รายงานวิจัยฉบับสมบูรณ์

โครงการนโยบายและทิศทางนโยบาย ด้านผู้สูงอายุในอนาคต

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และสำนักงานกองทุนสนับสนุนการวิจัย

The synthesis of the National Policy on Ageing

Executive Summary
The synthesis of National Policy on Ageing

The papers on National Policy on Ageing and Long Term Care Needs and Policy from five study countries, being Korea, HongKong, Malaysia, Singapore and Thailand, are reviewed and summarized as follows.

1.<u>The profile of ageing population</u> in the five countries are similar. They have been undergone demographic transition and most recent economic changes. Low fertility and mortality have been observed with longer life expectancy. Advance in medical and health technology have brought the World on unprecedented volume of elderly people. Singaporean elders were 15% since last decade, the highest ranking in elderly programs and activities and the other countries are followed.

During 1999-2000, three strata of countries are observed with regards to expectancy of life at birth. Higher levels in Hong Kong and Singapore, lower levels in Malaysia and Thailand, while Korea is in the middle. Females expected longer life span than males in all 5 countries and the differences are around 5 years between 67 years for male and 70 – 74 years for female in first stratum. Hong Kong and Singapore expect longer life in the ranges of 75 – 76 years and 80 – 82 years for male and female respectively. Korea is in the middle of the 5 counties, 71.0 and 78.6 years for both respective sexes.

The increase of most vulnerable group, females of old-old age group are evidenced in every countries, reflecting the increasing diversity in the elder's diseases and health risk factors. The old- old people live longer with sex ratios of male to female being 0.66 for Thai as compared to 0.85 for Malaysian. In Hong Kong, Malaysia and Thailand, similar patterns are observed. The windowed and divorced female elders are about two to three times of males in old-old age group.

Impression of the issue is, the older women who have a longer life expectancy, prevailing of unavoidable chronic illness and sometimes coincide with an inadequate financial resources may accentuate the needs for formal long term care. The lack of research data on aging women per se is a gap that needs to be addressed especially those of middle-class and the urban poor.

2. Data for estimating needs for long term care of elderly is most superative for policy decision. The severity of mental impairment as well as physical impairment have to be considered. At the individual level, apart from the measure of ill-health in terms of burden of diseases, indirect measure that reflects physical independence in self-care activities, the ADL_s and prevalence and severity of long-term disability presented by Korea and, Thailand (national survey) and Hong Kong are good examples. It is estimated that 14.8% of Thai elders 60 years and over who need LTC in 2000. Korean estimated number of 19% aged people 65 and over in need of formal LTC in the same year.

Age-specific prevalence of dementia and suicide death rate among elderly are used for determining size of mental impairment and community mental health status. Moreover it gears towards specific intervention of health and psychological care.

Age-specific prevalence of senile dementia in Thailand is quit similar to Singapore around 3-4% , while Korean rate of this respective condition is estimated to be higher at 8.2% of elderly 65 years and over in year 2000. The differences may due to diagnostic means and cohorts in the survey.

Hong Kong elderly suicide rate of 28 per 100,000 is presented as opposed to 12 per 100,000 among general population, of which is lower than Singapore rate (50 per 100,000). The respective rates for most advanced countries are 20 in USA, 16 in Australia and 12 in New Zealand. In contrast to Thailand where elderly suicide rate remains lower than 10 per 100,000.

3. The rapid growth of Thai aged population is demonstrated by sheer number and proportions to total population. Approximately it will be double in growth rate within the next 20 years. The elders aged 60 and over, are 5.6 million in 2000; this will be 11.3 million in 2020.

Three percentage of the Thai female elderly are single while only one percent of the male counterpart are. The difference is remarkable higher among elderly female living in urban areas and also increased with age. In Thailand, the older person aged 75 and over and women in particular , had high prevalence of living alone (6.5%) and living with a non- relative (5.6%).

4. Regarding family structure, country development has brought about changes in family where smaller family size and preference of nuclear family are replacing the expanded family structure and larger family size.

Moreover, households of elderly living alone without caretaker is more prevailed especially in urban area.

The data of **Malaysia** reveal of increasing in nuclear household and a little decrease of extended family during the 1980 and 1991 with average household size, being 5.2 to 4.8 for total , 4.9 to 4.8 for nuclear family and 7.1 to 6.5 for extended family. **Singapore** is increase in "*elderly only*" households from 1.8% in 1990 to 2.8% in 1999. The increase of 3% in one - person household is a matter of concern due to the problem of social isolation , vulnerability to depression and suicide.

Currently almost all ASEAN aged population are cared by informal systems mainly by families , relatives , neighbors and others in various circumstances. However, those who are cared for by the informal system will be out - numbered those who utilize formal care services in the future.

Needs for care-giver specifically trained for elderly care is the issue for further consideration.

5. <u>The deeply rooted Asian culture that stresses the importance of filial piety dictates to care by family.</u>

Although, the traditional value of filial piety seems to be still relatively well upheld, but ways of realizing this value are changing, become more practical, reasonable and reciprocal. The individualism and a nuclear-family orientation is developing and expanding. All of these changes tend to weaken the consciousness of familial support and care for the elders by the family and within the family.

Thailand is a Buddhist society and a filial piety culture. Therefore, the needs and the problems of the elders is recognized as an individual not a society. Despite the elders in the urban area are confronted with the needs for services and caretakers especially among the middle and poor elders.

The informal care by family requires the strengthening of our value system that stresses on filial piety and responsibility of children towards parents should further cultivated through publicity and fiscal incentives that reinforce such virtues. The media can be crucial for awareness creation and the dissemination of information. The education system can be used to instill and reinforce the culture of filial piety among the young as well as to foster the sense of obligations of the young towards the elderly.

6. Three groups of elder are classified regarding needs for LTC, healthy and independent, functional dependent and sick people whether acute or chronic. Policy in every country for the first group is for them to live with their adult children or relatives at home as long as possible and external help will come when changes occur to them. The second group needs social welfare services in daily living and services related to health and health risk surveillance. The needs for the last group may range from primary medical care to highly skilled institutional medical care.

The LTC for all three groups of elder is different in each country it depends on characteristic, culture, values and health status of the people. Advance in medical and health technology, the wealthy, and the stable politic seems to confirm the LTC policy for elder people.

The primary care units in the universal coverage scheme in healthcare finance have to explore the feasibility to provide community/home care services. Therefore, the primary care services, particularly the "Home Healthcare" for every elderly in needs, will be inevitably established in the near future.

7. In line with **the process of formulation of the National Policy for the elderly** in **Singapore**, step of review was conducted for the last policy before the new one is putting into shape. Two important characteristics are the various Committees and the publicity. The Singaporeans give many inputs thus become an important consideration in the Committee' deliberations.

In response to the needs of long-term care from the survey, the government of **Korea** established a policy planning committee. The first report of the committee (2001) recommends the government to set up mid and long-term policy development plans and some important basic research projects.

In 1982, **Hong Kong,** after five years of the plan. Revised the first plan. The Central Committee was set in 1987, function as an advisory panel on health and social welfare services with a special focus on the elderly people.

A monitoring system of Malaysia has been put in place to monitor the progress of all activities for the period 1997-2005. This control mechanism

provides checks and balance as well as evaluates the progress of programs and activities.

The plans responsive to the policy of Thailand should be documented at the range of time, addition with the priority sets of the plan. The delegation of the authority and responsibility should be noted. Both the health and social plans must take action by the government, NGO, community, private and voluntary organizations in concert with a budget plan. Without a corresponding to policy programs and financing methods the policy plan cannot be properly implemented.

The monitoring system of the Thai Policy should be the most important part for the policy implementation. This will evaluate the progress of program and activities. The development of a coordinated, systematic and responsive database is essential for government to make informed decision for policy formulation and planning, to assess the impact, and to operate programs effectively.

The evaluation of the plans and programs of the elders ie, the senior club, the social service center and the Aged Home, will help to make decision and reform the roles of each sector. Some programs may be decentralized to the community organization or private organization or NGO and the government should set up a mechanism for control the quality of services.

8. The administration of long term care facilities and services in each country are varied depending on their infrastructure of the governances. Mostly social welfare services are provided by Ministry of social welfare. Institutional medical and health facilities are rendering services by Ministry of Health. The problem is that services for aged are multidisciplinary and elder people's issues are multidimensional. In Australia, the government has solved the problem by creating a Ministry for Aged, while some countries have combined the Ministry of Health and welfare in one roof.

In **Singapore,** most of the community-based social facilities fall under ***the Ministry of Community Development and Sports*** while nursing home facilities, hospices, community and chronic illness hospitals belong to ***the Ministry of Health***. The government established the ***Inter-Ministerial Committee on Ageing Population*** to be the co-ordinating body.

The ***Social Welfare Department*** of **Malaysia, Hong Kong and Thailand** are responsible for social services.

Community care services subsidized by the government of **Korea** are delivered through the ***Ministry of Government Administration and Home Affairs (MGAHA)***. Currently social welfare policies made by the ***Ministry of Health and Welfare*** are implemented through the general administrative agencies of central and local governments under the control of the MGAHA. So, the delivery system of social welfare services is fused with the general administrative system.

Almost all of state-owned social services in Thailand are run by the Department of Social Welfare under the Ministry of Labor and Social and Welfare. In term of social services are more advanced compared with health services. Recently, there is no information available to demonstrate the coordination between the social and health services of formal LTC.

9. **Living arrangement is significant for family support.** Resident home with friendly environments including transportation is essential for elderly people. The government of Singapore is set up housing grants, apartment, tax incentive and infrastructure to support for the elders, as well as **Hong Kong.** The government of **Malaysia** has recently tried the community caring village and plan for accessible to the transportation of the elderly both in the rural and the urban areas.

10. Quality control, accessibility and coverage of the services for elderly should be taken into consideration and further set as policy directions.

Quality control aspect of LTC services is the important issues for both private and state-owned facilities. As example, quality assessment mechanisms are introduced by government of Hong Kong and Korea on a decentralized management for private nursing homes.

Korea is also established the minimum living standard through the National Basic Livelihood Security Law in 1999, as well Malaysia has developed the standard of care that would be accessible to all.

Such mechanisms should be explored for feasibility of introducing them in our county.

