, needy families, the disabled and handicapped, the aged, the sick and injured, and ethnic minorities. It has long been criticized for its passive role in providing services to target groups.

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While health and social services in the public sector lie within separate ministries – the Ministry of Public Health and the Ministry of Labour and Social Welfare, respectively – there is no intersectoral cooperation other than that for medical care covered by social security funds. Thus, there appears to be a great deal of fragmentation at the national level aside from the cooperation on this new scheme.

There are also major NGOs in Thailand that are involved in health and social service provision. There are at least 247 NGOs that have active roles in health care, and 6364 NGOs are registered as social welfare entities. They range from those working on health advocacy, to those involved in health provision of various kinds, to selected target populations.

2.2 Decision-making

Policy setting in Thailand is done mostly at the central level, but some local level initiatives exist. There is a general move towards more decentralization in the area of health provision, but it is unclear whether this will affect the policy-setting sphere.

Budget allocation also happens mainly at the central level but there is a move to allocate a greater share to local authorities – from 9% to 35% in the next five years (by 2006). Provision of services have long been and are currently provided mostly by the central government, but with an increase in tax revenue allocation there will be an increased responsibility for the provision of services at the local level.

Although there is an attempt to decentralize many public services, the responsibility for health and social services at the local level is limited at the present time. Variations at the local level can be seen in services provided by communities and NGOs. Licensing of professionals is generally done at the central level by the MOPH.

4 Financing of health and social services

The Thai health care system reflects the entrepreneurial, market-driven nature of its economy, which is exemplified by its pluralistic (mixed public and private) system of health financing. In Table 1, below, the sources of financing for health care in Thailand in 1994, 1996 and 1998 are displayed. These figures demonstrate the significant contribution of private expenditure to overall spending on health care throughout the years from 1994 to 1998.

However, the table also shows that public sector financing for health care over this period has become the dominant source of funding, with its share of the total expenditure on health services having increased from 48.77% in 1994 to 61.1% in 1998.

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**Table 1. Sources of finance
and approximate share (1994, 1996 and 1998)**

Sources of Finance	1994	1996	1998
1. Ministry of Public Health	28.56%	28.9%	35.0%
2. Other ministries	3.8%	6.2%	5.5%
3. Local government	7.76%	3.8%	4.4%
4. Civil Servants Medical Benefit Compensation (CSMBS)	4.34%	8.0%	9.3%
5. State enterprises	1.3%	1.4%	1.7%
6. Social Security Fund	2.7%	3.9%	4.7%
7. Workmen's Compensation Fund	0.31%	0.5%	0.4%
Public expenditure (1–7)	48.77%	52.7%	61.1%
8. Private insurance	1.77%	2.3%	2.4%
9. Traffic accident	1.95%	1.4%	1.4%
10. Employer benefits	1.49%	2.2%	2.1%
11. Households	44.38%	41.3%	33.0%
12. Non-profit organizations	1.63%	0.1%	0.1%
Private expenditure (8–12)	51.22%	47.3%	38.9%
Total expenditure %	100.0%	100.0%	100.0%
Total expenditure (million baht)	128 305.11	171 470.83	178 129.05
Total expenditure as % of GDP	3.56%	3.72%	3.85%

Source: Tangchaorensathien et al. (1999) The 1994 NHA.
Pongpanich et al. (2000) 1996 and 1998 NHA.

Traditionally, the pluralistic nature of financing (and provision) in Thailand has made it difficult to provide equitable services, and contributes to inefficiencies and variable levels of quality of care.

4.1 Government financing and expenditure for health and social services

Prior to the 1997 economic crisis in the country, Government budget allocations to public health grew moderately. During the period 1992–1996, health expenditure accounted for 5.4%, 5.8%, 6.3%, 6.5% and 6.7% of the total government budget for those years, respectively. From 1977 to 1992, health expenditure, as a percentage of the GDP, expanded from 3.4% to 5.9%. Total health expenditure rose, in real terms, from 853 baht per person in 1977 to 2689 baht in 1992.

These trends demonstrate an increasing commitment of the Government to spending on health services. Figures in 1998, the last year where such statistics were available, showed that Government spending for health accounted for approximately 6% of the total Government budget and the total health expenditure was estimated at 4% of GDP.

Financing for health services through public service outlets has traditionally been through budget allocation practices based mainly on the size of health facilities, past performance and the needs of programmes. Implementation was done through agencies responsible for specific programmes. Even at the present time, budgets are hardly ever allocated to tackle the needs of well-defined population groups, but rather for problems that would affect a broad range of target populations.

As an example, even though there is a long-term plan for the elderly, the emphasis is not on developing a service system or care package aimed at them, with a special line of service delivery. Rather, on services for the elderly – health, social and clinical-Pongpanich et al. (2000) – will be integrated within the existing health and social service delivery systems.

4.2 Government pooled programmes

At the end of the 1990s, approximately 35-40% of the Thai population were not covered by any health insurance scheme and had to pay user fees whether they went to public or private health care facilities. The Government initially attempted to combat this problem by issuing 'voluntary health cards' for the near-poor and 'low income cards' for indigent children, the elderly, veterans, the handicapped, and certain religious and political figures. In 2001, a new reform was implemented to replace these initial attempts. This new reform is intended to provide universal health insurance to all Thai citizens.

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After this reform, and as things currently stand in Thailand, there are essentially four Government health insurance programmes:

- The Civil Servants' Medical Benefit Compensation (CSMBS) Programme, which covers civil servants.
- The Social Security Fund (SSF), which covers employees in firms with more than 10 workers.
- The Workmen's Compensation Fund (WCF), which also covers employees in firms with more than 10 workers (the same population as is covered by the SSF), but which operates on different financing principles and has separate management.
- The new universal health insurance coverage, which is intended to cover the remainder of the population.

In order to clarify the coverage and financing mechanisms of these four programmes, some further details about each of these programmes will now be provided.

4.3 Civil Servants Medical Benefit Compensation (CSMB)

The CSMB is a fringe benefit provided to civil servants. It was estimated in 1998 that this programme covered approximately 11% of the Thai population. The provider payment mechanism of the CSMB is fee-for-service, and its funds derive from general tax revenues. The CSMB is administered under the Ministry of Finance.

4.4 Social Security Act of 1990

The Social Security Act of 1990 was considered a major watershed in the history of welfare development in Thailand. In essence, it enabled participants of programmes to enjoy benefits without a sense of obligation or stigma. In other words, welfare is now perceived as an individual right rather than charity, as was once the perception.

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Under the Act, the Social Security Office was established to organize and operate the programme and the Social Security Fund was assigned the administrative work. The insurance coverage includes the following seven categories:

- off-the-job accidents and sickness;
- physical disability;
- maternity;
- death and survivors;
- family allowances;
- retirement; and
- unemployment.

The Social Security Act provides for the welfare of those working in places with more than ten employees. In fact, it covers only about five million people, or slightly less than 10% of the total population. It is now being expanded to cover those workplaces with fewer employees and is expected to eventually cover around 20% of the total population. The scheme offers six different benefits, including:

- access to free medical services with a minimal exclusion list (yet it is still a poorly-defined core package);
- long-term pension benefits (old-age benefits);
- unemployment;
- maternity;
- disability; and
- death benefits.

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This scheme has led to competition between service providers. Aside from access to public health facilities, beneficiaries are entitled to use private facilities that contract with the Social Security Fund. Payment for such care is done through capitation. This scheme has also brought the issue of regulating quality of care in public and private hospitals into focus.

4.5 Workmen's Compensation Scheme

The Workmen's Compensation Scheme covers expenses for medical care arising from work-related accidents and offers compensation for loss of body parts based on physical disability. It covers the same population as the Social Security Scheme but operates on different financing principles and has separate management. Both are under the Social Security Office, which is part of the Ministry of Social Welfare and Labour.

Those covered by the Workmen's Compensation Scheme (WCS) are reimbursed for all medical expenses up to approximately US\$800 per illness episode and also receive monetary compensation for medical conditions leading to disability. The most common medical conditions covered by this scheme are injuries resulting from machine operation. Such accidents may lead to short-term or long-term disability or suffering of varying severity.

There are also cases for which eligibility is subtler, which have led to disputes between the employees and the WCS. This is especially true for medical conditions that may be attributed to the long-term exposure to hazardous agents present in the workplace. However, the lack of medical evidence and unclear information with regard to certain agents and their relation to health conditions has created a number of conflicts. This has led to a proposal to establish separate organizations to deal with such problems, the better to compensate workers in cases of severe health impact due to working conditions.

