



Long-Term Care: Choices for Thailand as a Middle-Income Country

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Abstract

Background: The demand for long-term care services in Thailand is rising rapidly because of an increasing of functional limitation of the aging population. Meanwhile, the preparation and arrangement of public long-term care system in Thailand are not available to meet the needs of these people.

Aim: The aim of this study was to review the literature on the definition of long-term care, analyze the long-term care system that affect the quality of life, operation of care providers, and the policy management in selected countries to be the lesson learnt for Thailand.

Method: The research strategy covered computerized journal databases: EBSCO, PsychInfo, Routledge, BioMed Central, Blackwell, Elsevier Science, and Palliative Medicine database from 1996 to 2015. The selected articles included quantitative and qualitative studies related to long-term care system policies and benefits.

Results: Long-term care is the system to support dependency groups such as elderly, disable, or people with mal-cognitive function. It has formal and informal care which can enhancing well-being in biological, psychological, and social factors of individuals. Many countries has its own management depends on the context. Thailand also has the unique context to develop long-term care system beginning from health care aspect and expand to social care aspect.

Conclusion: Long-term care is a multi-dimensional system. Many countries invest in health care, social, psychological, and financial part to complete the system. As Thailand is one of many countries that try to setup the appropriate long-term care system but not only the holistic long-term care system that Thailand has to concern, the sustainability aspect for running the system properly should be the key factor for policy makers to consider as well.

Keywords: Long-Term Care Policy, Elderly, Adult Aging, Aging Population, Quality of Life, Consumer Needs, Services, Benefit Package, Providers, Management.

Introduction

When National Statistical Office of Thailand (2012) surveyed the ageing people situation in Thailand, they found that the ageing population increased to about 5.9 million people or 9.4% in 2002, then the number of aging population rose to about 7 million people or 10.7% in 2007, and finally to about 11.8% in 2010. It is found more than a third of the elderly in Thailand reported having at least one functional limitation, and that individuals over the age of 70 were much more likely than those in their sixties to be disabled (Knodel & Chayovan, 2008). Thailand formulated the National Long-term Plan of Action

for Elderly (1986-2011), which covers health, education, income and employment, and social and cultural aspects. Later, a Working Committee on Policy and Action for Elderly was set up to formulate the Essence of the Long-Term Policies and Measures for Elderly (1992-2011) to help accelerate welfare actions (UNFPA Thailand, 2006). In this context, Long-term care providers are included such as formal care providers (e.g. health professionals) and informal care provider (e.g. family members), places of services may be in homes and communities or in care institutes. Long-term care has many kinds of services at home such as housekeeping and personal care as a home helper, and remodeling and assistive devices as a



visiting nurse. It also has many kinds of services outside home includes day care, day care with rehabilitation, short-stay respite care; institutional service including nursing homes, homes with more medical services, chronic-care hospitals. Moreover, the demand for long-term care has been increasing as a result of the increase of elder population all over the world these past few decades. In Japan, Tamiya et al (2011) found that the population was ageing rapidly because of the long life expectancy. As a result, the number of people aged 65 years or older had almost doubled (from 15 million to 29 million from 1990 to 2010) that is 23% of the population. On the other hand, the demand for long-term care has also been increasing by people under the age of 65 because of their disability. According to Kaye, Harrington, & LaPlante (2010), about half of community-dwelling Americans needing long-term care are younger than 65.

World Health Organization (2003) has noted that the trends in the needs for long-term care reflect two interrelated processes: (1) the growth in factors that increase the prevalence of long-term disability in a population; (2) the change in the capacity of the informal support system to address the consequences of these changes. In many countries, policy makers have begun to pay increasing attention to long-term care in many aspects to support and manage these services that will become the best way to give treatments for consumers, to provide equal opportunity for people to access long-term care, and to help consumers and providers meet their satisfaction under long-term care conditions.

The more physical functional limitations people have, the more demanding the long-term care because, especially in the near future. However, a good long-term care system management is unique for each country, each community, each available supply and each group of clients (the most important factor). In

this article, we reviewed long-term care systems from many countries and various styles of long-term care system management to find an appropriate way for Thailand's long-term care services. To support depending people, we consider that the well-being of clients and providers may come from many factors such as physical well-being, psychological well-being and social well-being. This means that these factors implicate a holistic well-being for long-term care service's burden, and therefore an approach from the field of is brought to fill in the answers of holistic well-being. This approach is named biopsychosocial determinants of health. From the long-term care's literature reviews from many countries, we found the answers why we have to cogitate about long-term care systems and services to find out about the benefits that clients and providers may gain from long-term care.

