วารสารวิชาการสาธารณสุข
ปีที่ 27 ฉบับที่ 4 กรกฎาคม - สิงหาคม 2561

Journal of Health Science
Vol. 27 No. 4, July - August 2018

*นิพนธ์ต้นฉบับ* *Original Article*

# Elderly Health Care at Community Level in Thailand

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**Abstract:** A participatory action research was designed to explore the process of an elderly health care program development at the community level. The researcher acted as a facilitator of the elderly health care in the community. Qualitative data were collected through participatory observation and in-depth interview. The participants were health workers, health volunteers, and the elders selected from twelve elderly care units in 12 health regions of Thailand. The scope of study included enhancing workforce preparedness through cultural and social responsibility, provision of health care services to older adults in the communities, specific support groups, and increased community participation to improve health care quality for the elderly at the community level. This study indicated that every community had health services for the elderly across physical, psychological and social services. However, the coverage and capacity of service levels varied due to different social context and potential of culture and community. In summary, the models for health care of the elderly could be divided into three different levels: (1) the conventional practice model for elderly care, (2) the better practice model for elderly care, and (3) the best practice for elderly care.

***Key words:*** **health care, elderly, community level**

## Introduction

In the past two decades, many new industrialized countries including Thailand have social and economic changes. There has been an increasing economic growth shifting from agricultural sector to industrial and service sectors.[1] With the aging of the world population, more than one-quarter of the world's population will be over the age of 60 by the year 2100.[2] As in most other countries, the proportion of elderly people is increasing every year in Thailand due to decreased birth rates and increased longevity. The proportion of those 60 years and older in Thailand was approximately 9.2% in 2005; and is expected to reach 17.1% in 2025.[3] The average life expectancy is predicted to increase from 70.8 years in 2005 to 76.8 in 2025. As individuals live longer, health promotion behaviors become more important, particularly with regard to maintaining function and independence and improving quality of life (QoL).[4,5]

Issues in health promotion for older persons are related to their independence in everyday life, high cognitive and physical function, and active engagement with life. The scope of health promotion and aging of the US Department of Health and Human Services[6] highlights regular exercise, smoking cessation, avoiding excessive alcohol use, proper nutri-

tion, and having age-appropriate immunization. These issues are encouraged with the intention of reducing the potential life years lost from premature mortality, and ensuring better quality of remaining life.[7] There are considerable evidences that health-promoting behaviors of older adults offer the potential for improving health status and QoL as well as reducing the cost of health care.[8-10]

The aging population in Thailand will have significant economic and political implications that will affect the nature of society and so of national future. The elderly will require more funding to support different social programs, resulting in the change of the pattern of the federal budget. As the elderly becomes less able to access information, their voting behaviors may change. Finally there is the cost of supporting the care and maintenance of the elderly population – a cost that will be borne by a workforce that is growing proportionally smaller compared to the size of the supported population.[11]

The concept of empowerment is to empower people which are ensuring the way their health is to be promoted and acknowledging the value of their perspective. It is about helping people to acquire the skills and self-assurance to take greater control of their lives and their health.[12] Principles of empowerment have been used in preventive intervention covering a variety of health problems. The interventions have ranged from HIV prevention in minority populations to general health promotion in large cities.[13] Choksawadphinyo K used empowerment-based model for enhancing self care of persons living with HIV/AIDS in Thailand.[14] The proposed model guided the clients develop ability to solve their problems by themselves, which would lead to conduct appropriate self-care and improve their health and well-being. In addition, Squire A[15] explains that older people should have their fundamental needs for autonomy and empowerment met so that they could participate in their chosen lifestyle. This requires the provision of health promoting environment in the community. Statutory and voluntary sectors should be responsible for providing care that older people can choose for themselves, having a positive view of the health of older people and accepting them as partners in promoting and maintaining their health care. Empowerment and autonomy can still work along with interdependence such as living together, and support one another, respecting older people's values and beliefs and helping them to make their choice of care.