4.6 Universal health insurance plan

The 2001 reform seeks to create a large national health insurance fund to pay providers at a prospective capitation rate for inpatients within a specified budget ceiling using DRG weights as criteria for reimbursement. Such a payment method will provide the opportunity to create awareness and incentives among service providers, for meeting health needs of various population groups if an age-differential capitation rate can be properly devised.

Despite the positive ramifications that may be realized with the adaptation of the new universal financing system, there are also potential pitfalls. It is possible that the present reform will become a threat to the existing health care system if it fails to become a proper financing model and does not provide adequate funds. This will result in a lower quality of health care within the universal health insurance scheme.

4.7 Concluding thoughts

Within the present public system of health service provision, it is important that health service providers understand innovative service provision. In this way, they can more effectively address the changing health needs of the population. Even within the present health insurance schemes there are no clear benefit packages. Although beneficiaries can receive health services without having to pay for them out of pocket, the range of services available is supply-driven. If providers of health services are not capable of providing a range of health services, those services will not be available.

In the new universal health insurance scheme it is expected that the national authority or the local health purchasing bodies will be capable of specifying a range of health services (the core package) that will be made available. However, it remains a challenge for those managing the health insurance scheme to specifically identify certain health service packages and develop the necessary payment methods to ensure that they will be properly delivered within the prospective payment system.

Keeping in mind that efforts will be made to include LTC services within the financing framework of health care pooled programmes, the changes taking place in the central Government, and in the political as well as social development arenas, make it quite likely that the services for LTC – either health or supportive services – will be developed based only on an individual's ability to pay. The LTC gap in the Thai health system then may not be adequately reduced. Those who can afford to pay can certainly have access to the available limited supply of services, while very few will be available and accessible for the poor.

In such cases, the demand for home helpers may be the only thing that will be quite obvious. It will demand clear policies on how to direct the education of such home-helpers, as well as on the changing roles of health service providers to improve outreach and home-based care.

As for those who have to depend on whatever care is available from health providers in the public system, the major challenge first involves ensuring that the central and local governments identify the needs for such services. Next, those governments must obtain the needed financial and technical support, from whatever sources of budget are available for social services in the future. This effort requires very strong leadership and good informational support from the Ministry of Health.

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Again, it is important to emphasize that the likely scenario for the future definitely involves serious debate about the justification of including various types of LTC within the collective financing system. However, many of the services required will be left to the individual's ability to pay.

Financial support for certain supportive services, such as prosthetics or daily subsistence payments for the poor, may be made available through various charitable NGOs that are supported by general donations from the public. The law on the rehabilitation of the disabled will make certain prosthetic supports available, but will be unable to meet many current cases due to limited implementing capacity. This has been obvious since the first draft of the legislation was enacted in 1991.

5 *Service delivery system*

Under the Ministry of Public Health, there are three levels of health care provision:

- primary health care, including health centres;
- secondary care, including community and general hospitals; and
- tertiary care, including general, specialized, and regional hospitals.

A greater proportion of money is spent on curative care than on health promotion or preventive care. However, a large number of programmes have been developed in the latter areas.

Service delivery through the MOPH is comprised of health centres and community, regional and general hospitals. Health centres provide primary care at the Tambon level and referrals to higher levels of service. The centres are staffed by junior sanitarians and technical nurses and have, on average, 3.5 personnel per centre. Their catchment areas cover a population of 5000.

They deliver mostly preventive and health promotion services, e.g. nutritional, dental, and MCH programmes, mainly through an outreach community-based approach with village volunteers. The centres also provide basic curative care under supervision of community hospital doctors. Staff members are assessed through a monitoring system set up by planning departments.

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Health centres have little autonomy, due to central planning and budgeting, although this has improved because of the new universal style health coverage that will encourage them to perform in a manner similar to high quality primary care units (PCUs) under the supervision of community hospitals. Additionally, their autonomy will be encouraged by a newly codified right to keep some of the new revenue generated by a budget allocation method that allows them to be less dependent on central department programmes and projects.

Community hospitals serve as the first referral level for curative care. The number of beds in these facilities ranges from 10 to 120. Their major roles are to provide comprehensive services to the population in their immediate catchment areas. They have a greater potential than the health centres for outreach services and innovative programme development. The main staff is comprised of doctors, nurses, dentists, pharmacists, junior sanitarians and general supportive personnel. There are no specialist posts in community hospitals.

General and regional hospitals are located at the provincial level. The number of beds in such facilities ranges from 200 to 700. Their main responsibility is to provide secondary and tertiary care. They serve as referral centres for specialized medical services. One of their roles is to provide comprehensive health services to people in the catchment area through their departments of social medicine.

Staffing is similar to that in community hospitals but includes specialists as well as physiotherapists, laboratory technicians, etc. Because these facilities have a larger pool of staff and a greater potential to generate revenue, they are more autonomous and have the ability to provide newer types of health services including outreach and institutional care. Funds from the central ministry account for 30–70 % of their total revenues.

Traditional Thai medicine is practised both in and outside hospitals. Other alternative medicines also exist in the community, with supervision by the Medical Registration Division. Traditional Thai medicine and other alternative methods practised in Thailand are generally not covered by any insurance schemes and require private payment. However, in some parts of Thailand traditional healers and healing facilities (e.g. centres for traditional Thai massage) may receive financial assistance from local health centres.

In general, Thai people seek professional health care, at various facilities, for 70% of their illness episodes. Seventeen per cent of the population self-prescribes, and 14% seek treatment through traditional healers. Average utilization rates are 2.8 for outpatient visits and 0.08 for admissions per person per year.

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5.1 Access to care

Access to care is problematic in many parts of Thailand due to the absence of affordable public transportation and the lack of adequate facilities nationwide. People living in Bangkok and the local vicinity have better access to care than people living in other parts of the country.

In general, people living in certain big cities of regional importance, with more developed health facilities and greater levels of economic development, tend to have better service facilities in their localities. Long-term care services, on the other hand, vary from region to region.

There is also differential access to care due to the competition that has arisen between service providers under the Social Security Scheme. Beneficiaries have access to public health facilities and are also entitled to use private facilities that contract with the Social Security Fund. Payment for such care is done through capitation. This scheme has also brought into focus the issue of regulating quality of care in public and private hospitals.

As health services organizations in Thailand are mostly public, the entitlement types of health services available to the Thai population should, in theory, be relatively uniform throughout the country. In reality, however, there are differences in the types of health services available to people in various localities and to those with various levels of social status.

5.1.1 Variation due to service availability

Public hospitals in various provinces and districts vary in the range of health services they provide. Tertiary care is available to the population in only 14 of the 75 provinces. Rehabilitation services are not available in all provinces.

In certain provinces and districts, there are medical school hospitals or military hospitals where certain types of health services may be more readily available. Facilities for radiation therapy for people with cancer may not be available in many provinces as there is a total of only 36 units in the country.

Psychiatrists are also not readily available in all provinces. Facilities in Bangkok have the broadest possible range of services and expertise available in the country.

5.1.2 Variation due to entitlement among population groups

Civil servants and their dependents have the best entitlement for health care, as they are covered, as an employment benefit, by central funds from the Government . Their ability to access such care is limited only by geographic or transportation barriers.

Employers in the formal sector with more than ten employees offer the benefits of the social security system and, as previously described, have relatively generous medical and health benefits including other types of financial compensation. The indigent population has access to unlimited health services, but in practice there are various social and other financial barriers to care as a result of personnel attitudes and service availability.

5.1.3 Variation due to health services autonomy

Variation due to health services autonomy is the result of public facilities being quite autonomous in taking up new initiatives to address health problems or health service needs of the population. This is made possible through autonomy in the financial management of hospitals and also to a certain degree in the local government.

Hospitals and health centres, as well as provincial health offices, can create new programmes or health services on their own initiative if they are able to mobilize funding from various sources. The majority of financial support comes from hospital revenue through user charges.

Also, because of the lack of concrete support from the central government, many new programmes are implemented by local health authorities and hospitals according to their own priorities and standards. For this reason, there are national programmes, such as health-promoting hospitals and home health care, being implemented with a wide range of intensity and quality. High priority programmes are implemented and made available quite uniformly throughout the country.

Since LTC is quite new in Thailand, there are not yet any established programmes with concrete financial supports. Health services available to those with long-term care needs vary from one geographical area to another. The same applies to other related social services. They are made available uniformly only when they are of high priority and have concrete targets and financial support. Otherwise, service availability varies from one area to another depending on the priorities and capabilities of the staff in each locale.