Objective

The aim of this study were:

1. To review the characteristics of long-term care system in selected countries and suggest appropriate characteristics of long-term care system for Thailand.
2. To synthesize the lesson learnt from many countries in long-term care policy and its outcomes in biological, psychological, and social aspect that affect the quality of life, operation of care providers, and its management.

Methods

Undertaking a review of qualitative and quantitative literatures is a way to gain a better understanding of long-term care in many dimensions such as its services, its benefits and its limitations. My strategies for searching included examining computerized journal databases such as EBSCO,

PsychInfo, Routledge, BioMed Central, Blackwell, Elsevier Science, and Palliative Medicine.

Keywords included long-term care policy, elderly, adult aging, aging population, quality of life, consumer needs, services, benefit package, providers.

For inclusion and exclusion criteria, the researcher included the papers which describes the characteristics of providing and managing long-term care in institution, community, and home setting. Also, the following criteria were selected such as (a) insurance policy; (b) setting of service; (c) tax incentive; (d) the primary focus on the importance of long-term care; (e) a preparation for staff in long-term care; (f) the publication date between 2000 and 2015; and (g) the publication in an English-language and Thai journal. Grey literature studies that satisfied the above criteria were also eligible for inclusion. However, there are a few paper which is related with the mentioned criteria but have to be excluded because of researcher's language skills such as Japanese, Chinese, and France papers.

To examine the dimensions in Long-term care, we followed the Biopsychosocial Determinants of Health Approach in Health Psychology field, because this approach will help build a converging operation of holistic well-being focusing on the biology or physiology underlying health, the psychology or thoughts, feelings and behaviors influencing health, and the ways that the society and culture in long-term care influence health intervention and health promotion.

Literature Findings

Long-term care: Definition

There are many definitions of long-term care but all the definitions go along with the meaning of taking

care of people for at least 3 months, especially an elderly person, who has a problem or problems with his or her function. OECD Health Data (2008) gives a definition of Long-term care, as a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living. However, definitions of long-term care may be adapted depending on each institute and location. For example, in Germany, consumers must receive services more than 50 hours per month for those services to be defined as long-term care services. In Austria, the threshold for receiving the long-term care allowance has recently been increased to 60 hours of care needs per month (Allen et al, 2011). Thailand Elderly Developing Strategy (2010) gives a definition in long-term care, as care services covering every dimension such as health, economy, and environment for elderly people who need daily living support because of chronic illnesses or physical disabilities. Foundation of Thai Gerontology Research and Development Institute (2012) gives a definition in long-term care as every dimension of taking care such as health, economics and environmental health for an elderly who has to be faced with the difficulty from a chronic illness, or decrepitude taking care by formal health care staffs and informal staffs, such as family members, including health services in family, community and institute. Mosby's Medical Dictionary, 8th edition (2009) gives a definition of long-term care as the provision of medical, social, and personal care services on a recurring or continuing basis to persons with chronic physical or mental disorders. The care may be provided in environments ranging from institutions to private homes. Long-term care services usually include symptomatic treatment, maintenance,



and rehabilitation for patients of all age groups. Institute for Safe Medication Practices Canada (2000) describes that long-term care is defined as care provided in facilities offering accommodation for people who require on-site delivery of supervised care, 24 hours a day, 7 days a week, including professional health services and high levels of personal care and services (e.g., in nursing homes and residential continuing care facilities). The acuity of people receiving long-term care is generally less than that of patients in acute care or complex continuing care settings. Medications for residents in long-term care are usually provided by community pharmacies. In the context of this study, researchers define long-term care as taking care provided by formal professional health care staffs and informal staffs to people who cannot live their lives by their own part because of health problems such as chronicle illnesses in elderly people.

In terms of types of the long-term care, in this study, we divide the types of long-term care by formal and informal health care's needs. Formal long-term care service is provided by health care professionals such as a physician, nurse, occupational therapist, physical therapist, psychologist and etc. Long-term care clients receive services from these professionals in institutes such as nursing facilities, assisted living, and community-base care centers. The professional staffs in these settings provide health care in specific professional services of care areas and these kinds of services are licensed and confidential. Informal long-term care service is provided by workers who provide non-health professional skill services. They provide services to clients in terms of daily living services such as bathing, cleaning, laundering, feeding, and etc. these kinds of workers can also be the clients' relatives or other employed workers. The clients receive services from former mentioned institutional care or

non-institutional care such as adult day care, homes for older persons, hospice care and client's home.