This study aimed to demonstrate that helping elderly people participate in a health care program and contribute to the community by sharing their life experiences will enable them to be included as worthwhile members of that community rather than being viewed as a burden.

## Materials and Method

The author applied a participatory action research, which was a qualitative approach that lends itself for informing community changes. Participants were selected from 12 regions of public health services of Thailand. They were comprised of different groups including older people, health staff, health volunteers and representative from local government staff.

Data were collected by 2 activities:

1) Participant interview using questionnaires during needs assessment process.

2) Focus group discussion during implementation and monitoring process.

**Data Analysis**

Qualitative data were analyzed by using content analysis of the interaction process among the elderly in health promotion programs. The given sharing information was recorded; exchanged life experiences among the members during the group meetings were interpreted. After that, the summary of the interpretation was constructed in order to explain the situation and quality of the elderly health care in the community.

## Results

Basic health services for the elderly were observed in every community. They covered physical, psychological and social aspects. However, the coverage and capacity of the services varied due to different sociocultural contexts and capacity of service providers, and community settings (Table 1). The findings were categorized into three different models: (1) the conventional practice model for elderly care, (2) the better practice model for elderly care, and (3) the best practice for elderly care.

First, the conventional practice model for elderly care provided health care for the elderly in the community through health services focusing on primary care performed by community health promoting hospitals. The comprehensive services covered the elderly needs including physical rehabilitation for the Alzheimer's patients or any other specific health problems. This model had no "day care center" at the community; however, it had an "elderly health club" to organize activities in the community to promote bio-psycho-social programs among the elderly.

Second, the better practice model for elderly care provided health care to the elderly in the community through health services, primary care, with a service unit, including the comprehensive health care services to meet the needs of the elderly and Alzheimer's patients on specific health problems. This model organized the "elderly school" to provide a space for organizing activities for the elderly in the community. This level of services was expected to develop a rehabilitation or day care center for the elderly.

Third, the best practice or comprehensive elderly health care model: this model provided health care for the elderly in the community focusing on primary care organized by community health promoting hospitals. The comprehensive services covered the elderly needs

**Table 1 Health services for the elderly and health facilities in the community.**

| Health services | Responsible sectors | Findings |
|---|---|---|
| 1. Health promotion, disease prevention | health staff, nurses, health volunteers | 12 health care centers |
| 2. Primary health care services - Thai traditional medicine clinic | health staff, nurse, thai traditional medicine, health volunteers | 12 health care centers |
| 3. Home health services, home care | health staff, nurse, health volunteers | 12 health care centers |
| 4. Referral services | health staff, nurse, health volunteers | 12 health care centers |
| 5. Rehabilitation services and physical therapy (day care) | health staff, nurse, health volunteers | 1 health care centers |
| 6. Hot line | health staff, nurse, health volunteers | 12 health care centers |

including physical rehabilitation for the Alzheimer's patients or other specific health problems. The model also provided care for lifestyle-related health, and enhance the care and rehabilitation services for the elderly and disabled in the community. This level had developed a rehabilitation or day care center by the cooperation of organizations and partners in the community.

Based on the focus group discussion, all of those health care services needed to extend in order to increase degrees of empowerment and control. However, not all communities could provide the same quality of care for the elderly; it depended on significant responsibilities, work priorities, and collaborative partnership among community members and health professionals. Moreover, elderly health care required community involvement, or engaging in their own desire for enhancing community power.

## Discussion

This study indicated that every community had health services for the elderly across physical, psychological and social services. However, the coverage and capacity of service levels varied due to different social context and potential of culture and community. The summary model for health care of the elderly could be divided into three different levels. Since the elderly health care program was provided at the elderly health club where the elderly lived, easy access to the program; the group dynamic among residents could be the reasons for the high attendance rate, and consequently time or environmental effects was not considered.