5.2 Services provided by the Department of Public Welfare (DPW)

5.2.1 Types of services

As previously mentioned, there is a wide range of services available for people in need. The Department of Public Welfare (DPW) provides services for children, HIV/AIDS patients and their families, the disabled, the elderly, and immigrant workers. These services are briefly described below:

5.2.1.1 Services for children

■ Family support

The DPW provides financial support for poor families and those dealing with behavioural problems in children in the areas of child rearing, counselling, healthcare, and the provision of milk, stationery, school uniforms, etc.

■ Foster care placement

The DPW helps find foster families particularly for children in the orphanages of the Department of Public Welfare. In 1999, 654 children were placed in foster homes.

■ Residential homes for children

For cases lacking better alternatives, orphans and abandoned children are sent to children's homes, children's shelters, or child protection homes. In 1999, there were a total of 24 such children's homes.

■ Child adoption promotion

The DPW arranges adoption placements and attempts to ensure the wellbeing of adopted children through regular assessments of adoptive families.

■ ***Regulation of private children's homes and child day care centres***

The DPW also supports, promotes and regulates private provision of children's homes and child day care centres. Recently, the private sector has played a more vital role in social service provision for children. Private services are under the supervision and regulation of the Department and must meet their standards through the issuance and withdrawal of licenses. The Department also provides personnel training, meeting and seminars, and supplemental support through provision of food and toys.

■ ***Protection of children's rights***

According to the 1972 Revolutionary Decree Number 294, abused and neglected children and those being unlawfully exploited are protected under the DPW through various programmes of child welfare protection. Furthermore, the DPW works in cooperation with the National Council for Children and Youth Development and the International Programme on Elimination of Child Labour of the ILO. The DPW is also working to protect women and children according to the 1997 Measures in Prevention and Suppression of Trafficking in Women and Children.

5.2.1.2 Services for disadvantaged women

■ ***Provision of social services and vocational training in welfare protection and establishment of vocational development centres for women***

Services include shelter homes, welfare and protection for women, and welfare and vocational training centres for women. In 1999, there were four shelter homes, three welfare and protection centres, and seven welfare and vocational training centres for women throughout the country.

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■ *Welfare and vocational training for women in communities*

Services are aimed at disadvantaged women and particularly prostitutes. The Department coordinates with the Ministry of Foreign Affairs to protect and rescue involuntary prostitutes. The DPW runs vocational training services for disadvantaged young women, unemployed, and retrenched female workers.

■ *Revolving fund for women's self employment*

The DPW has allocated 50 million baht for setting up a revolving fund to provide loans to women who have completed vocational training courses and have become members of an occupational group.

■ *Cash grants for HIV infected women*

■ *Anti-prostitution campaign*

5.2.1.3 Services for the destitute

The DPW provides services to beggars and vagrants in the form of care in reception homes and homes for the destitute, and provides vocational training in vocational training centres.

5.2.1.4 Services for people with disabilities

The DPW has set up the Office of the Committee on Rehabilitation of Disabled Persons in accordance with the 1991 Rehabilitation of Disabled Persons Act. Services include entitlements, support to families of people with disabilities, provision of assistive devices, community rehabilitation programmes, subsistence allowance vocational training, disability regulation enforcement in places of employment, interest-free loans for small business investment, residential care, and various programmes protecting the rights of people with disabilities.

5.2.1.5 Disaster relief

The DPW has long provided assistance to and rehabilitation services for victims of both natural and man-made disasters, particularly those who are in need of immediate assistance. Services include five regional disaster relief centres, disaster preparedness and disaster relief programmes, and coordination with other organizations that provide assistance.

5.2.1.6 Services for families and communities

Various services include financial support and counselling for families and communities with economic and social difficulties. Many service centres are set up for particular target groups such as those living in poor areas. These service centres also work with NGOs in arranging services and programmes in the community, e.g. home visits, mobile services, and pre-school child care.

5.2.1.7 Services for older people

Services for the elderly seek to maintain well-being, particularly for those who are socially isolated and vulnerable, and to prevent homelessness, abuse, and family neglect. The DPW also initiates campaigns to support family caregiving. Services for the elderly include: residential care, social service centres, mobile units, and emergency shelters. Additionally, there are programmes specifically for older people, i.e. monthly subsistence allowance, subsistence allowance from the private sector, and service centres located in temples.

5.2.1.8 Other programmes

The land settlement development programme was initiated in 1940 to allocate uncultivated land for farming to the poor, needy, and landless people. Currently there are 44 land settlements, located in 35 provinces, under DPW auspices. Service provision ranges from financial support to technical assistance in occupational development.

In addition, services for members of the hill tribe have been developed to promote quality of life and social inclusion. Services include vocational and environmental conservation training, child development centre support, basic public utility development, and revolving funds for social and occupational development.

In addition, the DPW owns 29 lending institutions that provide loans to the needy and control the interest rates of private lenders. In 1998, the Office of Public Lending contributed 29.31 million baht to Government revenue.

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5.3 Elements of the nature of health and social provision that may impact LTC

Historically, health services in Thailand have been dominated by the development of the public sector, which has been the major provider of health care for those with low socio-economic conditions. Evolutionary health services in the public sector tend to seek alternative approaches with the aim of improving health rather than mere expansion of curative services.

Community participation, better balance of budget spending for preventive and curative services – as well as the creation of outreach services and home-based care – have been gradually receiving more emphasis from public providers. However, this has not been the case in the private sector, which grew tremendously during the economic boom period – mainly to cope with demand for curative care. This demand resulted from dissatisfaction with the crowdedness of the public sector and the relatively less pleasant attitudes encountered among public providers.

This does not mean that health services in the public sector did not also benefit from the rapid economic growth. On the contrary, during the same period the Government invested heavily in the public sector, although mostly in curative services. There was an almost threefold increase in the budget of the Ministry of Health budget in the 5-year period of the 7th Health Development Plan (1991–1995) with approximately 35% of the total budget used for capital investment in 1994. The public sector has also been able to increase its budget to cope with the increasing demand for free medical services for the indigent population, while also expanding its coverage of free services to other population groups such as community leaders.

Neither public nor private providers have focused on rehabilitative services. This could be due to a lack of explicit demand from the population. There have been no systematic approaches to identifying such population groups. All kinds of barriers to such services exist, the most important being the lack of qualified personnel and their distribution.

Although there was concern over the lack of health personnel in rural areas, that concern was focused on doctors, nurses, dentists, and pharmacists. Only these four categories were obliged to serve in rural areas, for a period of time after graduation. Such compulsory service was never extended to physical therapists, and training for auxiliary personnel in physical therapy and rehabilitation was discontinued after less than ten years.

CASE STUDY: THAILAND

Supportive services for those needing LTC lag behind other health services. The public welfare system is a recent concept, although various types of charitable organizations have long existed in Thai society. However, most such organizations and their services were available on a charitable basis, and all depended upon how much the supply side was willing or able to provide. There were relatively fewer explicit demands from those who needed them. People who might have benefited from a better welfare system placed themselves at the mercy of Government machinery, or sought help from the more prosperous population.

Thailand took fifty years to decide upon the first Social Security Act – the first attempt to systematically institutionalize the social welfare system and to move away from the charitable approach. The Department of Public Welfare was moved into the new Ministry of Labour and Social Welfare, when this Ministry was established after the passage in 1992 of the law on the social security system.

There are still programmes which are operated on charitable basis. They tend to be very passive and limited in scope, and they lack the flexibility to deal with the needs of target populations with different socioeconomic backgrounds. The fact that these programmes and organizations are in a ministry separate from that of Public Health make it difficult for them to be well coordinated in responding to the need of their priority target population groups. LTC needs tend to partially met, on either the health or the social aspect of the services required.

5.4 Auspices of service providers

As mentioned previously, there is a pluralistic system of health care provision in Thailand. Accordingly, services are organized and provided by both the public and private (for-profit) sectors. Among the numerous changes taking place is the increasing presence of the private sector in the provision of health services.

The Ministry of Public Health is the major organization responsible for care and provides about 90% of public services. The private for-profit sector accounts for 70% of all hospitals and hospital beds, and most of the primary care services. There are also private for-profit clinics and pharmacies. This sector is rapidly expanding, particularly in Bangkok and other urban areas. Thirty per cent of hospital care is public. Overall, public health care services have been extensively developed by the various governments during the past 40 years.

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Generally, services for those requiring long-term care are provided through a mix of public and private institutions. However, public outlets are still serving the needs of the majority of those requiring long-term care.