Enhancing well-being: Long-term care service's burden in Biological factor

Physical comfort is a kind of biological well-being and one kind of quality of life. Long-term care can provide biological well-being to consumers because long-term care facilities provide health professionals, who can give advice and give interventions or medication to maintain and improve consumers' physical health. Thus, Kane (2001) notes that physical comfort includes being free from physical pain and discomfort, including shortness of breath, nausea, constipation, joint pain, and so on. It includes being comfortable in terms of temperature and body position. To some older people, it even includes crisp, freshly laundered sheets. It certainly includes having one's pain or discomfort noticed and addressed. In addition, functional competence; such as the ability to eat, the ability to sit out of bed, the ability of toilet using, the ability to have movement in the room or house, the ability to get dressed, the ability to bathe, the ability to control excretion, is the outcome that many clients in long-term care want, especially in young adults who want to be as independent as they possibly can.

According to Ohta et al. (2006) the more day-care services community-dwelling frail adult use, the lower mortality rate. Tomita et al. (2010) also found that respite care and day-care service use could prevent elderly people from being hospitalized.

2009-2010 NHA Working Group (2011) divides elderly people into three groups: (1) totally independent group; (2) dependent group in some tasks; and (3) totally dependent group. Totally independent group is a group of elderly people who can live their daily living by him/her self. Long-term care staffs usually promote these elderly people's health by



screening health risk factors and bring this group of people to be a participated volunteer for promoting other groups of health. Dependent group in some tasks is a group of elderly people who need long-term care support occasionally to improve their biological well-being. Totally dependent group is a group of elderly people who constantly need long-term care services such as physiological services. Health system services have to improve abilities of staffs or professionals and develop efficient health care system to support the people.

Enhancing well-being: Long-term care service's burden in Psychological factor

The feeling of long-term care clients is an important issue; they may feel preoccupied with and doubtful about their physical health, and that makes their psychological health gets worse. To meet the needs of long-term care clients, psychologists have to constantly study the available updated empirical research. Powers (2008) found that the residents of long-term care facilities have significant needs for psychological services, since he found that a relatively small growing subset of the older adult long-term care population has greater needs for mental health services than does the general older adult population. According to Barusch (2012), clients medication does not change the feeling, but it will take the edge off. Some long-term care clients may suffer from psychological disorders such as depression, dementia-related behavioral disruption, anxiety, insomnia, somatoform, and etc.

Some long-term care clients may not suffer from a psychological disorder, but may only suffer from their negative feeling. These people need emotional therapy to improve their quality of life. Kane (2001) suggested that clients may have more comfortable feeling if they perceive the sense of attentions from providers such as security, kindness, meaningful

activity or words of encouragement, therapeutic relationship, enjoyment, dignity, power and autonomy, privacy, individuality, spiritual well-being, and disability rights. It is also noted that consumer-centered care is an approach including the way going beyond health and safety outcomes to include outcomes such as quality of life and autonomy. This approach is similar to the person-centered approach from the counseling field by Rogers in the 1940s and the 1950s to provide clients with opportunities to develop their inner growth by unconditional positive regard from their counselors' support.

To support psychological well-being, long-term care insurance of Japan was enacted in 1997 and implemented in 2000. Its official purpose was to help those in need of long-term care to maintain dignity and an independent daily life routine according to each person's own level of abilities. In addition, care managers, who can provide expert advice at no out-of-pocket cost, give advice to clients and staffs to meet their suitable interventions and jobs. However, they are not trained for counseling, but often have to act as counselors to both staff and consumers (Tamiya et al., 2011). Consumer direction in long-term care starts with the premise that individuals with long-term care needs should be empowered to make decisions about the care they receive, including having primary control over the nature of the services and who the services are delivered and how (Stone, 2000). Long-term care settings are in fact an ecological context, and it is one where the level of services, assistance, privacy, oversight, and autonomy are dramatically different from both independent living and acute care hospital settings (Power, 2008; Frazer, 2006).