11. Education and Training

Malaysia and T**hailand** seem to have pronounced education and training for the elders. They are orientation for approaching aged livelihood, training for vocation after retirement and upgrade skills for gainfully employed, training for volunteers to assist in community outreach programs,

with inclusion of training of caregivers specific for the elderly. **These should be pursued with quality and audit mechanism put in place.**

12. Advocacy and Public Awareness

Apart from education and training, mass media is effective mean to reach universal coverage of the target. A motto for promotion of healthy ageing through life style approach should be simple, short and meaningful for publicity.

Hong Kong key messages is a good example, ***"be active, eat well*** and ***quit smoking***". We in Thailand have also created our motto, the important task is to following up their popularities among the target groups.

As well as the policy level, Hong Kong advocates the promotion for, '***sense of security', 'sense of belonging', and 'sense of health and worthiness'.*** Two principles of all policy and services for elderly in Hong Kong are set for a clear directions, '***Ageing in place' and 'continuum of care***'(2000).

The three-pronged approach of **Singapore** (1999) is very interested in terms of ***"Heartware", " Software" and "Hardware***". **Singapore set** a great deal of money being spent on lifelong public health education. Public education is a key mechanism in implementing the "*Heartware*".

Where "Heartware" refers to the individual's and society's value, attitudes and perceptions of ageing and senoir citizens. "Software" refers to development of policies, programs and services that constitute the community infrastructure. The "Hardware" refers to the built of environment such as housing infrastructure and transport system.

13. Research as evidenced based for policy decision.

Comprehensive data for policy making is for them to perceive ageing as social problem which are set of problem negatively affects a large number of peaple, judged to be undesirable in the light of social values and that regained callective action. Major aspects of ageing problems related to economic independence, difficulties in health care, role loss and difficulties in social activities and socio- psychological conflicts as well as feeling of alienation.

It is evidenced that each country has under-taken lots of research regarding ageing of the population and needs for services. The government of Korea conducted two national surveys for assessment needs of long term care. In response to these needs, the Committee was established and recommended the government to set up mid and long-term plans, and research projects for the elders.

Apparently, Thai acodemic researchers are active in providing the factual situation and needs of elder people ,and have projected its long term

impacts. Additional essential data for development of the second National Long Term Plan for older persons of Thailand are also proposed.

14. Model development and research is also essential for long term care services in specific culture and traditions.

To promote health in old age, we often forget that old people themselves, together with their families, relatives and friends, have a key role in maintaining a good quality of life. The present challenge to community agencies and to health and other professional is to find a balance between actions designed to support (rather than undermind) the efforts of elderly people and their families to look after themselves, without at the same time neglecting their welfare needs.

A comprehensive system of geriatric step- down care after the patient is discharged from the hospital of **Singapore** is very interesting because it includes provision of professional staff, training programs, development of quality assurance and sharing of resources. In addition, Ministry of Health has a guidelines and standards of care and audit the providers.

The continuum of care for the sick from acute to community-based to home care should be the aim of the government's policy. It is recommended to conduct in-depth study to actually reform the primary care service at Thai PCUs to be holistic, continuous and integrated to cover whole range of social, psychological and health care for long- term sick people.

15. Housing and town planning in anticipating the growth of an ageing population, planning for township should take into account the facilities for the elderly. In line with the advocacy for the elders to remain in the community, infrastructure for the mobility of the elders in important and should be incorporated into town planning.

นโยบายและทิศทางนโยบายด้านผู้สูงอายุในอนาคต
(ด้านแพทยศาสตร์)
บทสรุปสำหรับผู้บริหาร

การศึกษาเอกสารนโยบายสำหรับผู้สูงอายุ จาก 5 ประเทศในภูมิภาคตะวันออกเฉียงใต้ (เกาหลี ฮ่องกง มาเลเซีย สิงคโปร์และประเทศไทย) ได้ข้อสรุปและบทเรียน ดังนี้

1. รูปลักษณ์ของประชากรสูงอายุ ในทุกประเทศที่ศึกษามีความคล้ายคลึงกัน คือ ได้ผ่านระยะของการเปลี่ยนผ่านด้านประชากร จนมาถึงระยะที่อัตราเพิ่มของประชากรอยู่ในระดับทดแทนหรือต่ำกว่าระดับทดแทน มีอัตราตายต่ำ ประชากรมีความยืนยาวของชีวิตโดยเฉลี่ยเพิ่มมากขึ้น เป็นเหตุให้ผู้สูงอายุเพิ่มขึ้นอย่างรวดเร็วทั้งจำนวนและอัตราเพิ่ม บางประเทศที่ล้ำหน้าไปก่อนคือ สิงคโปร์ มีสัดส่วนของผู้สูงอายุถึงร้อยละ 15 มาตั้งแต่ทศวรรษที่ผ่านมา ประเทศอื่นกำลังเพิ่มตามมา

ประเทศไทยมีการเพิ่มของประชากรสูงอายุอย่างรวดเร็วทั้งจำนวนและอัตราเพิ่ม จากการฉายภาพประชากร จะเพิ่มจำนวนเป็นเกือบ 2 เท่าในอีก 20 ปีข้างหน้า จำนวนประชากรอายุ 60 ปีขึ้นไปของประเทศไทยเท่ากับ 5.6 ล้านคนในปี 2543 จะเพิ่มเป็น 11.3 ล้านคนในปี 2563 ขณะเดียวกันอายุขัยเฉลี่ยในปี 2543 นั้นได้เพิ่มเป็น 67.3 ปีสำหรับผู้ชายและ 74 ปีสำหรับผู้หญิง และจะเพิ่มต่อไปอีก เนื่องจากการแพทย์สาธารณสุขที่ก้าวหน้าและการดูแลตนเองที่เหมาะสม ทำให้ประชากรมีอายุยืนยาวมากขึ้น ผู้หญิงจะอยู่นานกว่าผู้ชาย จึงมักปรากฏว่า ในกลุ่มอายุ 75 ปีขึ้นไปหรือผู้สูงอายุตอนปลายนั้น จะมีผู้หญิงมากกว่าผู้ชาย 2 ถึง 3 เท่าและอัตราส่วนนี้จะมากขึ้นตามอายุ ผู้หญิงสูงอายุในวัยปลายดังกล่าวนี้ มีสัดส่วนของผู้ที่เป็นหม้ายเกินกว่าครึ่งหนึ่งของกลุ่มเดียวกัน เป็นผู้ที่อยู่ในภาวะที่มีความเปราะบางสูงต่อการเจ็บป่วยด้วยโรคเรื้อรัง และการพึ่งพาต่อการดูแลตนเองในชีวิตประจำวันโดยผู้ดูแลในครอบครัวหรือสถานบริการที่ให้บริการต่อเนื่องระยะยาว(Long term care services)

2. ข้อมูลที่จำเป็นเพื่อการประมาณความต้องการของการดูแลต่อเนื่องระยะยาว ได้แก่ ความบกพร่องทั้งทางร่างกายและจิตใจ เป็นข้อมูลที่นำมาประกอบการพิจารณาเพื่อการตัดสินใจทางนโยบายในด้านสุขภาพทางกายนั้น นอกจากการวัดภาระโรค การวัดความสามารถในการทำกิจวัตรประจำวัน และระดับการพึ่งพา มีประโยชน์ในการจัดบริการที่เหมาะสมได้อย่างดี ประเทศไทยและเกาหลี ได้นำเสนอข้อมูล ADL และ IADL โดยกลุ่มอายุรวมทั้งอัตราความชุกของกลุ่มอาการสมองเสื่อมและอื่นๆ ที่เป็นข้อมูลจากการสำรวจระดับประเทศ

อัตราความชุกของกลุ่มอาการสมองเสื่อมของไทยใกล้เคียงกับของสิงคโปร์ ประมาณ 3 – 4% แต่ดูเหมือนจะต่ำกว่าของเกาหลี ซึ่งความแตกต่างอาจเนื่องมาจากเครื่องมือที่ใช้วัดและการสุ่มตัวอย่าง ประมาณว่าในปี 2543 ประมาณ 8.2% ของผู้สูงอายุที่มีอายุ 65 ปีขึ้นไปของเกาหลี มีอาการสมองเสื่อม และ 4% เป็นกลุ่มที่มีภาวะรุนแรง

ฮ่องกง นำเสนออัตราการฆ่าตัวตาย ประมาณ 28 ต่อผู้สูงอายุ 100,000 คน เปรียบเทียบกับบุคคลทั่วไปประมาณ 12 ต่อแสนคน ซึ่งต่ำกว่าสิงคโปร์ที่ อัตรานี้เท่ากับ 50 ต่อแสน ในขณะนี้ประเทศพัฒนาแล้ว เช่น สหรัฐอเมริกา มีอัตราฆ่าตัวตายในผู้สูงอายุ 20 ต่อแสน ออสเตรเลียและนิวซีแลนด์ ประมาณ 12 ต่อแสนคน ในประเทศที่พัฒนาแล้ว พบว่ามีการเฝ้าระวังการฆ่าตัวตายในผู้สูงอายุที่นำเสนอตัวเลขสถิติในรายงานสถิติสุขภาพประจำปี ด้วยถือว่าเป็นดัชนีวัดสุขภาพจิตที่สำคัญ

สำหรับประเทศไทย จากข้อมูลสาเหตุการตายที่ตรวจสอบแล้ว พบผู้สูงอายุฆ่าตัวตายน้อยมากเมื่อเทียบกับอัตรานี้ในกลุ่มวัยรุ่นและปลายวัยแรงงาน อย่างไรก็ตาม สถิติเหล่านี้ควรได้รับการวิเคราะห์ และ นำเสนออย่างต่อเนื่องต่อไป สำหรับผู้กำหนดนโยบายและสาธารณชน

3. ผู้สูงอายุในประเทศไทย ได้รับคำจำกัดความว่า เป็นผู้ที่มีอายุตั้งแต่ 60 ปีขึ้นไป และมักจะไม่ได้แบ่งเป็นกลุ่มย่อยลงไปมากกว่านี้ แต่ในปัจจุบันคนไทยมีอายุยืนยาวมากขึ้น ผู้ที่มีอายุ 100 ปีขึ้นไปมีอยู่เป็นจำนวนร้อยในปี 2543 คน และนับวันจะเพิ่มมากขึ้น