The majority of health facilities outside Bangkok are under the MOPH. The average number of general hospitals, community hospitals and health centres per province (with an average population of 700 000) are 1.2, 10.2, and 100 respectively. These facilities provide services at the primary through tertiary levels of care. Health volunteers assist health personnel in health centres, community hospitals, and general hospitals in all villages outside Bangkok. Medical schools and private hospitals provide mostly curative services, with no specific catchment population. Private clinics/polyclinics provide ambulatory services for drop-in patients.

There are various private providers of medical services including physicians, dentists, hospitals, drug distributors, and traditional healers. Although private health services have increased rapidly throughout the past decade, medical practitioners are still scarce. Forty percent of the urban population uses private services, whereas 50% use public health centres. Most private providers are also employed by Government health programmes and work only part-time in private practice. Their earnings as private practitioners are normally much higher than their salaried Government positions.

The balance between public and private contractors under the Social Security Scheme has changed over time and the share of the private sector has increased. In 1994, the private sector comprised 32% while in 1999 it held 45% of contracted health facilities. Furthermore, the share of registered workers in private facilities has also changed according to the same trend. The private sector more than tripled in market share during the first three years of this scheme. It rose from 16% in 1991 to 53% in 1993. By April 1999, the private sector covered 58% of approximately 5 million beneficiaries.

Many NGOs in Thailand are also involved in health care and social services. At present, a coordinating committee for NGOs is attempting to establish links to and a communication network with the Government health sector. Most notable among the thousands of NGOs are those working with the disabled. Sources of income vary from one NGO to another. Some organizations depend on domestic donations, while others receive external funding.

The Ministry of Public Health provides an annual budget of approximately US\$1 million to support various NGOs including a Government fund dedicated to NGOs working specifically with HIV infection. There are also 'private foundations' that assist and empower family caregivers providing them with certain tools as well as regular technical supervision and ad hoc consultation.

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Health care and social services are provided not only by formal institutions but also by traditional informal institutions. The family and religious institutions have also played an active part in providing welfare for the populace. The State has played a lesser role, on the assumption that families will continue to take care of their own welfare needs. Since the Social Security Act of 1990, however, the role of the state in welfare provision has gradually increased.

5.5 Human resources and training

Doctors, nurses, pharmacists, dentists, and other health care personnel must have professional licences in order to practise in Thailand. In addition to these providers, health volunteers work at the village level, with roles centred on health education and information distribution rather than care provision. There is no specific training required for paraprofessionals, although there are assistant nurses and technical nurses who are trained mainly for work in hospitals.

The MOPH also employs community health personnel, including technical nurses, midwives, and health personnel. Since 1991 the educational requirements for health personnel have included secondary school education and two years of training. In 1996, there were an average of 3.08 health personnel per health centre. Recent interest has also been expressed by a private caregiver agency in caregiver training for the elderly, in a health school located in Chonburi .

5.5.1 Doctors

There are about 20 000 doctors throughout Thailand. The doctor to population ratio widely varies from 1:900 in Bangkok to 1:9000 in the north-east region. Although the number of new medical school graduates has increased faster than has population growth, a total of about 2000 doctors in the community hospitals serve 60% of the population. The ratio of GP to specialist was 45: 55 in 1998. Doctors do not provide care in the homes of disabled patients.

5.5.2 Nurses

There are about 57 000 nurses throughout the country. The nurse to population ratio ranges from 1:400 in Bangkok to 1:2000 in the north-east of the country. The majority of nurses work for the MOPH and only 10% work in the private sector. The annual graduation of nurses is about 6000. Recently, the MOPH's nursing colleges have been pressured to reduce this annual rate of production. However, such pressure does not exist at university nursing faculties. Nurses working at selective local health centres provide care in the homes of disabled patients.

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5.5.3 Social workers

Social workers require four years of training and receive a bachelor's degree from the Department of Social Administration or Social Science at various universities. Special training is optional as is professional practical training in various service settings. Generally, there are two types of social workers: professional social workers who provide counselling and social therapy for support, adjustment, rehabilitation, prevention, and development programmes; and general social workers who provide general management services.

5.5.4 Psychologists

Psychologists require special training beyond graduation. They provide general and specialized counselling. Basic training requirements range from degrees in education, to social work, to professional nursing.

5.5.5 Physical therapists

Physical therapists are crucial health personnel in the provision of long-term care. They number about 650 at the present time. Seven faculties in seven universities – five public and two private– train physical therapists, with an annual production rate of 240–330 per year. There has been no immediate plan to train more than this number, nor to introduce policies requiring service in the public sector and particularly in rural areas. There are also medical doctors who specialize in rehabilitation, but their numbers are fewer than physical therapists and it has not been a popular specialty among medical school graduates.

5.5.6 Alternative health care providers/Traditional healers

Thailand offers training at specialized schools for Ayurvedic practitioners. Those who undergo informal training can also apply for licensing from the Medical Registration Division. This is an example of a traditional practitioner who receives systematic training and licensing. Like other types of traditional healers, they have no systematic support for training but are allowed to take licensing exams and qualify for practice.

There are also various types of spiritual healers, most commonly found in the north-east region, who practise locally and are therefore not regulated as are other health providers. Generally, Thai traditional healers provide services in rural areas. Health care in urban areas is dominated by modern medical practitioners. In some cases where good relationships exist between local health centres and local traditional healers, healers may receive financial support from the health centres.

5.5.7 Paraprofessionals

There are many different types of paraprofessionals trained to work solely in MOPH facilities but they are few in number. Paraprofessionals include technical nurses, dental assistants, dental nurses, junior sanitarians working at the health centre level, pharmacist assistants, cytologists, lab technicians, radiation technicians, and others.

Training for technical nurses generally involves two years following high school. However, there currently fewer trainees due to an increase in this training time from two to four years in an attempt to upgrade them to professional nursing.

Common problems of most paraprofessionals include the lack of clear career paths/ladders, coupled with low job status and low morale. The length of the career of a paraprofessional is relatively short. There are only a few categories of paraprofessionals who are permitted to work independently in order to augment service provision to the rural population. Because the Ministry of Public Health is undergoing reform and has been mandated to reconsider its manpower production and health service provision, many of the Ministry schools that train paraprofessionals are in a transition period involving reorganization and redefinition of their roles.

With the recent migration of young women from rural areas into urban settings to seek jobs, there has emerged a new pool of paid home helpers for those with chronic health conditions. This has given rise to a self-initiated school focusing on the training of young men and women in the care of children and the elderly. Although this approach has expanded gradually, the duties of these home-helpers have been somewhat limited as a result of resistance by certain professional organizations to their employment in this area of work.

5.5.8 Support staff in social welfare services

Support staff are employed as permanent public employees, not as civil servants. Education beyond a secondary education, that is higher than matayom 3, is required of these support staff. They provide assistance to residents in various welfare homes.

5.5.9 Volunteers

Health volunteers work at the village level, with roles centred on health education and information distribution. They are not involved in the provision of care.

3 Summary of long-term care provision for the elderly and disabled

Broadly speaking, people requiring long-term care fall within three categories, based on problems affecting their health status:

- chronic diseases;
- disability; and
- ageing

Clearly, overlaps occur among these categories. As mentioned previously, the number of people with chronic health conditions, both from communicable and noncommunicable diseases, has increased progressively within the Thai population.

The proportion of elderly (those over age 65) is also projected to reach 11.4% of the total population by 2025 – a large increase from today’s estimated 5.2%. The number of people with disability has been estimated at approximately 5%, according to the latest national survey. The total estimated number of people within these three categories may be as high as 30% of the total population.

In general, there is as yet neither a systematic approach nor any concrete policies concerning LTC. Accordingly, it is difficult to identify clearly the service infrastructure for these population groups. In addition, few human resources are dedicated solely to providing LTC.

However, these conditions present both a disadvantage and advantage of the Thai health system. That system tends to integrate services, rather than to specifically single out particular problems or the needs of particular population groups and to establish dedicated facilities to deal with them.

Generally, however, services for those requiring long-term care are provided through a mix of public and private institutions. Public outlets are still serving the needs of the majority of those requiring long-term care. Although the types of service and support provided are both medical and supportive in nature, those available are still far from meeting the real needs of the target groups.

On the whole, LTC for those in need of such care is still far from adequate. There exists a wide gap between demand and existing supply of services – medical as well as supportive.