Self assessments of health status provides a convenient and reasonably valid indicator of coverall health that typically relates well to other more



objective measures and are reasonably effective predictors of mortality (Knodel & Chayovan, 2008; Idler, 1997). National Statistical Office Report in The 2007 Survey of Older Persons in Thailand (2008) found that older women were more likely to report problem with their emotions than older men and thus receiving more psychological attention and intervention.

Enhancing well-being: Long-term care service's burden in Social factor

Local context plays a critical role of appropriate long-term care. In rural area, many key services were not available in some communities. In urban area, the number of waiting list continue to grow across develop world. Kuluski, Williams, Berta, and Laporte (2012) suggested that home and community care services is the excellent choice for rural area, nonetheless people in urban area may fit with institutional long-term care. Long-term care settings provide an environment for the provision of interventions and services. Long-term care settings prevent consumers such as older adult or disability child to live alone, it can help clients practice social skills and reduce begetting of depression opportunity. Twigg (2009) suggests that it is good to have family members involve with taking care long-term care consumers; the family provides services that are warm, cheap, and distortionless.

In USA social context, neither the inequity nor the inadequacy of Medicaid long-term care services is a problem. Therefore, to have a larger effect on the allocation of long-term care financing, tax incentives would need to increase private insurance coverage for those who are at a higher risk of spending down to Medicaid eligibility (Goda, 2011). This tax incentives concept can help people gain more satisfactions with their society. Moreover the source of payment for long-term care in the community and in nursing homes is Medicare. Medicare and Medicaid are the primary payers, and the people are likely to receive federally

funded services (Kaye et al., 2010). That can reduce people's financial burden and improve their quality of life in the society.

Long-term care management in each country

In some OECD countries that most of them are western countries, according to Lundsgaard (2006), countries put different weight on formal and informal care. In addition countries have different considerations regarding public and private resources. As seen in Table 1 and Table 2, he describe that in Korea and Spain, long-term care is provided informally and based on private resources. On the other hand, in The Netherlands, Norway and Sweden, long-term care is provided as part of the formal services and their resources are based on public fund. Canada and Unites States do not support much in financial terms to informal care, but clients can hire and supervise a personal care assistant for a specific number of hours, called consumer directed home care program. Moreover in Arkansas, Florida and New Jersey provide cash & counseling program where clients pay only 60% of services fee. Austria, Luxembourg, Germany, Ireland, the United Kingdom and Australia support informal care by sharing payment with private sectors such as the clients own part or the clients' family. In addition, all public support for home care in Austria is through cash allowance for long-term care in which recipients can purchase formal care if they wish. Clients' relatives can be employed or supported from public sectors in Norway, United States, Austria, Luxembourg, Germany, Ireland, Australia, Canada and Japan. In the Netherlands, the person who can be employed or supported by public sectors must be a relative who is not living with clients. In the United States, that person must not be the client's spouse. In the United Kingdom, the person may be clients' relative or close friend who can be employed or supported. Lundsgaard (2006) also mentions that, there are different proportions of



public and private providers of formal care services depending on the social and health policy in different countries. The United States, for example, provides public funding of long-term care for low income people. Therefore, the medium and high income groups, which comprise the majority of USA's population, choose to pay for private institutes to meet their needs. That is the reason why there are more institutes than public institutes in the United States, as seen in Figure 1.

In terms of funding sources, each country has managed different proportions to support long-term care systems; for example, Italy's central government sector provides 50% of the administrative services for long-term home care, and the other 50% of long-term home care charges come from private funding (Nesti et al., 2004). Luxembourg gets their funding from electric energy tax and gains 1% by law from insurance contribution of private income (Baldini & Beltrametti, 2007). Norway's incidence of funds comes mainly from central government tax and long-term care users fees (OECD, 2005). Germany's funding comes from public and private health insurance; long-term care insurance contributions such as home care allowance, regional government tax revenue from various social services, central government tax revenue and private funding (Roth & Reichert, 2004).