ในการศึกษาเกี่ยวกับผู้สูงอายุ ได้แบ่งเป็น 2 กลุ่มอายุเป็นอย่างน้อยคือ ผู้สูงอายุตอนต้นคือ อายุ 60 ปีถึง 74 ปี และผู้สูงอายุตอนปลาย คือ อายุ 75 ปีขึ้นไป และอาจเพิ่ม"กลุ่มอายุสูงสุด" ตามนิยามของ UN คือ ผู้ที่มีอายุ 80 ปีขึ้นไป ทั้งนี้เนื่องจากแต่ละกลุ่มดังกล่าวจะมีสภาวะทางกาย ทางจิตและภาวะพึ่งพา รวมถึงความต้องการการดูแลที่แตกต่างกัน

มีข้อสังเกตว่าในทศวรรษที่ผ่านมา ได้มีกลุ่มทำงานของประเทศไทยที่เกี่ยวกับอนามัยการเจริญพันธุ์ของประชากรกลุ่มที่พ้นวัยเจริญพันธุ์หรือวัยหมดประจำเดือนได้ใช้คำเรียกชื่อผู้ที่อยู่ในวัยระหว่าง 45 – 55 ปี ว่า "วัยทอง" ซึ่งอาจทำให้เกิดความสับสนกับกลุ่มผู้สูงอายุ(60ปีขึ้นไป) ที่เคยมีนักประชากรศาสตร์ของไทย เรียกวัยสูงอายุ คือ กลุ่ม 60 ปีขึ้นไปว่า วัยทองเช่นกัน อาจทำให้สับสนได้

ในการให้ข่าวสารแก่มวลชน ควรทำความเข้าใจให้กระจ่างในเรื่องกลุ่มอายุเหล่านี้ด้วย

4. ผู้ดูแลผู้สูงอายุในครอบครัวกำลังจะมีจำนวนลดลงเรื่อยๆ ด้วยแต่ละครอบครัวมีลูกน้อยลง ครอบครัวไทยสมัยใหม่จะมีลูกโดยเฉลี่ย 2 คน และไม่เลือกเพศ คือจะเป็นชายล้วน หญิงล้วน หรือชายหญิงก็ได้ คนเหล่านี้จะมีการศึกษาสูงกว่ารุ่นก่อน มีโอกาสทำงานตลอดชีวิต มีโอกาสที่จะต้องไปทำงานคนละพื้นที่กับพ่อแม่ ทำให้เป็นไปได้ว่า ต่อไปผู้ดูแลผู้สูงอายุในครอบครัวไทยจะลดน้อยลง

สำหรับประเทศสิงคโปร์และเกาหลีที่มีเชื้อสายจีน มีประเพณีให้บุตรชายคนโตเป็นผู้ดูแลครอบครัวและทรัพย์สินมรดก ซึ่งรวมถึงการดูแลพ่อแม่ ปู่ย่าตายายด้วย ฉะนั้นผู้ดูแลผู้สูงอายุก็ควรจะเป็นบุตรชายคนโตและภรรยา แต่รัฐบาลก็ไม่แน่ใจว่า จะดำรงอยู่เช่นนี้อีกนานแค่ไหน จึงได้ออกกฎหมายให้บุตรเป็นผู้เลี้ยงดูบิดามารดา เป็นผู้ออกค่าใช้จ่ายในยามเจ็บป่วย ถ้าไม่ทำตามก็จะถูกฟ้องร้องได้ แต่ก็มีกฎหมายลดภาษีแก่บุตรที่ให้พ่อแม่อยู่ด้วย และมีมาตรการอื่นๆ เพื่อช่วยให้ผู้สูงอายุมีบุตรเป็นผู้ดูแล

สำหรับประเทศไทย ประเพณีได้ระบุค่อนข้างชัดว่า บุตรคนโตจะอยู่ดูแลพ่อแม่ แต่ก็มีผลการวิจัยที่ว่า ถ้ามีลูกหลายคน ลูกสาวคนหนึ่งคนใดจะอยู่กับพ่อแม่ ไม่ว่าจะแต่งงานหรือไม่ จากผลของการศึกษาจะพบว่า เป็นลูกสาวคนเล็กที่ไม่ได้แต่งงาน ซึ่งในรุ่นต่อไป ลูกสาวเหล่านี้ก็จะกลายเป็นผู้สูงอายุที่มีโอกาสสูงที่จะอยู่คนเดียว

ปัญหาที่น่าจะเกิดกับผู้สูงอายุในเมืองมากกว่าในชนบท คือผู้สูงอายุที่ไม่มีเงินทอง ไม่มีผู้ดูแล และเข้าไม่ถึงความช่วยเหลือต่างๆ ถูก(ถีบ)ทิ้งกลางถนน ดังเป็นข่าวลูกเอาแม่ไปทิ้ง ที่เกิดในกรุงเทพฯ เร็วๆ นี้

ผู้สูงอายุรุ่นต่อไปของหลายประเทศ น่าจะมีความต้องการที่แตกต่างกับผู้สูงอายุในปัจจุบัน ด้วยการศึกษาสูงกว่าและมีจำนวนมากขึ้น สามารถประกอบอาชีพได้ต่อเนื่องระยะยาว หรือมีการฝึกอาชีพใหม่ๆหลังการเกษียณอายุ ทำให้ผู้สูงอายุเหล่านี้ productive ได้ยาวนานกว่าเดิม รวมทั้งมาตรการส่งเสริมสุขภาพต่างๆและพฤติกรรมทางสุขภาพที่เปลี่ยนแปลงไป น่าจะทำให้ภาระโรคเปลี่ยนประเภทไป จึงมีความจำเป็นต้องติดตามสถานการณ์เป็นระยะๆ เพื่อเป็นพื้นฐานในการกำหนดนโยบายที่ดี

5. วัฒนธรรมไทยที่ให้คุณค่าความกตัญญูต่อผู้ให้กำเนิด ซึ่งสะท้อนถึงการดูแลทุกข์สุขต่อผู้สูงอายุในครอบครัว อาจจะเป็นไปในรูปของการส่งเสียข้าวของเงินทอง หรือการไปเยี่ยมเยียนถ้าไม่ได้อยู่ด้วยกัน ซึ่งเป็นวัฒนธรรมที่ตกทอดกันมานานหลายชั่วอายุคน จนทำให้นักวิชาการไทยและนักวิชาการต่างประเทศที่เข้ามาทำการศึกษาในประเทศไทย เชื่อว่า ความกตัญญูจะยังคงอยู่กับคนไทยส่วนใหญ่ตลอดไป ซึ่งจะทำให้ผู้สูงอายุที่ต้องอยู่คนเดียว ขาดคนดูแลทุกข์สุข หรือถูกทอดทิ้งน้อยมาก และเข้าใจว่า ความต้องการบ้านสงเคราะห์ต่างๆจะน้อยมาก ไม่เกิน 2-3%

ประเทศอื่นๆในเครืออาเซียนทุกประเทศที่ศึกษา ก็มีประเพณีสืบทอดในเรื่องความกตัญญูเช่นเดียวกับประเทศไทย มีการตั้งสมมติฐาน จากการเปลี่ยนแปลงวิถีชีวิตและค่านิยมของคนรุ่นใหม่ ที่นิยมความเป็นอิสระแก่ตัว มีครอบครัวขนาดเล็ก และด้วยความเคร่งเครียดทางเศรษฐกิจ อาจทำให้เกิดความถดถอยในค่านิยมของความเป็นครอบครัวที่มีคนหลายรุ่น ลดทอนการส่งเงินให้พ่อแม่ หรือการงดเยี่ยมเยียน ทั้งอาจจะทำให้ผู้สูงอายุมีภาระเพิ่มขึ้น โดยต้องเลี้ยงดูบุตรหลาน ในกรณีที่พ่อแม่ต้องไปทำงานในพื้นที่อื่น หรือยิ่งไปกว่านั้น การระบาดของเอดส์ในประเทศไทย ทำให้ลูกที่โตแล้วเจ็บป่วยกลับมาป่วยและตายในอ้อมอกพ่อแม่ แล้วทิ้งลูกกำพร้าไว้ให้เลี้ยงอีกด้วย

มาเลเซีย และเกาหลีใต้ ให้ข้อเสนอในการจรรโลงวัฒนธรรมและคุณค่าของความกตัญญู กระชับความเชื่อมโยงของครอบครัวหลายรุ่น สำหรับคนรุ่นใหม่ จำเป็นต้องมีการให้ข้อมูลข่าวสารเป็นระยะๆโดยสื่อมวลชนรวมถึงบทเรียนในชั้นเรียน และการศึกษานอกระบบต่างๆ ที่สำคัญต้องมีตัวอย่างให้เด็กและคนรุ่นใหม่ให้เห็นหรือสัมผัสความเป็นครอบครัวตัวอย่างทั้งความกตัญญูเป็นพื้นฐานของวัฒนธรรมไทย และความสัมพันธ์ที่ดีระหว่างรุ่น

สำหรับสิงคโปร์ แม้จะไม่ได้กล่าวถึงเรื่องนี้อย่างตรงไปตรงมา แต่การดำเนินโครงการ[1]ให้เงินกู้เพื่อที่อยู่อาศัยที่จะมีพ่อแม่อยู่ด้วย หรือการสร้าง studio apartment หรือการตั้งเป้าหมายเรื่อง Heartware[1] ที่จะใช้ระบบการศึกษาในการจรรโลงวัฒนธรรมนี้ให้อยู่ในจิตใจของคนทุกรุ่น

6. ประเทศไทยเป็นเมืองพุทธศาสนา ซึ่งน่าจะเป็นลักษณะเด่นกว่าประเทศอื่นๆ ในแถบเดียวกันที่มีหลักยึดเหนี่ยวในปรัชญาของพุทธศาสนาโดยเฉพาะในเรื่องพรหมวิหารสี่ เมตตา กรุณา มุทิตา อุเบกขา และความเอื้ออาทรที่จะช่วยให้ผู้สูงอายุและเด็กกำพร้าอยู่ในบ้านและชุมชนได้ นอกจากนี้การไปวัดของผู้สูงอายุ จะเป็นการปรับจิตใจ อารมณ์ของผู้สูงอายุให้สงบ มีสติที่จะมองสภาพแวดล้อมด้วยใจที่เป็นกลาง การมีกิจกรรมร่วมกันกับคนต่างรุ่น ได้ช่วยเหลือซึ่งกันและกัน ก็จะช่วยให้ชีวิตในบั้นปลายสงบสุขและเป็นที่พึ่งของลูกหลานสืบไป ถ้าทำได้ถึงขั้นนั่งสมาธิ วิปัสสนา จะทำให้เกิดสุขภาวะทางจิตวิญญาณได้เป็นเท่าทวีคูณ