3.1 Identification of target population groups

Age and degree of dependence on others are two important criteria that can help to target more effectively the various population groups that may require long-term care. Using these two criteria, it is possible to map various types of conditions that may pose needs for long-term care within the Thai context.

These types of conditions are as follows:

- Those with common chronic illnesses such as tuberculosis, hypertension and diabetes mellitus, and HIV infected people. These are mostly people in the active working age group, with some in the elderly age bracket.
- The elderly population, especially those without proper family support.
- Those with disabilities ranging from sensory limitations such as blindness or severe hearing loss (two among the top five groups of disabled people in the country) to limitations in movement due to accidents or severe neurological conditions. These people are also mostly among the active age group, with some being children. People with long-term mental and neurological disorders include children who are mentally handicapped as a result of the mix of preventable and unavoidable congenital defects.
- The elderly population with disabilities of various types, especially those without proper family support. These disabilities may result from diseases such as cerebrovascular, accidents, or injuries without proper rehabilitation, or they may be simply degenerative conditions.
- Those providing care to people requiring long-term care of various kinds are also target group for LTC development. These caregivers range from family members, to those working in charitable organizations (including temples), to health professionals and support staff. This target group requires special attention to ensure that caregivers can effectively carry out their roles and functions, crucial to improving long-term care.

Table 2. Summary of target population groups

<i>Target population</i>	<i>Size of group</i>
Group 1: people with chronic illness	
<i>Tuberculosis</i>	31 081 ^a
<i>Hypertension</i>	4.3 million ^b
<i>Diabetes</i>	1.8 million ^b
<i>Living with HIV</i>	670 000 ^c
Group 2: elderly people	
<i>Living alone</i>	4.3% of elderly population ^d
<i>Without proper family support</i>	15.8% of elderly population ^e
Group 3: disabled people	
	1.02 million ^f
Group 4: elderly people with disability	
	108 000 ^g
Group 5: care provider	
<i>Professional/formal care provider</i>	
<i>Informal/family care provider</i>	Unclear
^a Notification report, Epidemiology Division, 1999	
^b Only working population, Churapawan 2000	
^c Estimated people living with HIV under heterosexual risk reduction scenario	
^d 1995 data from Chayovan's unpublished paper (1999)	
^e Using (Chayovan's) survey data assuming all elderly people reporting dissatisfaction with no adequate indirect support are those living without proper family support	
^f NSO, 1996 Health and Welfare Survey (all people with impairment – may overestimate the disabled)	
^g Derived from 1996 HWS	

Among those with health conditions that require long-term care, the third and fourth groups are those traditionally considered to be the more relevant targets for long-term care development. However, one should not focus only on organizing long-term care based on the present estimate.

Rather, it is interesting to note that many of those causes that may lead people to ultimately require LTC or depend on others for help can be prevented or averted through various types of preventive efforts and programmes. These programmes can be conducted through various sectors of society and not necessarily the health sector.

Among the various target population groups in need of long-term care we can assign the type of services required according to the specific needs of the various population groups. Such services consist of both health care and social service support and are not necessarily rendered by health professionals only.

3.2 Description of current long-term care services

3.2.1 Hospital-based services

■ Rehabilitation services

Rehabilitation services are part of hospital services, although not all hospitals have such services available. All of the hospitals at the provincial level, and approximately 80 community hospitals offer such services.

There is a national centre for rehabilitation in the Ministry of Public Health. However, its scope of services and coverage is limited by its location near Bangkok, as well as by the limited budget and personnel available. Its mandate has been somewhat broadened by the legislation on the rehabilitation of the disabled introduced in 1990, but its capacity still remains quite limited.

Even though auxiliary personnel for physical therapists exist in the Thai health system, their numbers are few. Moreover, most work with professional physical therapists rather than in the rural areas, where professional personnel may be lacking.

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3.2.2 Home-based care

■ Home care

Home-based care is a recent development in the Thai health system. These services – offered through targeted development projects – are organized and managed by two different divisions of the Ministry of Public Health. One home care programme covers exclusively public hospitals of the Ministry of Public Health. All 92 provincial hospitals, but fewer than 10% of community hospitals, provide home-based care.

One of the initiatives emphasizing home-based care is the 'health promoting hospital'. The aim is to reorient hospitals so that they build a continuum of services that range from health promotion to rehabilitation. The key strategies consist of public mobilization as well as system development for identification of patients for early discharge along with continuous home-based care. Although the initiative does not target people with needs for long-term care as the primary objective, it has the potential to develop a system for public hospitals that can evolve and meet the health needs of such target groups. Currently, there are 350 MOPH hospitals enrolled in the health promoting hospitals programme.

A second initiative emphasizes proactive care provision aimed at the development of health teams that provide continuous health care to people with a wide range of health problems such as tuberculosis, hypertension, diabetes mellitus, cerebrovascular accidents, etc. This initiative also has the potential to address more effectively the health needs of those requiring LTC.

■ Emergency care service

An emergency home service exists for elderly people who are experiencing severe family stress and want to separate themselves temporarily; for elderly people from the provinces who need to go to hospitals in Bangkok but have no accommodation there, for elderly people who are waiting for their relatives to return home after medical treatment in hospitals in Bangkok; for elderly people who are waiting to enter institutional care, and for elderly people from regional provinces who come to stay in Bangkok. The funded length of stay does not exceed 15 days and the basic maintenance and social work services are provided.

■ *Caregiving services*

There are many agencies providing trained caregivers to look after older people in their own homes. Usually, these services are costly, so users are middle to upper class. The poor must rely on their own families to look after their older relatives.

Care providers in private home-based care for the elderly (and children) have special training provided by their own schools. The Ministry of Education is entrusted to register and oversee the performance of the training schools for these care providers. However, the nursing council is not in favour of this type of school, and cites concern over quality of care and violation of professional nursing standards under the jurisdiction of the council.

3.2.3 *Community-based support programmes*

■ *Community self-help groups and civic groups working in health care*

Health service providers in rural areas working under the Ministry of Health have been quite instrumental in creating social groups of various types working to improve the health of people in local communities. The two most notable groups are those dealing with the elderly and people with HIV infection. Although historically this approach began with the training of village health volunteers, the number and types of community groups have expanded with changing health needs.

At present, there are village health posts operated by village health volunteers who provide simple care for common health conditions. There are also clubs and groups for the elderly organized by health personnel in almost all provinces, covering about 5% of the villages (approximately 4000 clubs in a total of 80 000 villages throughout the country).

In addition, a large number of community groups working with HIV infected people are supported by the network of health personnel and other local NGO's. Some of these are supported by the budget from the Ministry of Public Health.

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Community involvement in support programmes also includes community-based outreach by village volunteers working through MOPH health centres which provide primary care – mainly prevention and health promotion services – at the Tambon level.

■ *Mobile units – Ministry of Social Welfare*

A mobile unit service consists of social workers, nurses and specialists who visit the elderly in the community, and disseminate information about health and social care. The unit serves as a medical check-up and scan point for health and social problems of older people in the community. The service operates at least once a month. In 1992, the work of the mobile unit was operated at the Din Daeng Elderly Social Service Centre in Bangkok and the Lop Buri Elderly Social Service Centre in Lop Buri, another province in central Thailand.

■ *Temples*

In 1998, recognizing the important role of temples in Thai communities, the DPW launched a community-based project for older people in temples throughout the country. It is hoped that these centres will enable older people to continue living at home rather than in institutional care. In 1999, DPW received funding of 43 million baht from the Miyazawa loan project to provide revolving funds for these centres. Currently, there are 200 centres nationwide and they are allocated 50 000 baht in revolving funds. Another 140 000 baht will be provided to each of them to purchase materials and equipment for physiotherapy, exercise, and office appliances, etc.

■ *Rehabilitation services in the community*

DPW has encouraged families and the community to participate in the rehabilitation of disabled people in the community using locally-available resources and community wisdom. DPW has cooperated with village welfare assistant centres and other Government and nongovernmental agencies in care provision.

■ *Social service centres for the elderly*

The Department of Public Welfare established the first social service centre for the elderly in 1979. It provides non-resident services to males and females over sixty years of age who live in nearby areas. By the year 2000, 17 centres serving 207 800 elderly people had been established.

Services provided include medical check-ups, physical therapy, occupational therapy, activities of interest to members, recreational activities, exercise and sports, social work services, counselling, problem solving, study visits, information, and annual religious ritual participation in various festivals.

■ *Social organizations*

There are two types of social organizations, those that emerge from the people themselves, and those which are supported by the government.

The two principal Government-supported organizations are described here. They are the Village People Welfare Centres and the Tambon Administrative Organizations (TAO).