Further study is needed to cover elderly populations with different residential statuses or various health statuses, along with additional strategies to consider the characteristics of the targeted population.[16-18] Promotion of health and wellness should be considered, particularly for all health care providers in all community levels who work with the elderly people. Some health care providers claimed that because of their age, activities pertaining to prophylactic measures, health and wellness maintenance would not be helpful to elderly people. On the contrary, wellbeing should not be regarded as a concept specifically relevant to younger individuals. The wellness concept is applicable to every age from the young to older adults. It was indicated that every community had services for the elderly across physical, psychological and social services. The coverage and capacity of service levels varied depending on a different social context and potential of culture and community. Thus, the appropriated model for health care of the elderly should include the health care of the elderly in the community through health services, primary care, with a unit of health services in community health promoting hospitals, including the comprehensive health care services to meet the needs of the elderly and Alzheimer's patients on specific health problems, as well as the problems of health and lifestyle-related health and enhance the care and rehabilitation services for the elderly and disabled in the community. Therefore, a rehabilitation center and physiotherapy/or service seniors (day care) should be developed through the cooperation of organizations and partners in the community. Since the elderly population is at high risk of major diseases and defects, members of health care units should handle their education carefully. Through

such education, benefits are provided regarding protective and wellness development for all elderly people.[13,19]


## Acknowledgments

*The financial grant of this research work was from the Ministry of Public Health; and Faculty of Public Health, Burapha University, provided literature and reviewed the paper.*


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**บทคัดย่อ: การดูแลผู้สูงอายุในระดับชุมชนของประเทศไทย**

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การศึกษานี้มีวัตถุประสงค์เพื่อศึกษากระบวนการพัฒนาระบบการดูแลสุขภาพผู้สูงอายุในระดับชุมชน โดยผู้วิจัยทำหน้าที่เป็นผู้อำนวยความสะดวกในการจัดกระบวนการแลกเปลี่ยนประสบการณ์ด้านการดูแลสุขภาพผู้สูงอายุในชุมชน เก็บรวบรวมข้อมูลเชิงคุณภาพ การสังเกตการณ์การแบบมีส่วนร่วมและการสัมภาษณ์แบบเจาะลึก ผู้เข้าร่วมโครงการประกอบด้วยผู้ปฏิบัติงานด้านสุขภาพอาสาสมัครสาธารณสุขและผู้สูงอายุที่ได้รับการคัดเลือกจากกลุ่มผู้สูงอายุจากเขตบริการสุขภาพรวมทั้งสิ้นจำนวน 12 เขต ในประเทศไทย โดยกำหนดเป็นศึกษาในด้านการให้บริการด้านการดูแลสุขภาพแก่ผู้สูงอายุในชุมชน กลุ่มสนับสนุนเฉพาะและกระบวนการมีส่วนร่วมของชุมชนเพื่อปรับปรุงคุณภาพการให้บริการสุขภาพผู้สูงอายุในชุมชน ผลกระทบจากการวิจัยแบบมีส่วนร่วมมุ่งเน้นไปที่มุมมองด้านการดูแลสุขภาพผู้สูงอายุในระดับชุมชน ผลการศึกษาพบว่า ทุกชุมชนมีบริการสุขภาพแก่ผู้สูงอายุ ทั้งบริการด้านสขภาพ-กาย สุขภาพจิต และบริการสังคม ความครอบคลุมและคุณภาพของบริการแตกต่างกันตามสภาพสังคม ศักยภาพของวัฒนธรรม และลักษณะของแต่ละชุมชน โดยสรุป สามารถแบ่งรูปแบบบริการสุขภาพผู้สูงอายุออกเป็น 3 ระดับคือ ระดับปกติ ระดับดี และระดับที่เป็นเลิศในการบริการผู้สูงอายุ

***คำสำคัญ:*** **การดูแลสุขภาพ, ผู้สูงอายุ, ชุมชน**