7. นโยบายเกี่ยวกับการดูแลผู้สูงอายุนั้นเหมือนกันในทุกประเทศคือ ผู้สูงอายุควรอยู่กับครอบครัวนานที่สุดเท่าที่จะอยู่ได้ แต่เมื่ออยู่ไม่ได้หรือมีความต้องการการดูแลจากสถาบันที่ให้บริการทางการแพทย์หรือทางสังคม รัฐจะเข้าไปช่วยเหลือให้ทันกับปัญหา

ตามทฤษฎี จะแบ่งประชากรเป็น 3 กลุ่มใหญ่ๆคือ

1) กลุ่มที่มีสุขภาพดีและอยู่ตามลำพังได้
2) กลุ่มที่ต้องได้รับการช่วยเหลือในชีวิตประจำวัน
3) กลุ่มที่ป่วย อาจจะต้องการการดูแลในระยะสั้นหรือระยะยาว

กลุ่มแรกควรมีบริการเพื่อส่งเสริมสุขภาพ และจรรโลงสภาวะสุขภาพดี ให้คงอยู่ได้ตามอายุโดยอิสระไม่ต้องพึ่งพาบริการของรัฐ กลุ่มที่สองต้องการบริการทางสังคม คือ ผู้ช่วยเหลือหรือผู้ดูแลในชีวิตประจำวันและการเฝ้าระวังทางสุขภาพ ส่วนกลุ่มที่ 3 ต้องการการดูแลด้านการแพทย์และเวชปฏิบัติตามสาเหตุซึ่งอาจเป็นการดูแลที่บ้านหรือสถานพยาบาลที่ต้องการความต่อเนื่องของบริการ

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[1] "Heartware" หมายถึง ทัศนคติและการรับรู้ถึงคุณค่าของผู้สูงอายุ โดยบุคคลและสังคม

นโยบายการดูแลผู้สูงอายุทั้งสามกลุ่ม มีความแตกต่างกันในแต่ละประเทศที่มีเอกลักษณ์ วัฒนธรรม ค่านิยมต่อชีวิตและสุขภาพ ระดับความร่ำรวย และความก้าวหน้าทางวิทยากรของประเทศ ความมั่นคงทางการเมืองและวิธีคิดของผู้นำประเทศ ดังจะได้เพิ่มเติมในตอนต่อไป

นโยบายของไทยคล้ายกับว่า ไม่เน้นการลงทุนด้าน institutional care เนื่องจากวัฒนธรรมและประเพณีเกื้อหนุนให้ผู้สูงอายุอยู่กับครอบครัว และการให้บริการด้านสวัสดิการสังคม เช่น เบี้ยยังชีพ บ้านสงเคราะห์ และจัดให้มีชมรมผู้สูงอายุ เป็นต้น แต่ดูเหมือนไม่ได้มีนโยบายเพื่อจัดบริการที่ผสมผสานบริการด้านการแพทย์และสังคมที่เพียงพอที่จะช่วยชุมชนในการให้ความช่วยเหลือแก่ ครอบครัวที่อาจมีปัญหา ไม่ว่าในระดับเล็กน้อย ระดับที่ต้องพึ่งพาหรือบริการฉุกเฉินที่ต้องการความเฉพาะทาง ซึ่งดูเสมือนว่า นอกจากครอบครัวแล้วผู้สูงอายุอาจขาดความช่วยเหลือจากสถานบันทางการแพทย์หรือเวชปฏิบัติที่ทันกาลได้

ในประเด็นของการรักษาพยาบาลนั้น ผู้สูงอายุมีสิทธิได้รับบริการรักษาพยาบาล โดยไม่เสียค่าใช้จ่ายในโครงการสวัสดิการประชาชนด้านการรักษาพยาบาล (สปร.) ตั้งแต่ปี พ.ศ. 2535 จนในรัฐบาลปัจจุบันที่ได้มีนโยบายคุ้มครองสุขภาพของประชาชนโดยถ้วนหน้า ในโครงการ 30 บาท รักษาทุกโรค ในหลักการศูนย์สุขภาพชุมชน จะเป็นด่านแรกในการให้บริการเวชปฏิบัติแก่สมาชิกทุกคนอย่างมีประสิทธิภาพ ฉะนั้นควรมีพัฒนาการจนถึงระดับที่จะให้บริการต่อเนื่องระยะยาวแก่ผู้สูงอายุได้ โดยอาศัยประสบการณ์จากประเทศเพื่อนบ้านและการวิจัยเฉพาะท้องที่ (local area research) ของเราเอง

8. กระบวนการกำหนดนโยบาย การนำนโยบายไปสู่การปฏิบัติและการประเมินนโยบาย

ตามทฤษฎี การเกิดนโยบายที่ดี ขึ้นอยู่กับคุณสมบัติของฝ่ายรัฐบาลและฝ่ายประชาชน การสร้างสติปัญญาให้แก่รัฐบาลผู้มีหน้าที่ทำให้เกิดนโยบายที่ดี การมีประชาชนที่ตื่นตัวและพยายามที่จะให้ข้อเสนอแนะ ข้อวิจารณ์และความสามารถในการรับฟัง หยุดคิด หาข้อมูล ความรู้เพิ่มเติมแล้ววิเคราะห์หาสิ่งที่คิดว่าดีและเหมาะสมที่สุดสำหรับสังคมโดยรวม

อย่างไรก็ตาม การกำหนดนโยบายจะต้องชัดเจนว่า จะทำอะไร ใช้เงินอะไร มอบหมายให้ใครทำ แปลนโยบายมาเป็นยุทธศาสตร์ แผนงาน การตรากฎหมายและการบังคับใช้กฎหมาย การเงินและงบประมาณ ที่สำคัญคือกลไกการประเมินนโยบายที่ควรจะกำหนดไว้ตั้งแต่ช่วงเวลาที่กำหนดนโยบายเพื่อวางแผนเก็บข้อมูลที่จะนำไปปรับใช้ในการกำหนดนโยบายครั้งต่อไป

จากการศึกษาเอกสาร พบว่า แต่ละประเทศมีจุดเด่นในประเด็นต่างๆ ที่น่าจะนำมาศึกษาในรายละเอียดต่อไป คือ

8.1 ประเทศสิงคโปร์โดดเด่นมากในเรื่อง กระบวนการกำหนดนโยบาย ได้กำหนดให้เรื่องผู้สูง

อายุเป็นวาระแห่งชาติ ตั้งแต่ปี 1989 แล้วมีการดำเนินการมาโดยตลอด รวมทั้งการมองไปข้างหน้า จึงเป็นประเทศที่ก้าวหน้าที่สุดในเรื่องของผู้สูงอายุ

ประเทศสิงคโปร์เป็นประเทศที่ร่ำรวย มีเสถียรภาพทางการเมือง การปกครอง มีประชากรจำนวนไม่มาก มีภาวะผู้นำที่มีสายตาอันยาวไกล ประชากรมีวินัย ควบคุมได้ เป็นประเทศที่รัฐเข้าถึงทุกคนได้ด้วยระบบคอมพิวเตอร์ ภาษีเงินได้ส่วนบุคคลสูง ระดับเดียวกับประเทศในยุโรปและสหรัฐอเมริกา ด้วยรัฐบาลไม่ต้องการเป็นรัฐสวัสดิการ จึงเป็นหลักการที่ประชาชนต้อง**ร่วมจ่าย**ในทุกบริการที่รัฐจัดให้

นอกจากการดำเนินการในปัจจุบันแล้ว ยังได้วางเป้าหมายในอนาคตด้วย ในศตวรรษที่ 21 นี้ สิงคโปร์ยังคงจะเน้นเรื่องสัมพันธภาพระหว่างรุ่น เป็นการเตรียมการรองรับปัญหาที่น่าจะเกิดขึ้นจากสภาพความเป็นอยู่ ที่เป็นครอบครัวเดี่ยวมากขึ้น โดยเฉพาะมีแนวโน้มว่า หนุ่มสาวจะครองตัวเป็นโสดมากขึ้น มีการประเมินผลแล้วนำผลที่ได้มาปรับ ตัวอย่างที่เห็นได้ชัดเจนคือ ระบบเงินออมเพื่อตัวเองและพ่อแม่ การสร้างที่อยู่อาศัย แม้สิงคโปร์จะออกตัวว่า ไม่ใช่รัฐสวัสดิการ แต่สิ่งที่รัฐทำให้กับประชาชนก็นับว่า มีค่า มีความหมาย เช่น การลดภาษี การให้กู้ยืมเงินเพื่อสร้างบ้าน ฯลฯ การที่รัฐระดมพลังที่จะช่วยให้ผู้สูงอายุอยู่อย่างเข้มแข็งให้ได้และอยู่ในครอบครัวและชุมชนอย่างมีความสุข การช่วยเหลือเรื่องผู้ดูแลโดยการใช้เพื่อนบ้านในการดูแลช่วยเหลือกัน เป็นจุดเด่นของการดำเนินงาน

แม้ว่าจะมีปัญหาในการบริหารจัดการในเชิงโครงสร้างบ้าง แต่รัฐบาลก็ได้ตั้งคณะกรรมการประสานงานระหว่างกระทรวง เพื่อแก้ไขปัญหา หากว่าหลักการของประเทศสิงคโปร์ยังเป็นเรื่องการทำงานอย่างมีหลักการ สามารถปรับเปลี่ยนได้จากข้อมูลหลักฐานที่ปรากฏ รวมทั้งมีการคาดการณ์ไปข้างหน้าด้วย ทำให้เชื่อว่า ประเทศจะสามารถแก้ไขปัญหาได้ในที่สุด

สำหรับ LTC สิงคโปร์มีบริการทุกชนิด ทั้งบริการในโรงพยาบาลและในชุมชน/ที่บ้าน การให้บริการ step down care ที่ติดตามผู้ป่วยตั้งแต่ออกจากโรงพยาบาลและการให้บริการที่บ้าน ปัจจุบันได้เริ่มทดลองบริการที่ท้าทายความสำเร็จ คือ โครงการ case management ที่ติดตามประเมินสถานะภาพของผู้สูงอายุเป็นรายบุคคล โดยบุคลากรทางการแพทย์ พยาบาล นักจิตวิทยาและนักสังคมสงเคราะห์ เพื่อให้ความช่วยเหลือได้ตรงกับความต้องการ แม้นว่าจะมีปัญหามากในทางปฏิบัติ เนื่องจากการเข้าถึงผู้รับบริการที่ต่างวัฒนธรรมและค่านิยม และการขาดแคลนผู้ให้บริการ แต่ถ้าทำได้จะเพิ่มทั้งประสิทธิภาพและประสิทธิผลของการให้บริการ ที่น่าติดตามศึกษาในรายะเอียดต่อไป