On the other hand, eastern countries such as Japan, have spent much less than the aforementioned countries on medical care because there is no cash benefit from the government for home care workers, who are clients' relatives. Because of filial piety values, most informal providers are female family members. The Japanese government considers spending their budget only for the formal care in communities and institutions. The quality of formal care is best assured by relying on trained, licensed, and supervised because

the Japanese government provides formal services only. In addition, Japan's long-term care services provide care managers who can give expert advice at no out-of-pocket cost to clients (Tamiya et al., 2011). In Asian countries, filial piety values have been considered. Many countries, such as Thailand and Singapore, provide an annual tax relief for people who have to look after their elderly parents. Rozario and Rosetti (2012) mention that family care is the best form of care for frail older adults. Thus long-term care policies in Asian countries tend to promote formal community-based care. For example, in Singapore, formal community-based care is seen as a more cost-effective way than institutional care, and this enables frail older adults to remain in the care of their families within the community (Rozario & Rosetti, 2012; Mehta & Vasoo, 2000). Hong Kong gains financing sources from the government's general revenue on the public side and direct out-of-pocket spending for private purchased care, in approximately at 9:1 ratio (Chung et al., 2009). In Hong Kong, the government sets up 18 Elderly Health Centres and 18 Visiting Health Teams to enhance the primary health care for its elderly population. Hong Kong Visiting Health Teams usually outreach into the community to collect elderly health data. They have to collaborate with other community partners and arrange promotive and preventive health care activities in the community such as health talks, health and psychological support groups and health promotion projects. (Lin et al., 2011) Hong Kong institutional care has traditionally been mostly provided by the public or non-profit sectors, the latter directly unvented by the former. Private operators in addition to non-governmental organizations have been contracted to provide beds and services (Chung et al., 2009). Malaysia's institutional long-term care is mostly available in urban areas. The



argument for the elderly to remain within the community has heralded the emergence of community care for older people in Malaysia. In addition public elderly home is provided for unemployed and homeless elderly people only (Ong Fon Sim).

In Thailand, long-term care in Sub-district Master Model is a long-term care project for improving the elderly well-being. This project focuses on improving the elderly health. The role of sub-district Health Promotion Hospital concerning long-term care for the elderly in the community comprise 6 step: (1) making plan and projected for the sub-district; (2) appointing a long-term care committee board; (3) collecting elderly data in the sub-district; (4) screening ADL persons aged 60 years and older; (5) registering ADL persons; and (6) giving successive long-term care services. Long-term cares in the sub-district Master Model were cooperated by Sub-District Health Promotion Hospital, Health volunteers, and Sub-district Administration Organization. These organizations have established long-term care activities such as Healthy Elderly Club, well-trained health volunteers, Standard Home Health Care, and community care for elderly people (2) and (3). Thailand's policy response context, The 30 Baht Universal Health Care Scheme helps reduce the burden of the families in supporting the health care needs of their elderly parents and relatives. In addition, the Government has taken on other initiatives such as life-long education, day centers for health care and promotion, social activities for the elderly (UNFPA Thailand, 2006). The Department of Social Welfare of the Ministry of Labor and Social Welfare is mainly responsible for long-term care services, in terms of the formal long-term care provided by state organizations, but social services are more advanced than health services (Jitapunkul, Chayovan, & Kespichayawattana, 2002). Orton (2010) has prescribed since 1990 that

the people in labor force who are not public servant have to spare their salary 3% combine with another 3% from the entrepreneur into the Retirement Savings Fund in every months, which the people receive an old-age benefit after the age of 55 in the form of Old Age Pension Benefit that is receivable on monthly basis or receivable in lump sum amount.

Discussion

Providers in Long-term care

For long-term care providers, it is important to keep in mind that they are part of the environment in long-term care facilities to help consumers get better by respecting the values that respond to the spiritual as well as the mental and physical needs. According to Erikson's 1963 developmental theory, older adults evaluate their level of satisfaction with how they have lived. Still we have to study more to promote care worker welfare as Tamiya et al. (2011) mentions that many care worker still have lower pay, more difficult working conditions, and lower chances of promotion than do worker in other specialties.

Providers in Long-term care: Professionalism

Long-term care clients need help from many health professions depending on the kinds of health problems. Elderly people who are faced with physical illnesses usually need help from physicians, nurses and other professional staff who can deal with these physical illnesses. Functionally inform elderly people usually need help from occupational therapists. Depressed elderly people will become helpless and people really need help from psychologists. All the characteristics of health care professionalism are important to patients, health care organizations and health care professionals as a whole. Health care professionals that demonstrate professionalism successfully are more likely to provide high-quality patient care (Lacey, 2012). According to

Fazekas (2007), a professional is a collegial discipline that regulates itself by means of mandatory, systematic training. It has a base in a body of technical and specialized knowledge that it both teaches and advances. It sets and enforces its own standards and it has a service rather than a profit orientation, enshrined in a code of ethics. To put it more succinctly, a professional has cognitive, collegial, and moral attributes.