Village People Welfare Centres are run by the Centre Committee, comprising the head of village, the assistant head of a village, and the head of the relatives of the village. The Department of Public Welfare provides the first endowment of 12 500 baht. In 1999, there were 67,884 centres throughout the country, and provincial social workers support the operation of the centre.

Tambon Administrative Organizations are the smallest local administrative organizations. Their administrative committees are elected by local people. Some of the functions of the Department of Public Welfare are considered suitable for allocation to the TAO. Among these functions are provision of subsistence allowances to older and disabled people, social service centres, and Village People Welfare Centres.

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3.2.4 Institutional and residential Care

Homes for the Elderly

Under the Ministry of Labour and Social Welfare, several residential services for the elderly have been developed. The Department of Public Welfare has operated homes for the elderly since 1953 with the main purpose of providing residential care to needy persons who meet the following criteria: over 60 years for females and 65 for males; homeless; no relatives to live with or unable to live happily with their own families.

Services provided include lodging and food, clothing, personal and therapeutic activities for physical rehabilitation, recreational activities, traditional festival activities, social work services, and traditional funeral services. In response to the increasing demands of an ageing population, large numbers of homes for the elderly were established in the 1990s. Many nursing homes for older people are also provided by private sector.

There are three types of homes for the elderly, those provided free-of-charge, hostel-types, and private houses. Free-of-charge services are provided for poor elderly people in all homes. The hostel-type service is provided for elderly people who can afford monthly charges, and provides individual rooms to recipients. A private house is provided for elderly people who are financially able to own houses built in the compound of the institution and which conform to the house designs of the Department. The houses become the property of the Department of Public Welfare after the death of the owners and their spouses.

Services provided in these homes include health services, medical treatment, physical therapy, appropriate sports and exercise for the elderly, informational and educational activities, nutrition, social work, recreational and religious activities, and funeral assistance for elderly who have no relatives.

Residential care is provided for persons with disabilities who have been abandoned or neglected by their families. In 1999, nine homes accommodated 3779 persons. In 2000, the total number of elderly receiving residential care was 2807 (Department of Public Welfare, 2000). This small number of places reflects the limited provision of governmental residential homes. The number of places is insufficient to meet demand, and there is still a waiting list – despite the fact that residential care is not popular in the Thai culture, which stresses the importance of family members caring for elderly relatives.

Services in the homes comprise basic necessities, medical rehabilitation, educational rehabilitation, vocational rehabilitation and social rehabilitation. Although the homes provide medical services for their residents, those who need long-term medical care usually are not appropriate for this kind of facility.

Table 3. Number of elderly in public institutions in Thailand

<i>Year</i>	<i>Number of elderly in institutions</i>
1985	1675
1987	2144
1989	2150
1991	2144
1999	2631
2000	2807

Source: Department of Public Welfare.

3.2.5 Other services

Provision of assistive devices

Assistive devices (e.g. hand-operated tricycles, wheelchairs, artificial hips, eye lense replacements, etc.) are provided free of charge to impoverished disabled people. Funding is provided by the Government budget and public donation. In 1999, DPW distributed devices to 1497 persons, from a budget of 4.8 million baht. The law on the rehabilitation of the disabled has made a substantial contribution to increasing the budget available for the provision of assistive devices. However, the available budget and the ability to provide needed devices are still far from meeting the demand.

Vocational training

The DPW provides vocational training courses to disabled people. These courses are offered in seven vocational rehabilitation centres for people with disabilities, and in a vocational training centre. Furthermore, DPW cooperates with the Ministry of Education to provide those who have completed vocational training with both vocational and mainstream education certificates.

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3.3 Linkage between the health services and other supportive services

In reviewing the situation concerning the need to support certain population groups, it becomes obvious that support for living expenses – or at least for travel and other expenses related to care-seeking – is crucial. The low socioeconomic status of many requiring LTC makes it very difficult if not impossible for them to gain access to health services even though they do not have to pay for them. In terms of general support by family members, the issue is not whether they are willing to assist the patient but whether they can afford it. In many cases, the family cannot even afford the daily living expenses of its members, let alone the time to care for those needing LTC. In such instances, the need to earn money for daily living is more pressing to family members. Without such opportunities, other support rendered to the target population will not be as useful as it might be.

In the Thai context, such support exists through the work of the DPW. However, the scope of supports is limited, and the possibility of reaching those in need must be further improved. For example, seed money to support the disabled seeks to make it possible for disabled people to resume normal activities that can also generate income for them. Where the disabled person cannot be expected to work, and must be cared for by family members, the fund cannot be made available to non-disabled family members. Such support violates the principles set forth by the Department. As a result, family members who are poor remain without job opportunities. If the objectives of such funds could be broadened to include the general welfare of the disabled, it would be possible to make such funds available. Accordingly, family members supporting the disabled could also take better care of themselves.

3.4 Concluding thoughts

In general, social services for population groups needing LTC may seem broad. However, there are a number of limitations in the services provided. First, there are fewer than 100 social workers per province, and they are posted only at the provincial level. These social workers have a broad target population and those needing LTC are just a small proportion in their priority target groups.

Another limitation involves linkage with the health service sector. Most health personnel work at levels below the provincial level, and therefore do not have close communication with social workers. In addition, traditional bureaucratic organizational boundaries do not facilitate such close communication. If health and social workers were at the same level, the smaller work settings of the districts and sub-district would automatically facilitate the collaboration across agencies. A further limitation involves a lack of flexibility to meet the various types of demands of those in need.

4 General questions pertinent to LTC development

4.1 Assessment of the main gaps between needs and present long-term care services available.

The gap between needs and services available for long-term care exists for almost every group of target populations. Most of the gap is due to shortages of qualified personnel, coupled with barriers to care which are due either to physical remoteness or financial limitations. Also, most people will be seen and their needs assessed only when they seek services at outlets. Even then, their needs may not be properly assessed. Outreach health services are available only in certain localities (districts or tambons or municipalities).

However, the range of health services provided and the ability to assess those needing LTC also vary from one area to another. Welfare workers conduct home visits, and community development or agricultural workers serve at the village level, and they may come across those needing LTC. However, such initiatives are random and can only identify the more severe cases.

NGOs that work with the community may help in identifying certain cases. Annual surveys have begun to attend to specific population groups, mostly those with disabilities of various kinds. Such surveys may provide a beginning for finding those with needs for services. However, these surveys are based on statistical sampling and are not intended to search for those with LTC needs.

Generally, this identification stage is still very much fragmented. The most reliable agents would be health workers in various localities, if properly reoriented and trained to understand the needs of such target groups.

4.1.1 Gaps in needs by service type

4.1.1.1 Rehabilitation services

The most pressing need involves minimizing the gap between supply and demand for physical rehabilitative services. such services are particularly inadequate for the poor. Even those with injuries from traffic accidents – young people with a high potential for recovery if given continuous care in the critical early stages – suffer from lack of continuity of care.

In most instances, this is due to the lack of qualified manpower and an effective follow up system. With increasing life spans and more people suffering from, for example, cerebrovascular accidents, there are growing numbers of patients who have not received appropriate rehabilitation services.

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These services are highly inadequate, due to limited infrastructure and manpower. Physical rehabilitation is the most widely available service, although only 650 physical therapists and 187 physicians are working in rehabilitation medicine. There are even fewer health professionals working in occupational rehabilitation – only 60 in the entire country – in rehabilitation of various sensory capabilities such as hearing, speech, and vision.

Even when cases are identified they have to be sent to specialized centres located only in certain cities and provinces. Most of these centres are in Bangkok or in large cities with medical schools, and are operated by public agencies and NGOs.

4.1.1.2 Prosthetics and accessories for the disabled

Supportive utilities such as wheelchairs, crutches and prosthetics that could help to reduce dependence are not widely available and should be considered as high priority. They are provided mainly by NGOs for the lower socioeconomic population or even the middle class. However, since 1991 the legislation on rehabilitation for the disabled has mandated that the public sector provide essential prosthetics and accessories for the disabled. It also mentioned the need to modify buses, roads, and buildings to facilitate travel by the disabled.

However the true capacity to fully implement the law is still very limited. In 1997, less than 15% of disabled gained access to the devices they needed. Few changes have been made in public facilities, and few services are available to help families or community groups in modifying the living environment in the household or in the community .