8.2 ประเทศมาเลเซีย มีกระบวนการนำนโยบายไปปฏิบัติ ไม่ว่าจะเป็นการวางแผนงาน การตั้งคณะกรรมการชุดต่างๆ และระบบควบคุมกำกับที่จะช่วยในการประเมินผลกิจกรรมและโครงการ เป็นเรื่องที่น่าสนใจติดตามในรายละเอียด

ในด้านบริการดูแลต่อเนื่องระยะยาวนั้น แม้ว่าจะไม่มีนโยบายชัดเจน แต่รัฐบาลได้ดำเนินการต่างๆมากมาย ทั้งด้านบริการทางการแพทย์ และการเตรียมการรองรับปัญหาในอนาคต ด้วยการอบรมเพิ่มศักยภาพของบุคลากร การให้การศึกษาแก่ผู้สูงอายุปัจจุบันและการเตรียมความพร้อมสำหรับผู้สูงอายุในอนาคต การวางแผนด้านการเงินเพื่อช่วยเหลือผู้สูงอายุ รวมทั้งมาตรการลดภาษีให้กับบุตรที่ดูแลพ่อแม่หรือคนพิการด้วย

8.3 ประเทศเกาหลีเป็นประเทศที่วัฒนธรรมความกตัญญูยังเข้มแข็ง จนทำให้เกิดการเข้าไม่ถึงบริการหรือการไม่ยินดีรับบริการช่วยเหลือจากรัฐ เพราะกลัวเสียหน้า ถ้าผู้ใหญ่ของครอบครัวต้องไปอยู่บ้านสงเคราะห์ ทำให้รัฐต้องเน้นนโยบายและตรากฎหมายเรื่องเกณฑ์การรับประกันมาตรฐานการดำรงชีวิต(minimum living standard) มาตรการที่โดดเด่นคือการมีส่วนร่วมขององค์กรพัฒนาเอกชนในการกำหนดนโยบายและโครงการเกี่ยวกับผู้สูงอายุ ภาคประชาชนเองก็มีบทบาทในการทบทวนกฎหมายที่เกี่ยวข้องกับผู้สูงอายุ

หลังจากมีนโยบายและแผนพัฒนาฯแผนสุดท้ายที่ได้ให้ความสำคัญในเรื่องผู้สูงอายุแล้ว รัฐบาลเกาหลีได้ทำการสำรวจความต้องการของผู้สูงอายุทั้งด้านสุขภาพและด้านสังคมสวัสดิการถึง 2 ครั้งด้วยกัน และทำให้รัฐบาลตัดสินใจที่จะกำหนดแผนระยะกลางและระยะยาวเพื่อตอบสนองต่อความต้องการจากการสำรวจ

8.4 ประเทศฮ่องกงเป็นประเทศที่มีปัญหาที่ดินสำหรับอยู่อาศัย เมื่อเปลี่ยนการปกครองมาอยู่ภายใต้การปกครองของประเทศจีน จึงทำให้เศรษฐกิจไม่ฟูฟ่องเหมือนเดิม ผู้สูงอายุที่มีฐานะยากจนและมีสัดส่วนเพิ่มมากขึ้น มีความต้องการที่อยู่อาศัยมากกว่าเดิม ซึ่งส่วนหนึ่งจำเป็นต้องย้ายออกจากบ้านลูกเนื่องจากความจำกัดของขนาดที่อยู่อาศัย รัฐบาลถือเป็นภาระสำคัญ ต้องเตรียมที่อยู่อาศัยให้แก่ผู้สูงอายุเหล่านี้ มาตรการคือให้เอกชนสร้างและเก็บค่าเช่าจากผู้สูงอายุ ซึ่งรับเบี้ยเลี้ยงชีพจากรัฐที่พอเพียงสำหรับค่าเช่า ขณะเดียวกันรัฐได้กำหนดมาตรฐานขั้นพื้นฐานของบ้านหรืออาคารที่พักอาศัยเหล่านี้ และมีชุดทำงานประเมินมาตรฐานเป็นระยะๆ นอกจากนี้ได้มีกระบวนการประเมินความต้องการของผู้สูงอายุ โดยชุดบุคลากรที่มีศักยภาพ ที่เป็นจุดเด่นของงานนี้(สิงคโปร์จะนำเกณฑ์มาตรฐานและหลักการประเมินเหล่านี้ไปใช้ในประเทศของตน) ที่นับว่าครบถ้วนและครอบคลุม ที่เป็นหลักการหนึ่งของรัฐเพื่อตอบสนองความต้องการของผู้สูงอายุได้อย่างมีเหตุมีผล

เรื่องที่อยู่อาศัยนี้ เป็นปฏิบัติการที่รองรับหลักการหลักคือ “ageing in place” และ ”continuum of care” ของฮ่องกง

9. การบริหารจัดการเรื่องผู้สูงอายุ ไม่ว่าจะดำเนินการโดยกระทรวงสาธารณสุขหรือกระทรวงสวัสดิการสังคม แต่ละประเทศมีข้อสังเกตที่น่าสนใจ เช่น การบริหารจัดการโดยกระทรวงสาธารณสุข

และกระทรวงพัฒนาของประเทศสิงคโปร์ ซึ่งทำให้เกิดปัญหาในเรื่องการประสานงาน รัฐก็ปรับแก้โดยการตั้งคณะกรรมการประสานงานขึ้นมาเชื่อมต่อการทำงาน หรือการใช้ Elderly Commission ของประเทศฮ่องกง ในการประสานงาน โดยออกคู่มือแนวทางในการทำงานร่วมกัน ในส่วนของประเทศเกาหลี การผสมผสานงานบริการในการบริหารระดับท้องถิ่น ซึ่งคล้ายกับการกระจายอำนาจของกระทรวงสาธารณสุขของประเทศไทยที่จะรวมเอางานสาธารณสุขผนวกเข้ากับงานของท้องถิ่น ซึ่งเกาหลีเองเกิดปัญหาการให้บริการแก่ผู้สูงอายุไม่ได้ดำเนินการโดยผู้ที่รู้จริง ซึ่งประเทศไทยเองภายหลังจากการกระจายอำนาจงานสาธารสุขให้แก่การปกครองส่วนท้องถิ่น อาจจะประสบกับปัญหาเดียวกันนี้ได้ในอนาคต

10. การบริการด้านที่อยู่อาศัย สิงคโปร์ลงทุนในเรื่อง Housing Project มากว่า 20 ปี ที่มีนโยบายส่งเสริมความสัมพันธ์ระหว่างรุ่น ที่ให้พ่อแม่ ปู่ย่าตายายและลูกหลานอยู่ในอาคารเดียวกันหรือติดกัน มีการให้ incentive แก่บุตรที่ให้การดูแลพ่อแม่ มีข้อมูลว่าประชากรสิงคโปร์ประมาณร้อยละ 75 อาศัยอยู่ในอาคารของรัฐบาล รัฐจึงสามารถจัดการกับที่อยู่อาศัยได้ง่ายกว่าประเทศอื่น

ดูเหมือนว่า รัฐบาลทดลองอยู่ตลอดเวลาว่า บริการใดจะเหมาะสมกับคนสิงคโปร์มากที่สุด เมื่อปลายทศวรรษที่ผ่านมา ได้เริ่มโครงการ studio apartment สำหรับผู้สูงอายุที่มีฐานะปานกลางที่อาจอยากอยู่คนเดียว หรือเมื่อเกษียณอายุต้องการบ้านที่เล็กกว่าเดิม โดยที่ studio จะอยู่ในอาคารหลังเดียวกับลูกหลาน จัดชั้นใต้ดินให้องค์กรเอกชนสาธารณประโยชน์มาทำกิจกรรมทางสังคม และจัดอบรมในเรื่องต่างๆในตอนกลางวัน นอกจากนี้ใน studio apartment ดังกล่าวจะได้จัดสภาพภายในและทางเดินที่มีราวเกาะ มีลิฟต์เลื่อนขึ้นลงอำนวยความสะดวกและความปลอดภัยแก่ผู้สูงอายุตามเกณฑ์ รวมทั้งสัญญาณติดต่อกับภายนอกจากในแต่ละห้องเมื่อมีเหตุฉุกเฉิน ซึ่งนับว่าครบวงจร รัฐบาลกำลังประเมินความเหมาะสมต่อไป

การปรับสภาพแวดล้อมให้มีความเป็นกันเองและให้ความปลอดภัยแก่ผู้สูงอายุและผู้ทุพพลภาพ มาตรการปรับสภาพภายในบ้านที่อยู่อาศัย เพื่อป้องกันอุบัติเหตุในบ้าน เช่นการลื่นหกล้มในห้องน้ำ จัดให้มีสัญญาณเรียกหน่วยงานภายนอกเมื่อมีเหตุการณ์ฉุกเฉิน สายด่วนเพื่อปรึกษาหารือ ที่สำคัญคือยานพาหนะ เพื่อผู้สูงอายุจะติดต่อโลกภายนอก เช่น ไปวัด ไปพบแพทย์ ไปร่วมงานสังคม หรือชมรม self helped ต่างๆ เพื่อแลกเปลี่ยนประสบการณ์ จำเป็นต้องมีระบบเฝ้าระวังเพื่อให้ข้อมูลสนองตอบต่อความต้องการบริการเชิงรุกได้

11. การรับรองคุณภาพของบริการ เป็นส่วนสำคัญของการให้บริการ หลายประเทศได้ตระหนักถึงการควบคุมคุณภาพของ nursing home และสถานพยาบาลที่ดำเนินการโดยเอกชน เช่น มาเลเซีย ฮ่องกง เกาหลี ได้เริ่มดำเนินการให้มีมาตรการเพื่อการรับรองคุณภาพของสถานพยาบาลเหล่านี้ โดย