Providers in Long-term care: Client Focus

Long-term care clients in each part of country are from diverse backgrounds. It would be profitable if long-term care settings could adapt itself to process along with cultural norms. Policy makers in the local government have to keep in mind this social context issue. National Statistical Office of Thailand (2011) has predicted that in 2022 ageing population in Thailand will have increased by 18%. Moreover, and from a study of focus groups in Thailand (United Nations, 2011) found that working-age adults anticipated receiving less support from their offspring than they were providing for their own parents. Consequently, as economic conditions and social services improve, older person may not need to depend on their children as much as in the past. However, (Knodel and Chayovan, 2008) suggest that an older adult living alone is usually viewed as being at a disadvantage. In case like this, palliative care supported by family members and professional staffs may be the answer for Thailand to help people in all parts of country. Palliative care is defined by the World Health Organization (2010) as an approach that improves the qualities of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and impeccable assessment and treatment of pain and other physical, psychological and spiritual problems.

According to long-term care services, it does not only refer to elderly clients, but in fact, also refers to the provision of services for non-elderly clients who suffer from difficulties to maintain physical or mental functions. Gleckman (2010) states that non-elderly long-term care users are found in USA in about 33% of all long-term care users. This includes children, or people of any age suffer from any injuries, or people with AIDS. The services provide for non-elderly clients often require more specific skills of the providers than those provide for elderly clients. This is because some groups of elderly clients need only daily living support care providers whereas some groups of non-elderly clients need occupational therapists or physical therapists to provide rehabilitations services for them to reduce or remove the difficulties of their functions. Tamiya et al. (2011) mention that most long-term care programs treat clients by means of cash allowances and thus providing similar treatments for both young and old client. However, unlike elderly people for whom appropriate long-term care services aim for the maintenance rather than improvement in health and functional status, most younger disabled people want a normal independent life and control over the organization serving them. However, many organizations and research studies tend to focus more on elderly clients. This results in incomplete systematic management of long-term care. In further research works, we have to consider more about this group of clients to finally improve and complete the long-term care system.

Providers in Long-term care: Continuous Improvement

According to Health Affairse (1994), professionals are expected to master new knowledge about their trade and to incorporate it continually into their practice. They also are expected to contribute individually to the knowledge base that informs their discipline. As



Berwick (1989) pointed that professionals must take part in specifying preferred methods of care, but must avoid minimalist standards of care. In addition, reinforcement in learning psychology theory may give benefit of gaining more motivation to improve professional skills. Smith (2012) mentions that one of the most important ways to help health professionals continue to improve their performance is to establish a system of regular feedback and let the health staffs know that they are a valued part of the clients' developmental process. Health professionals have to set goals clearly, because the clear goals can be more achieved easily than the unclear ones. In every successes step, health professionals have to be reinforced in positive ways such as rewards or positive words. However, the best continuous improvement occurs when health professionals continuously improve their knowledge and skills by themselves, or by their inner inspirations. This will lead to generously positive effect.

Providers in Long-term care: Partnership in health

Health has many dimensions, and each dimension has many processes. Every process and dimension of health needs specific professionals to give treatments and interventions. As we know, long-term care is a kind of service to improve individual health, and its programs also need many different professionals to service people. If partnerships in health realize this, they will help continue trainings for medical and non-medical staff on long-term care. The goal of trainings might be to enhance the professional capabilities and strengthen and expand the knowledge of medical and non-medical staffs in order to better address the needs of long-term care and reduce stigma and discrimination. Interpersonal relationship especially in long-term care involves closely working with clients, family members, people in community and professional associations to improve strengthening the society and health care delivery for clients.

Thailand context:

Social policy

According to Lum (2012), a few Asian countries and cities such as Japan, Taiwan, and Hong Kong have built a relatively comprehensive long-term care system over the last four decades. However, others, such as Mainland China, have only just recognized the need for a comprehensive system. In case of Thailand, the researcher divides the adult population into 2 groups. The first group of population is official or public servants. Most of population in the first group save up part of their revenue and put it in Government Pension Fund or Retirement Savings Fund. In addition, this group of population receives pension when they retire, so their financial health problems after retirement are of a lesser degree than non-official labor group. The second group of population is the non-official labor group such as freelance workers or housewives. Only small portions of the second group save up adequately for their post-retirement use, especially in housewives who live alone as we known as the empty nest people. That is why this second group of population is more likely to face financial health problems for long-term care services after retirement.