4.1.1.3 Holistic and continuous health care

This area includes counselling, emotional support, and palliative treatment, provided through private and public health service facilities. Most are provided on a passive reactive basis, i.e. only to those who gain access to health service facilities and only in those facilities where services are made available, and are quite limited in number. Counselling services are normally not available as a part of the comprehensive health services in either the public or private sectors.

However, many district hospitals and health centres have helped to organize community groups – such as women's groups and elderly groups – who could be used to provide some general support for certain target groups. At present, the emphasis has been on health for the elderly and children rather than on those with LTC. In those hospitals and health centres where holistic and continuous care is provided, family members play crucial roles – working with health teams led mostly by nurses.

4.1.1.4 Alternative health care

As has been mentioned throughout this chapter, people requiring long-term care or people with chronic health conditions seek help from many types of alternative health care providers. These include Thai traditional healers, folk healers, spirit healers, and the use of macrobiotics.

Most of the services sought are related to either physical or mental health conditions, and are normally used as a supplement or even a replacement for western medicine. However, they are rarely employed on a long-term basis except for certain types of care such as traditional massages or certain types of food supplements and special dietary practices.

4.1.1.5 Supportive services

A considerable gap also exists in the provision of essential services to help parents take better care of children with conditions of mental retardation and delayed development. Existing institutions and manpower are scarce, staff are overstretched, and admissions are limited. Although the total additional number needed to better cope with the existing identified cases may not be high, there is a general lack of concern and commitment to fill that gap. Incentives to attract people to work in this field are also lacking. Self-help groups among families suffering from similar conditions exist, but are not widely known and accessible to those of lower socioeconomic status.

4.1.1.6 Home help for those that require regular support for daily activities

With more elderly people suffering from cerebrovascular accidents, LTC at home has become a higher priority. It is unreasonable to expect that family members will be able to provide continuous care. Home helpers help share the burden of family members. However, the lack of acceptance from the nursing profession of such personnel has caused difficulties in the expansion and increase of training programmes.

Most of those doing this work are family members. Community members or neighbours can be mobilized to help, as in the case of villages where HIV infection is endemic. There are as yet no examples of community mobilization for other types of health conditions where long-term care is needed.

Those who are prosperous can hire home-helpers who are trained by schools (six-months of training is required for general care and help) endorsed by the Ministry of Education. Some middle class families may employ self-trained home helpers. These are normally girls from rural areas who came to the cities to perform housework and were recruited and trained by the employing family to attend to the daily needs of family members with LTC needs.

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4.1.1.6 Long-term institutional care

Long-term institutional care is quite rare. Monks serving in temples in certain areas may play significant roles through establishing hospices, such as for those with HIV infection and cancer. There are also nursing homes for the elderly established by the public sector, such as the Department of Welfare). An increasing number of private nursing homes and even private hospitals provide such care for the elderly. However these are affordable only for the prosperous. (One hospital advertises its services at approximately US\$2000 per month, excluding medication). A limited number of beds in public hospitals are available for those who are long-term bedridden. Most must be discharged and cared for at home, regardless of their condition and home situation. Only a few hospitals are beginning to provide continuous care at home after discharge.

4.1.1.7 Information systems

Information systems are fragmented and routine information collected by service providers barely captures the changing needs of the people. Staff at the local level gather information according to assignments, following centralized planning efforts. Population and demographic data is neither up to date nor accurate. Therefore, much-needed information is lacking for policy formulation.

4.1.2 Gaps in education and training for personnel

There is a great need to increase the number of various types of personnel if LTC needs are to be met. Training personnel to provide physical rehabilitation services will benefit from two different strategies. First is the use of Thai traditional massage to cope with the needs of certain population groups, especially those suffering from cerebrovascular accidents. Thai traditional massage is growing in popularity, and has been well documented in its ability to help people suffering from paralysis.

The other strategy to increase the number of trained personnel for physical rehabilitation could involve the training of auxiliary personnel. Courses for training auxiliary physical therapists in the Ministry of Public Health were discontinued due to lack of continuous support. There is also a need to change the law on practice of the healing arts, which governs various professional practices of health providers, to allow wider use of auxiliary personnel in the private sector.

Training for those with a loss of special sensory capabilities, such as sight and hearing, should also be more widely available and accessible to those who need them. However, there is a shortage of trained personnel and institutions that could become the basis for providing such services. Many blind people must depend on their family members or neighbours for help, rather than being properly trained to become independent.

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Well-supported programmes and institutions to train teachers to help children with delayed development and mental retardation, and their parents, could improve the quality of life of many with such conditions. The same approach could be applied to the training of teachers for the blind and hearing impaired.

With the prospect of the new health insurance system promising to eliminate financial barriers to essential health services, those needing LTC will still lack the necessary services if the supply of qualified personnel remains limited and if the system does not specifically identify such services as mandatory. However, the new insurance system may not explicitly address these gaps because of the limited availability of financial resources. It may even delay the improvement of such services, if greater attention is directed towards meeting other and more pressing needs.

4.2. Planned or current changes that will impact LTC.

4.2.1 Overall health system reform

The reform focuses on creating a health-oriented system, rather than one that focuses only on improving access to health services. This approach involves the mobilization of all sectors working towards improving the health status of the Thai population.

Various components are crucial to the system, and certain mechanisms can enable broad-based participation and development of sound public policy. Key components include health care financing as well as these policy development mechanisms. The overall health system reform seeks to develop national health system legislation that will serve as a master plan for the development of the health system of the future.

4.2.2 Reform of health care financing

The principal approach to health care financing reform involves making health services accessible to all – to achieve universal coverage. This approach will have implications for various insurance schemes. Present financing sources include CSMBS, Low income scheme, Voluntary health card, Social Security scheme, Workmen's Compensation, and Traffic Accident Fund. Each scheme has its contribution system and benefit package, and focuses mainly on health services.

Changes in the health care financing system under the new government health policy are at an early stage of development. There is not yet any specific reference as to how to deal with LTC. The emphasis is still on proactive preventive and health promotion services, and conventional curative care.

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However, there is an ongoing debate about certain types of services which tend to be very costly and disagreement about whether they should be included. These services involve chronic hemodialysis and the long-term provision of anti-retroviral drugs. An exclusion list specifies services to be excluded. Those services that are not mentioned on the list are assumed to be included. However, providers who are paid on a prospective capitation basis, with the mandate to pay for referred patients, will be forced to develop cost-effective ways to provide needed services.

Both opportunities and threats lie in the future of LTC during this development. On the one hand, the needs of those requiring LTC will become more obvious and there will be more demand for services. On the other hand, the existing supplies are limited and providers may tend to ignore the need to improve and include additional services due to the need to increase investment.

Such tensions between the new undeclared entitlement and the shortage of supply will eventually create a broader societal debate. The alternative is to wait until the tension has developed and then introduce the debate. That debate will involve the prospect and feasibility of including services for LTC and specifying the range of feasible packages to be included – the same way that the debate was conducted in connection with the provision of anti-retroviral drugs and hemodialysis.

4.2.3 Decentralization

The overall decentralization movement requires that the cabinet develop a national decentralization plan. This plan will follow constitutional requirements which transfer decision-making to the local level. Health and welfare services are considered public services for which local administrative organizations must be responsible. Decentralization will include the allocation of a greater share of the government's revenue to the local authorities, from 9% to 35% by 2006. Such an increased allocation is coupled with the increased responsibility of the local government for the provision of social services.

It is not yet clear how the local government will accept such added responsibility in health services, with the changes in the health care financing system of the country. However, it is very likely that the local government will have more decision-making authority concerning expenditure of money from the new health insurance system and be able to direct health service providers. Local governments should also be able to determine local health needs, and to use part of the money to create the necessary environment for other needed supportive services. The outcome will definitely depend on the awareness of the local authorities and the local population. However, it is expected that the central Government, through MOPH, will still have considerable influence on how the local government performs and decides on local health problems.

With the delegation of more responsibility and authority to local governments for social services provision and the allocation of more government revenue to the local government, more attention will be devoted to meeting the needs of the disabled through the improvement of public facilities.

4.2.4 Development of a national long-term policy and plan for the elderly

The development of the new national long-term policy and plan for the elderly is an ongoing development that will be finalized soon. Although the means to implement the proposed policies have not yet been fully identified and developed, the draft policy could serve as the platform for debate on the possible development of LTC. This will be especially important for elderly groups, both those with and without chronic illnesses and conditions.

The policy focuses upon promoting the health and well-being of the elderly through various types of supports and intervention, including the establishment of pension systems and family supports. Although it does not refer specifically to the development of LTC, the future policy towards the elderly, if realized, may contribute to the improvement of the quality of life of those with LTC needs. The elderly will not have to rely totally on the development of the health insurance system, which will tend to be limited in its scope of coverage and unable to deal with issues beyond health care.