ประเทศเกาหลีได้กำหนดให้ Ordinace เป็นกฎหมายควบคุมกำกับ Private Nursing Home ซึ่งเป็นอีกเรื่องหนึ่งซึ่งน่าสนใจศึกษาในรายละเอียด นับว่าเป็นการกระจายอำนาจการตรวจสอบของภาครัฐ

นอกจากการรับรองคุณภาพของบริการแล้ว ยังต้องพิจารณาถึงความครอบคลุมและการเข้าถึงประชากรสูงอายุเหล่านี้ ดังได้กล่าวมาแล้วว่า ที่ต้องพิจารณามี 2 กลุ่ม คือ ผู้ที่ต้องพึ่งพาในชีวิตประจำวันและผู้ที่เจ็บป่วยในระยะยาว ความครอบคลุมและการเข้าถึงบริการด้านการแพทย์และเวชปฏิบัติที่ต่อเนื่องระยะยาว

ประเทศเกาหลีได้กำหนดมาตรฐานการครองชีวิตขั้นต่ำสำหรับผู้สูงอายุ โดยออกเป็นกฎหมายเพื่อให้มั่นใจว่า อย่างน้อยที่สุดประชากรสูงอายุมีความเป็นอยู่ มีการดำเนินชีวิตที่ยอมรับได้ ในส่วนของประเทศมาเลเซียก็ได้มีการกำหนดมาตรฐานของการได้รับบริการดูแลที่ทุกคนสามารถเข้าถึงบริการได้ถ้วนหน้า

12. ระบบการศึกษาและสื่อมวลชน จะมีบทบาทในการช่วยทะนุบำรุงวัฒนธรรม ความกตัญญูให้คงไว้ รวมทั้งการส่งเสริมวิถีชีวิตเพื่อสุขภาพดีของผู้สูงอายุ ซึ่งเป็นหลักการขององค์การอนามัยโลกที่ทุกประเทศรับเป็นมาตรการหลักของประเทศ

การให้การศึกษาอย่างต่อเนื่อง ในระบบนอกและในโรงเรียน ไม่ว่ากลุ่มเป้าหมายจะเป็นคนรุ่นใด เป็นเรื่องสำคัญและจำเป็นอย่างยิ่ง ประเทศสิงคโปร์เห็นความสำคัญในเรื่องนี้จึงได้จัดสรรงบประมาณจำนวนมากในการให้การศึกษา lifelong education และใช้การศึกษาเป็นเครื่องมือที่จะส่งเสริม “Heartware” ที่จะทำให้คนรุ่นหลังยังคงรักษา เคารพและดูแลผู้สูงอายุ ตลอดไป สำหรับประเทศมาเลเซียได้กำหนดให้มีการศึกษาในโรงเรียนทุกระดับเพื่อให้เกิดความตระหนักถึงบทบาทและความรับผิดชอบต่อผู้สูงอายุ

นอกจากการให้การศึกษาแล้ว การรณรงค์ผ่านสื่อต่างๆ เพื่อให้สาธารณชนตระหนักและเข้าใจปัญหาอย่างต่อเนื่อง เช่น การกำหนด motto ในการรณรงค์ เพื่อส่งเสริมสุขภาพผู้สูงอายุ ควรเป็นข้อความสั้นๆที่ง่ายต่อความเข้าใจ ตัวอย่างเช่น ประเทศฮ่องกง ใช้คำว่า “Be active, eat well, and quit smoking” ในประเทศญี่ปุ่น กำหนด “ให้เดินวันละหมื่นก้าว กินอาหารหลากหลายวันละ 30 ชนิดและงดสูบบุหรี่” สำหรับไทยให้ความสำคัญกับ 3 อ.คือ อาหาร อารมณ์และออกกำลังกาย ซึ่งน่าจะได้รับการติดตามว่าคำขวัญดังกล่าวนี้ ให้ความหมายติดตลาดหรือเปล่า

การให้ความรู้โดยผ่านการอบรมระยะสั้น หรือสื่อชนิดต่างๆที่ผู้สูงอายุสามารถเข้าถึงได้ มาเลเซียและไทยมีโครงการให้ความรู้แก่ผู้สูงอายุที่ชัดเจนและหลากหลาย ซึ่งได้แก่ (1)การเตรียมตัวเข้าสู่วัยสูงอายุ (2)การอบรมเพื่อเพิ่มศักยภาพและทักษะในอาชีพหลังเกษียณอายุ ที่จะทำงานต่อไปได้ (3)การ

อบรมเพื่อเป็นอาสาสมัครช่วยงานชมรมต่างๆที่ต้องการประสบการณ์ส่วนตัวของผู้สูงอายุ เช่น ในกลุ่มช่วยตนเองของกลุ่มผู้เป็นมะเร็ง เบาหวาน ปอดอุดกั้นเรื้อรัง หรืออัมพาต เป็นต้น และ(4) การอบรมผู้ดูแลผู้สูงอายุ ซึ่งสมควรได้รับการสนับสนุน พร้อมมีกลไกตรวจสอบคุณภาพของการอบรมเหล่านี้

"โครงการคลังปัญญาผู้อาวุโส" ดำเนินการโดยสภาพัฒนาสังคมและเศรษฐกิจแห่งชาติเป็นโครงการของพระนางเจ้าพระบรมราชินีนาถที่สำคัญต่อการถ่ายทอดคุณค่าทางปัญญาของผู้สูงอายุ แก่รุ่นลูกหลาน เป็นทางหนึ่งของการสงวนคุณค่าของผู้สูงอายุไทย

13. การวิจัยเกี่ยวกับผู้สูงอายุ การดำรงอยู่ในสถานการณ์ที่ไม่มีนโยบายหรือมีนโยบายที่ไม่เพียงพอเป็นความเสี่ยงต่อความมั่นใจว่าคุณภาพชีวิตของผู้สูงอายุจะดีหรือไม่ การทำวิจัยเพื่อกำหนดนโยบายต้องเป็นการวิจัยที่มีคุณภาพ ทันต่อเหตุการณ์ ข้อมูลและข้อเท็จจริงที่ได้ จะนำมาใช้เพื่อกำหนดทางเลือกและผลกระทบที่อาจเกิดขึ้นของทางเลือกต่างๆก่อนที่จะสรุปหรือเสนอแนะเชิงนโยบาย เนื่องจากประเด็นของผู้สูงอายุมีความเฉพาะตัว จึงต้องการทีมนักวิชาการที่เป็นสหสาขาวิชา (multidisplinary) ในการศึกษาความต้องการของผู้สูงอายุในหลายมิติ

การศึกษาทดลองเชิงปฏิบัติการ หรือ Action research ที่สิงคโปร์ได้ดำเนินการในเรื่องบ้านที่อยู่อาศัยและ LTC services ด้านเวชปฏิบัติเป็นตัวอย่างหนึ่งของกระบวนการหาความต้องการ การควบคุมกำกับ การปฏิรูปโครงสร้างของบริการ กฎหมายและการดำเนินการเพื่อปรับแก้ปัญหา หากได้ผลดี แก้ปัญหาได้ รัฐบาลก็ได้คำตอบและทำต่อไป หากไม่ได้ก็ล้มเลิกไปได้ เป็นเรื่องธรรมดาที่ไม่น่าจะมีรูปแบบใดที่ออกมาดีเหมาะสมกับทั้งประเทศตั้งแต่ครั้งแรกที่เริ่มทดลองใช้ แต่ถ้ามีสมมติฐานแนวทางที่มีประโยชน์ การศึกษาทดลองจะช่วยปรับโครงการต่างๆตามข้อเท็จจริงที่ปรากฏ

ข้อมูลสภาวะของผู้สูงอายุในประเด็นของภาระโรคและความต้องการบริการต่อเนื่องระยะยาว (LTC) นั้น นับว่า ประเทศไทยมีข้อมูลที่มีคุณภาพเป็นข้อมูลระดับชาติที่สามารถนำไปใช้ในการกำหนดนโยบายได้ และสมควรจัดให้มีข้อมูลเช่นนี้ เป็นระยะๆ ต่อไป

ศาสตราจารย์สุทธิชัย จิตะพันธ์กุลและคณะได้คาดประมาณว่า ในปี 2000 มีสัดส่วนของผู้สูงอายุ 60 ปีขึ้นไปที่ต้องการบริการ LTCอยู่ถึง 14.8% โดยที่กลุ่มนี้ต้องจำกัดตัวเองอยู่ในบ้าน ต้องนอนติดเตียง ต้องพึ่งพาในการดูแลตนเองหรือเป็นโรคสมองเสื่อม และจะมีจำนวนถึง 700,000 คนในอีก 20 ปีข้างหน้า

การมีข้อมูลประชากรสูงอายุที่ชัดเจน สามารถระบุได้ถึงปริมาณความต้องการการดูแลด้านสุขภาพ ความช่วยเหลือด้านความเป็นอยู่ทางสังคมและสวัสดิการ จะทำให้รัฐบาลสามารถกำหนดนโยบายสำหรับผู้สูงอายุในระยะสั้นและระยะยาวได้

การวิเคราะห์ถึงระดับความรุนแรงของปัญหาตามอายุและเพศของผู้สูงอายุ ถือว่าเป็นข้อมูลประกอบในการตัดสินใจทางนโยบาย เช่น เรื่องที่อยู่อาศัย เมื่อมีการกำหนดนโยบาย มีการตรากฎหมาย

มีแผนงานรองรับและมีบ้านหรืออาคารที่ได้จัดเตรียมขึ้นสำหรับผู้สูงอายุตามเกณฑ์ที่ตั้งไว้ ประเทศไทยยังขาดข้อมูลรายละเอียดในเรื่องนี้

การดำเนินการต่างๆที่เกี่ยวกับผู้สูงอายุ โดยการดึงส่วนต่างๆเข้ามาเกี่ยวข้องด้วย ไม่ว่าจะเป็นองค์กรพัฒนาเอกชน ภาคเอกชน และองค์กรชุมชนเป็นเรื่องที่จำเป็นและมีความสำคัญในการเพิ่ม safety net ในการรองรับกับปัญหาที่จะเกิดขึ้นในอนาคต ซึ่งเป็นบทบาทที่รัฐบาลไทยต้องเร่งดำเนินการต่อไป

The Synthesis of the National Policy on Ageing

Objective of the Study

The objective of the study is to review the national policy on Ageing and Long term care in the 5 studied countries, being Hong Kong, Korea, Malaysia, Singapore and Thailand. The review focuses mainly on medical and health dimension of the ageing in needs for long term care. This study relies on the secondary data of the five papers. The policy directions and initiatives derived from other ASEAN countries would yield a meaningful and appropriate set of policy implementation, legislation and proper services beneficially to Thai in the near future. Other two domains, social security and welfare services, will be discussed at length by other reviewers. However, overlappings may be unavoidable since the Papers are independently reviewed.