To support the working population that has to look after their elderly parents, Thai social policy has enacted tax relief. In addition, the government sector should consider providing community-based long-term care which provides formal care services because, firstly, it is more worthwhile than providing subvention to every elderly curator in the country, and secondly, it is easier to access the services than to wait for health care support from the government and to receive the services in main public hospitals.

Public relations are an effective and convenient tool to propagate social long-term care dynamic and informal long-term care knowledge. In Thailand's 2011 severe floods, there were great struggles to fight



against record setting flood waters and, consequently, the population act in synchronized confusion. Thai volunteer animator Sipparpad Krongraksa produced informative pieces of short-animated videos aiming to help guide the lost population the animations drew light and exude tranquility over watchers; illustrating important tips in an entertaining and calming pitch called RoosuFlood. This way of public relations is succeed for helping people survive when they did not have information or were confuse with information and with managing their property in a situation of crisis. In case of long-term care, long-term care advertisements via the process of by public relations help long-term care system manage the process more easily by letting people know how important it is to fund long-term care, how and when to access formal long-term care services, where the formal services in their community are, and what services should the informal provider give to clients and what should not. According to policy of the family doctor team from the ministry of Public Health in April, 2015, focusing on long-term care services in district area, has raised awareness of health providers in primary health care and secondary health care unit in the district about long-term care and its management in Thailand. One of the pioneer of long-term care in Thailand has found in Lamsonthi hospital in Lopburi province which the long-term care system in this area does not rely on the health volunteer but rely on paid caregivers that come from the health volunteer in the past. This system has good connection with local government for running the holistic system such as formal care, informal care, supportive care and caregivers care.

Health policy

The common health problems affecting the people's well-being and demanding long-term care are (1) chronic illnesses in the elderly and (2)

physical or mental disabilities in every age group. In terms of long-term care institutes in Thailand, there are many formal services providing long-term care such as residential home, assisted living setting, long-stay hospital, nursing home, and hospice care. However, most of these organizations are private or NGOs institutes, except residential homes which are mostly government institutes run by Ministry of Public Health, Ministry of Social Development and Human Security and local governments. Long-term care unit provides services determined by clients' level of health care needs. Nevertheless, the classification of long-term care levels in Thailand is still not clear nor orderly. As a result each unit of the institutes provides many levels of care depending on the situation, but the services are not always provided by professional staffs in most situations. There are institutional services for older persons called the Home for Older Person which provides for low-income elderly people who are unable to stay with families and who are without any relative to stay with (Jitapunkul et al., 2002). As this institute is a kind of social assisted setting and therefore provides for normal function elderly people, there is often no professional health care staff. Still, many elderly people who need long-term care services in Thailand live in Home for Older Person because of the unclear division between social assisted setting and long-term care setting in Thailand. This problem is caused by a lack of long-term care institutes and by the fact that public nursing homes are not yet available in Thailand. As the number of the dependent elderly population is growing and many of them clearly need public Home for Older Person, it's time to provide public nursing homes with professional staffs. Moreover, public nursing homes should provide long-term care services for non-elderly people to improve



their health and elderly people to maintain their function as much as possible.

Strength and limitation of the study

This study collect the papers describing the long-term care system from many countries, thus the variety of the data in one aspect has shown in this study. The data also collect from both qualitative and quantitative data since 1996 to 2015. Especially, the data of Thai long-term care, the sources of data explain in Thai and up-to-date as its publish in 2015, thus, the data of Thai long-term care system quite up-to-date and has sense of valid. However, This study collect data in language of English and Thai because of the language skill of the researcher, many useful papers are exclude from the study because it not write in English and Thai, so some value details will be missed in this study. Some countries published long-term care papers but it's not up-to-date, thus the data describing long-term care system in a few countries may not up-to-date as well.

Conclusion

Long-term care is not one-dimensional system, but it is a multi-dimensional system. Many countries invest not only health care part for long-term care but also invest in social, psychological, and financial part to complete the system for support dependency, caregivers and providers groups. Moreover NGOs and social enterprise may have roles to verify the standards of long-term care services. As Thailand is one of many countries that try to setup the appropriate long-term care system to support the dependency group especially the elderly, community based care is the concerning factor to adapt for long-term care system because of the culture of piety value in Eastern-World context. However, as an globalization and urbanization, human resource for providing the service in long-term care system still be the factor to concern. The sustainability of the system is the most concerned key factor for policy makers to concentrate.