4.2.5 The attempt to use professional workers and family members for homecare

Another changing trend involves an attempt to create a better interface and interaction between professional care and family care, using both professional and family members for care at home. This has been made possible through both governmental and private facilities. There are private foundations that work with family members to empower them to better take care of their family members, providing the families with certain tools as well as regular technical supervision and ad-hoc consultation.

Some of these efforts involve self-organized self-help groups of family members. Some are charitable organizations funded through public donation. Public hospitals are also creating programmes and services that extend to the family and community level, as in the case of health promoting hospitals, home-based nursing care programmes in selected provinces, and district hospitals and teaching hospitals.

The Ministry of Health is also demanding that health service providers under contract for the new health insurance scheme provide active home-based health services provision. However, there is no specific reference to and requirement for them with regard to provision of LTC. However, it made a good starting point for future development of this important major health policy change.

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One important component of the effort to combine professional and informal services in the home is the development of the 'home-helper'. This approach has resulted from the migration of young girls from rural areas into urban settings looking for jobs. The increasing demand for home-helpers has also been a result of the ability of some people to pay for care for those with chronic health conditions. This has given rise to a self-initiated school for home-helpers focusing on training young boys and girls to care for small children and the elderly. This has expanded gradually, and is now extending to serve the demand from abroad for home-helpers for LTC.

4.2.6 Reform of public hospitals

The reform of public hospitals and health service facilities is another crucial component that will help to better incorporate and improve the services needed for LTC. Public health facilities will become more autonomous with the future health system reform. They will be monitored and required to be output-oriented and to respond to the demands of their target population. Thus, their management and the decision on the use of financial and human resources will be made to be more cost-effective and productive.

Use of existing trained manpower could be improved under the reform, although the number may not differ much at the beginning. On the other hand, there will be a greater willingness to accept and implement innovative services and programmes directed to outreach and home-based care, which may contribute to better interaction and supervision of the family members with relatives needing LTC. Such possibilities for the health facilities to use their personnel more properly will not only contribute to the provision of LTC but also to other types of health services. However, how this will proceed depends very much on the financing system provided to these health facilities. It depends upon whether the need to provide LTC will be properly identified and highlighted, or if these health facilities will be asked to focus only on prevention and the provision of conventional curative services.

4.2.7 Changes in private hospitals

There have been important changes in the private hospital business in recent years. Such enterprises have been in excess supply since the beginning of the economic crisis. There has been a gradual shift to use the excess beds and capacity to care for those with chronic conditions, with minimal services from professional medical and nursing personnel. As noted above, some private hospitals even advertise in newspapers, offering such services at the rate of US\$2000 a month for accommodation, food, and general supportive services, with medical services and medication at extra charge. The private sector is even planning to extend LTC services to other countries. These services would be packaged with Thai traditional health care and herbal medicines.

4.2.8 Development of legislation for the disabled

The development of legislation to improve the quality of life of the disabled is being advocated by NGOs working with the disabled, especially the blind and the hearing impaired. This is a continuation of the effort to modify existing legislation which tends to focus mainly on providing assistance to the disabled and was seen as overpatronizing. Some of the improvements from this legislation will certainly contribute to the enhancement of the quality of life of those needing LTC, especially those with physical handicaps who require assistance from others for daily living activities, and who may be trained and rehabilitated to become more independent.

4.2.9 Development of organizations, working conditions, and services for workers

The development of an organization and institutions for the safety and better quality of life of workers is another ongoing effort that may contribute to the improvement of LTC. Workplace injury has been one of the common causes of disability among the active young. Attention to the improvement of workplace safety as well as compensation to workers will not only prevent injuries, but will also help to provide the means to better support those who incur work-related injuries/handicaps. This could be in the form of financial compensation, or by the establishment of service facilities, or by the provision of a specific entitlement for services that will better address LTC needs.

4.3 Public concern about LTC

It is not easy to gauge how the public sees the need for the future development of LTC. It is fair to say that the health and quality of life of underprivileged groups have become the concern of society in general. This has always included concern for those with LTC needs. If the media can be used as a proxy to reflect public opinion, it is reasonable to conclude that there is growing interest in LTC.

If political campaigns can be used as another proxy for public concern on societal issues, it can be noted that the latest political campaign barely referred to the needs for LTC. The closest to such concerns was the demand from disabled groups that political parties clearly specify their policies towards them. The fact that Thai athletes did quite well in an international competition among disabled people might have contributed to the increased concern over their well-being. However there was no reference to the needs for better development of LTC for the disabled. The emphasis was more on providing supportive facilities in public places and job opportunities.

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However, such concerns can be judged as being only superficial. While there were debates and criticism about HIV-infected people being discriminated against, headlines about drug abuse, and articles about poor quality of health care in general, there was hardly any serious debate about the lack of LTC within the Thai health care system.

Although political parties drew up policies concerning the welfare of the disabled, there is hardly anything concrete taking place so far. Those in need of LTC also tend to be passively waiting for support to be rendered.

This could partly imply that Thai society in general may accept that people with LTC needs are the responsibility of the individual family, and that those needs do not correspond to the types of care that can be demanded from the system or society in general. For the poor family, it is up to those who are better off to offer any help they deem possible. Otherwise, it is up to family members to take full responsibility for the care of their relatives.

4.4 Key strategies for the future

The future of LTC in Thailand is at a very interesting phase of development with the ongoing reforms on all sides. On the one hand, the new financing system for health presents a highly promising opportunity to better address the health needs of those requiring LTC. On the other hand, the limited budget makes it quite impossible to specifically meet all the service requirements.

One key strategy should be aimed at informing the general public and various levels of decision-makers, national and local, about LTC needs and the potential to reduce the future burden through preventive activities. This might be more effective than proposing essential LTC services at this time.

Perhaps the best approach is to work with other developmental sectors, those involving both social and economic policy, to assure that serious attention is devoted to empowering family and community networks. These networks are the very foundation of societal fabric that will help to enhance self-reliance, in health as well as comprehensive and holistic development. It is imperative that all sectors work to strengthen the family and community as the basis for better health and quality of life, not only for those needing LTC but for the health and well-being of the population in general.

Together with all of these opportunities, and with the identification of some of the crucial partners and entry points for the improvement of LTC, it will still be essential to develop broader strategies to better address the future needs for long-term care.

Some of these strategies should include:

■ ***Involving and supporting family members as active participants in LTC***

Direct financial supports or external group supports must be limited to those who require assistance and who cannot afford such assistance through personal sources of income. Involving families in LTC requires technical supports as well as indirect financial incentives, and a system that helps to share the burden of family members. Most supportive and facilitating systems should be developed to supplement families' efforts, rather than creating a separate subsystem aimed at replacing the role of the family.

■ ***Development of understanding, concepts and capability among service providers and managers of service facilities***

Under the new financing system, service providers will be required to make decisions about service mixes for their target populations. The new system will be on a prospective payment basis, using a capitation rate for well-defined target population groups. Unless the needs for and benefits of LTC are seen in terms of both improving the quality of life of the target population and the potential savings in costs, then service providers will continue to deliver services through the conventional passive mode of operation that they have adopted in dealing with acute conditions in the past.

■ ***Defining LTC as one of the requirements in the service packages to be included in the future health insurance system***

This will make it obvious to providers that such services will have to be made available, rather than their provision being left to the discretion of providers and their managers. Conceptually, this is easy to say. In practice, it is impossible to define it down to the final detail – so a strategy to develop the understanding and capabilities of providers and their managers is still necessary in order to create more awareness and to bring more innovative ideas into the future development of LTC.

■ ***Strengthening and involving local governments and civic groups in local health planning and management***

Local governments, with their mechanisms to deal with health problems and needs of the population, will afford another important approach to making decisions on the use of resources in the future. They should be able to plan properly and provide support to appropriate civic groups to take active roles in providing LTC, or even to carry out activities that may reduce the need for LTC.

■ ***Capacity development of civic groups and communities to be active partners in carrying out LTC for those in need in the community***

■ ***Working with religious groups and various religious establishments in different localities as a basis for the provision of LTC to certain types of patients through semivoluntary workers.***

■ ***Promoting the role of the private sector in the training and development of LTC providers in the home***

The private sector can serve the LTC needs of people who can afford to pay for them. Further, they can develop various kinds of packages of care, through which they can work with both family members and supplement the existing health service provider network.

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