Most of the countries in the region of South – East Asia has been undergoing dramatic changes specifically the five countries under this study. The changes have been brought about by economic and social development , as well as by specific government policies. In turn, the demographic changes are influencing economic, social and health of the elders, both directly and indirectly.

Declining fertility throughout the region has made population growth at or below replacement level with specific to 5 countries under study. New population and development issues are emerging. These include the challenge of meeting reproductive health, needs of adolescent in the context of HIV/AIDS pandemic, rapid ageing of population, rapid urbanization, the challenges to family cohesion resulting from rapid social change and impact of poverty since 1997 as a result of the economic crisis.

Despite considerable diversified characteristics both between and within countries of the Region made each of them faces specific issues. For example, levels of urbanization differ widely as do level of education attainment, evidence of rising inequality in poverty and employment patterns within the countries. It appears that some commonalties in traditional phenomena and practices are observed among countries in the region with regards to their ageing populations, for instances, the traditional values of filial piety to older generations.

Organization of the Reports

The report begins with sessions on issues regarding the profile of ageing of the elderly population in the country and sense of urgency has been arises for the long term care (LTC) needs; types and demands needed which have been estimated for the next 10 to 20 years, current policy and practices; and lessons learned to overcome the need-gap of the elders. The last session is contributed to synthesize and propose most appropriate and feasible policy and issues for Thai elderly population for the next 2 decades.

Cut off Point as Benchmark for Ageing

According to the United Nations World Assembly on Ageing held in Vienna in 1982, "60 years and over" was adopted as the cut off age for deliberating issues on ageing. In our study, only two countries used "60 years and over", they were Malaysia and Thailand for the reason that their retirement age are 60 years, others used "65 and over" regardless of retirement age (Hong Kong, Korea, and Singapore). The cut-off ages will be remained as they are in this report.

I. Profile of Ageing Population

1.1 Ageing of Elderly Population

Theoretically, information required for determining the growth of ageing of the population are, life expectancy at birth, age – sex structure , their growth rate and median age of the elderly population. Two other proxy indicators determining vulnerability of ageing populations are "Young – Old" and "Old – Old " age groups and their sex ratios.

As discussed earlier, increase in life expectancy is an indication of living longer and growing of the elderly population. During 1999 – 2000, three strata of countries are observed with regards to expectancy of life at birth. Higher levels in Hong Kong and Singapore, lower levels in Malaysia and Thailand, while Korea is in the middle (Table 1). Females expected longer life span than males in all 5 countries and the differences are around 5 years between 67 years for male and 70 – 74 years for female in first stratum. Hong Kong and Singapore expect longer life in the ranges of 75 – 76 years and 80 – 82 years for male and female respectively. Korea is in the middle of the 5 counties, 71.0 and 78.6 years for both respective sexes.

1.2 Rapid Growth

Rapid growth of aged population is obviously demonstrated by sheer number and proportions to total population in the year 2000 and projected for 2020. For 2000, the proportions observed being 10.0, 7.1, 4.2, 8.4 and 9.0 percent in Hong Kong, Korea, Malaysia, Singapore, and Thailand respectively(Table 1). Malaysia seems to attain most rapid growth rate of around 2.3 times in the next 20 years, 2020. Similar growth rates are observed at 1.8 times for Korea and Thailand, while slowlier growth are apparent in Singapore and Hong Kong where an awareness in their ageing societies have been put into action prior to the last decade.

Table 1 Longevity of life and growth of ageing population

Country	**Life expectancy at birth 1999 – 2000(year)**		**Population aged 65 and over**			
			2000		**2020**[1]	
			number	**%**	**number**	**%**
	Male	**Female**	**(000)**		**(000)**	
Hong Kong	76.9	82.3	…	10.0[3]	…	13.0[4]
Korea	71.0	78.6	3371	7.1	6899	13.2
Malaysia[2]	67.6	69.9	1418.2	4.2	3209.8	9.5
Singapore	75.1	80.8	312	8.4	829	13.1
Thailand[2]	67.3	74.0	5559	9.0	11309	16.2

Source: … Not available

1/ population projection

2/ population aged 60 years and over

3/ 1996

4/ 2015

1.3Variations by Age: Young – Old, Old – Old

Regarding vulnerability of the ageing population , variations by age : the young – old and the old – old are taken into consideration. The young – old refers to people aged 60 – 74 years and the old – old is 75 years and over. Most vulnerable group is the old – old age group for being at risk of degenerative diseases which is mostly chronic and complex in nature, leading to loss of physical and social independence. However, women who have higher survival rate than men , is projected to be in higher proportion , much less than 1.0, in sex ratio in the old – old age group. The most vulnerable population seems to be women in the old – old and oldest age .

1.4 Gender Differences

Comparing between Malaysia and Thailand(Table 2), where data are available, the proportions of the old – old population in Malaysia appear to decrease from 21.1 in 1990 to 18.8 and 17.9 in 2000 and 2020 respectively. During similar time interval, Thai old – old population proportions are about same level for 1990 and 2000 but increased to 22.8 % in 2020. This phenomena are due to average life expectancy which is longer in Thailand. The old – old people lives longer with sex ratios of male to female being 0.66 for Thai as compared to 0.85 for Malaysia (Table 3).

Table 2 Number and percentage of elderly population classified into "Young – Old" (60 – 74 years) and "Old – Old" (75 and over), Malaysia and Thailand.

Age groups of elderly population		**1990 (000)**	**%**	**2000 (000)**	**%**	**2020 (000)**	**%**
elderly population (60 and over)	M	1,032.3	100	1,418.2	100	3,209.8	100
	T	4,014.0	100	5,822.2	100	12,470.7	100
Young- Old (60 – 74)	M	813.1	78.8	1,150.8	81.1	2,635.0	82.1
	T	3,134.2	78.1	4,561.7	78.4	9,633.6	77.2
Old – Old (75 and over)	M	219.2	21.1	267.4	18.8	574.8	17.9
	T	879.7	21.9	1,260.5	21.6	2837.1	22.8

Source: Ong Fong Sim, Ageing in Malaysia: National Policy and Future Direction, 2001.
Sutthichai Jitapunkul, et.al., National Policies on Ageing and Long-term Care for Older Persons in Thailand, 2001.
M= Malaysia, T= Thailand.

Table 3 Gender differences of ageing population, Malaysia and Thailand

Age	**1990**		**2000**		**2020**	
	Malaysia[1]	**Thailand [2]**	**Malaysia[1]**	**Thailand[3]**	**Malaysia[1]**	**Thailand[3]**
60 and over	0.89	0.86	0.88	0.86	0.85	0.81
60 – 74	0.92	0.91	0.92	0.89	0.89	0.86
75 and over	0.82	0.70	0.73	0.75	0.85	0.66

Source: 1 Department of Statistics, Malaysia , 1998.
2 Population census of Thailand, 1990.
3 Prasartkul, P.et al, Population Projection of the Elderly in Thailand, 1999 .

1.5 Marital Status, a Vulnerable Situation for Women Elderly.

The 1990/1991 census data shows that one in three elders over 60 years of age was classified as " widowed" and "divorced" category. Strong contrast between widowed male elderly who constituted only 12 – 15 percent of male elderly while female widowed constituted over half of respective group. In Hong Kong, Malaysia and Thailand , similar patterns are observed. Females live longer than males and even more pronounced in the old – old age groups. Widowhood was highest among females in oldest age group (Table 4).

Table 4 Characteristics indicating a vulnerable condition for the elderly 65 and over

	Hongkong		Malaysia*		Thailand	
	M	F	M	F	M	F
% single	5.0	4.4	2.0	1.5	1.1	3.0
% widowed , divorced	13.3	45.7	13.8	54.5	15.5	48.0
% no education	…	…	…	…	19.4	4.09
% not working	…	…	58.1	89.1	50.0	76.2
% inadequacy of income	…	…	…	…	63.0	65.9
* for elderly 60 years and over						

Source: Ong Fong Sim, Ageing in Malaysia: National Policy and Future Direction, 2001.
Sutthichai Jitapunkul, et.al., National Policies on Ageing and Long-term Care for Older Persons in Thailand, 2001.
Alfred C M Chan, Ageing Policy in Hong Kong, 2001.

2.Health Status of the Elderly

2.1 Measuring Health Status of the Elderly

The definition used in Malaysian report is chosen for its conformities to WHO definition of health and well – being (WHO 1984) , covering physical , mental and social health.

"Physical health status of the elderly" is assessed by looking at three subcategories (1) general physical health , (2) the ability to

perform basic self – care activities , and (3) the ability to perform more complex self – care activities to allow for greater independence (Kart 1997 , cited in Malaysia paper).

"Social health" is related to sense of belonging and state of felt loneliness.

"Mental health" refers to the capacity of individual, the group and the retirement to interact with one another to promote subjective well- being and optimal functioning and the use of cognitive, affective and rationale ability towards achievement of individual and collective goals consistent with justice. Depression appears to be most common of psychiatric disease but not oftenly recognized in elder people. Dementia dominates the older age psychiatry.

2.2 Current Health Status in Studied Countries

Health is important for it affects the elderly directly in physical health and life satisfaction. In personal terms, ill health can bring many losses: the loss of independence and autonomy, loss of mobility, loss of dignity and privacy, and loss of confidence and self - esteem (Sidell 1995 , cited in Malaysia paper). Indirectly, the issue of health affects the formation of human capital; mobilization of resources for health care for the elderly is an opportunity cost that could otherwise be employed in alternative applications. Much of the concern expressed over the issue of health and ageing population is the burden that this puts on the health care system.

2.2.1 Burden of Disease

In the post - demographic transition era in the South - East Asia region, health consequences of population changes have demonstrated the shift from communicable diseases to non - communicable diseases specifically among elderly population. Similar patterns of particular diseases burden to aged population appear in Singapore, Malaysia and Thailand. The chronic illness of Thai which become the leading causes of death and disability are : cirrhosis of liver, stroke, liver cancer, Diabetes, COPD and ischemic heart disease among men, whereas dementia, depression and osteoarthritis add up the list of burdens among women. HIV/AIDS which become first ranking of leading causes, does not appear directly as leading illness among elderly population (Thai Burden of

Diseases, BHPP of MoPH, 2002), nevertheless it put tremendously social and psychological burden upon Thai elderly people.