Table 1 Type of Care and Funding in OECD Country

Difference	Consideration on informal care	Consideration on formal care
private funding	Korea Spain	
Private and public funding	Austria Luxembourg Germany Ireland United Kingdom Australia Japan (before 2006)	Canada United States

**Table 1** (Cont.)

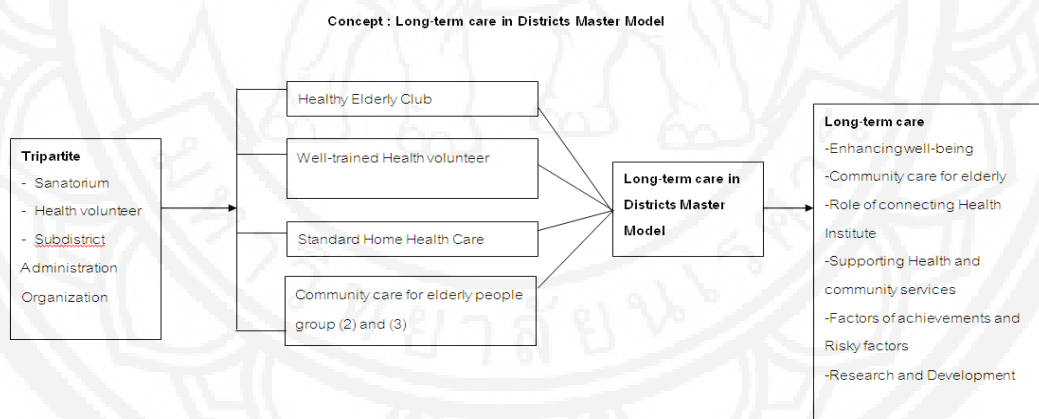
Difference	Consideration on informal care	Consideration on formal care
public funding		Japan (after 2006) Netherlands Sweden Norway Thailand

Sources: Adapted from Lundsgaard (2006)

Table 2 Methods of Supporting formal and informal care in OECD Country

Public support for formal care	Payments for informal care	
	Playing a considerable role	Playing a limited role
Limited choice	United Kingdom	Sweden Norway
Mixed	Austria Luxembourg Germany Ireland	Canada Netherlands Japan
Considerable choice	Australia	United state

Sources: Adapted from Lundsgaard (2006)

**Figure 1** Thailand's Long-term care in Sub-District Model

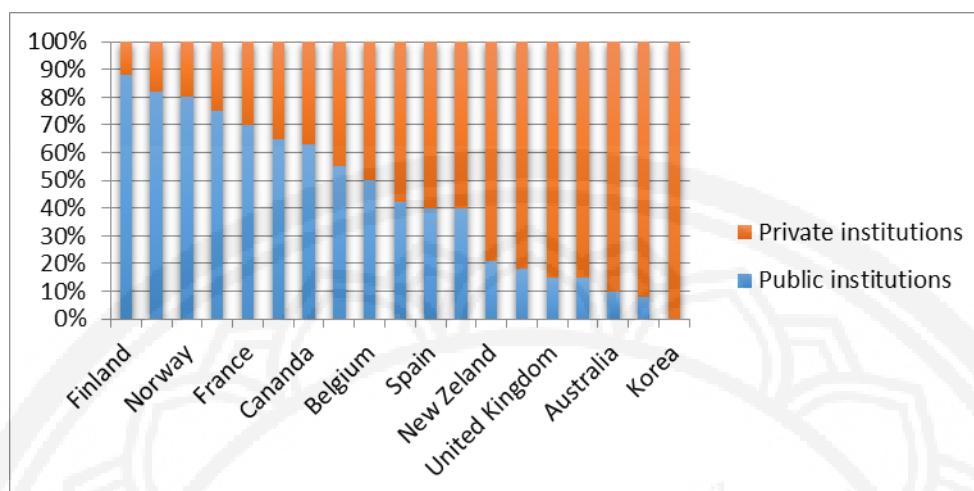


Figure 2 Lundsgaard's graph shows public and private long-term care institute for older people based on the number of residents in the late 1990s.

Sources: Lundsgaard (2006)

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