2.2.2Physical Health Status

Apart from the measure of ill - health in terms of the burden of diseases mentioned above , indirect measure to reflect physical independence in self - care activities, ADLs, and long - term disability which are presented by Malaysia, Thailand and Korea are to be discussed.

Activities of Daily Living (ADLs), a measure of physical independence in self - care activities , while self - care dependence is defined as in need of help or supervision in any self - care activities of daily living including feeding , grooming , transferring , toileting , dressing and bathing (Jitapunkul , S. , et al 1999, cited in Thailand paper).

On the whole, a high percentage of the elderly could do all the activities of daily living (ADLs). The ability to perform ADLs deteriorated with age. For those who could not perform all the ADLs, the main difficulties encountered were walking and go shopping , an activity that is related to the ability to walk. "Getting out of bed" was a problem only to the old – old age group , more so for the females than males. Males had better physical health compared to the females, more so at the older age groups of more than 70 years (detailed analysis by young – old and old – old age groups exemplified in Malaysian report , Chen et al 1986 , Health and Ageing in Malaysia, p.20). Thai data also indicated higher prevalence rate of dependency in self care activities among elderly women than men in all age groups, specifically those in 80 years and older (Table 5).

Korea has performed in-depth analysis to measure health status and prevalence by severity of physical loss of independence that increases with age, shown in Table 6, of which assistance is needed in personal care.

Table 5 Long-term disability and dependency in self - care activities, Thailand.

Long term disability			**dependency in self - care activities**	
Age	**Male(%)**	**Female(%)**	**Male(%)**	**Female(%)**
all ages	17.4	20.2	5.7	7.9
60 – 69	14.6	14.9	4	4.4
70 - 79	19.4	23.4	5.4	8.9
80+	27.6	36.0	16.1	20.9

source : Jitapunkul., et al 1999.

Table 6 Physical health status of the elderly Korean population, 1998.

	65+	**65 - 69**	**70 - 74**	**75+**
Healthy and independently (%)	13.3	14.8	12.4	12.2
Having chronic illness (%)	86.7	85.2	87.6	87.8
Having chronic illness but living independently (%)	43.3	56.0	44.6	25.1
Limitations in IADL (%)	43.4	29.2	43.0	62.7
Limitations only in IADLL (%)	11.5	4.8	10.9	21.8
Limitations only in ADL (%)	31.9	24.9	32.1	40.9
Limitations in 1 - 5 activities of ADL (%)	28.4	22.8	27.5	35.6
Limitations in all 6 activities of ADL (%)	3.5	2.1	4.6	4.4

Source: Chung et al.,1998

Figure 1 A Model of Social Performance Levels in Old people

self care	household chores	Social activities
feeding	household repair	pursuing hobbies
grooming	house work	shopping and outings
transferring	cooking	travelling
part - time job	care for pet	playing games
toileting	changing bed	attending religious functions
dressing	washing up	bank transaction
bathing	managing finances	collecting pension
cutting nail	gardening	visiting relatives
remaining continent	cleaning	attending doctors surgery
	cloth care	
	shopping	
	laundry	

Source: Adapted from Williams, 1986 at First Symposium on Gerontology 1996, cited in Malaysia paper.

2.2.3Measure of Disability

"Long-term disability" is defined in Thailand report as having limitations in any activities for 6 months or longer, while "total disability" is defined as having long-term disability or having no long - term disability but short- term disability recent limitation of activities due to current issues (Jitapunkul , S., et al, 1999, cited in Thailand paper).

The prevalence of disability among Thai elders is high. Data show that Thai elderly women have a higher prevalence of disability and dependency than men in all age groups. Most of the very severe and severe disability contribute to long-term disability (Table 7).

Table 7 Long - term disability and severity of Elderly Thai Population.

Severity of disability	Long - term disability(%)		Age groups(%)					
	all age		60 – 69		70 – 79		80+	
	Male	Female	Male	Female	Male	Female	Male	Female
over all	17.4	20.2	14.6	14.9	19.4	23.4	27.6	36.0
not home bound	13.7	14.6	12.3	12.5	15.4	17.4	16.1	17.8
home bound	2.5	3.5	1.7	1.3	2.7	4.0	6.9	12.5
chair / bed bound	0.6	0.8	0.4	0.6	0.5	0.9	2.3	1.3
totality dependent	0.6	1.2	0.2	0.5	0.7	1.1	2.3	4.4

Source: Jitapunkul , S.,et al 1999

It has been estimated that about 20% of the elderly population in Hong Kong have at least one form of physical disability, and about 50% have at least one chronic illness (Lau and Wong, 1997, cited in Hong Kong paper). These people are frequent users of hospitals in addition to other elders. The current hospital population contains 45% of patients aged 65 and over, with an average stay of 22 days- 50% more than mean.

2.2.4 Mental Health

Four measures have been used, cognitive assessment, senile dementia, depression, and suicide.

- ***Cognitive assessment of the elderly*** using cognitive score is reported by Malaysian team. The elderly age 75 years and over performed worst in respect of mental health. In terms of gender , the scores for elderly men were higher than that for women. They reported being worried-tense, having lost interest, feeling tired , being forgetful and paranoid. The proportion of elderly who managed a normal score decreases with age. When controlling for age, the cognitive score was significantly correlated to ADLs , regardless of gender(Chin, 1996, cited in Malaysia paper), but related to other social - economic variables , for instance, lower score among group with inadequate income and higher in those who were stable economically.

- ***Proportion of senile dementia*** are reported in Korean , Hong Kong and Thai reports. From the national health examination survey, 3.4 % of Thai elders are dementia. The prevalence rate increases dramatically with age, at the age of 60 – 69 years it is only around 1% but more than 30% at the age of 90 years and over. Age – specific prevalence rate of dementia among elderly in Thailand are quite similar to Singapore and other developed countries (Jitapunkul S., et al 1999, cited in Thailand paper). Korean prevalence rates of this respective condition is estimated to be higher at 8.2% of the elderly 65 years and over in 2000, 8.6% in 2010 and 9.0% in 2020 (Byun, et al., 1997, cited in Korea paper). It should be noted here that different diagnostic means and cohorts may make different in the estimates (Table 8).

Table 8_ Proportion of senile dementia among the elderly population , 1999.

Age	Thailand[1]	Korea[2]
60 - 64	1.0	7
65 - 69	1.2	5.2
70 - 74	3.5	12.2
75 -79	3.5	17
80 - 84	10.0	35.2
85 - 89	13.0	-
90 - 94	31.3	-

source 1. Jitapunkul, S., et al 1992. 2. Bae, S., S., et al 1999.

The survey of Hong Kong resident home indicates the prevalence of moderate to severe dementia is around 4% among population aged 65 and older. The projection by 2016 will be at least 43,600 dement elders from total population aged 65 and older, 1.09 million.

By the fact that 50% of the dementia elderly are caused by Alzheimer's disease (Phanthumchinda, K., et al, 1991, cited in Thailand paper). Dementia is one of the most burden some diseases for caregivers.

- ***Depression and suicide*** Depression has been the most common psychological symptom among elderly population, the average is around 45% among 65 years and older Hong Kong residents(Chen , 1997, cited in Hong Kong paper). About two-third who committed suicide have reported episodes of depression before the act. Hong Kong has elderly suicide rate of 28 per 100,000 as opposed to 12 per 100,000 among general population which is lower than Singapore (50/100,000)(Chi, et al, 1997, cited in Hong Kong paper). While the respective rates for most advanced countries are 20 in USA, 16 in Australia and 12 in New Zealand.

The growth of ageing and long life population is rapid, increase in awareness of these mental diseases which once thought of being shameful to ask for help from outside the family, are become demand for public services among ASEAN society.

2.2.5. Social Health and Well-being

Social health and well-being is related to the sense of belonging and state of felt loneliness. Measures of social aspects included perception of environment, activity participation and way of life .

Home environment is rated by Malaysian elders, as fair, good or excellent, for only small percentage that did not feel safe in their homes (Chen, et al, 1986, cited in Malaysia paper). The majority of them were staying with spouse or adult children, indicating that support are available to them be emotional, social or financial with exception of marginal proportion. Similar phenomenon is observed among other ASEAN countries in the study. Moreover, the elderly are still able to actively participate in home care activities, taking care of their grandchildren, the sick adult children like AIDS affected cases in Thailand (Knodel, et al, 2001, cited in Thailand paper), and helped to make family decisions.

Regarding activity participation and way of life, for the participation in community activities, the attendance declines with age and the decline being more pronounced for women. Rural elderly are more interested than the urban dwellers. Activities participated are as member of social organization, health development activity, group or society for elderly or retired people by nature of social network in each country, while Thai elderly with more proportion of women routinely participating in Buddhist ceremonies and related activities.

By above mentioned measures, health and well-being gaps among elderly population are identified and translated into policies and services. For promoting a sense of belonging essentially cover housing, community support and residential care domain of social welfare and services, to look after the livelihood of old age. While healthy ageing is the goal for health promotion and health maintenance for being positive and productive ageing. Elderly people are encouraged to lead a positive and active life, aspects include; being volunteers, furthering their own interest and improving intergeneration relations.

2.2.6 Ageing as Social Problems

Comprehensive data for policy making is for them to perceive ageing as a social problem. Social problem are sets of problem negatively affects a large number of people , judged to be undesirable in the light of social values and that regained collective action**.** ***Major aspects of***

ageing problems related to economic independence , difficulties in health care , role loss and difficulties in social activities and socio – psychological conflicts as well as feeling of alienation.

By the fact that health care provision alone cannot improve well – being of the needed elderly, more to think about is living arrangement, care-taker, and friendly and supportive environment. We have discussed in the last session the ranges and size of health problem of the elderly people. The burden which needs social and welfare services will be mainly described in the session on long term care of which leading to existing policies and practices by countries, and further to their directions of 2002 and beyond.

3. Long Term Care (LTC)

Definition adopted by Singapore is Long term care (LTC) includes the full range of health, personal care and social services provided at home and in the community for a continuous period to adults who lack or have lost the capacity to care fully for themselves and remain independent (Phillips in Borgatta and Montgomery, 2000, p. 1652, cited in Singapore paper).

The broad term covers both institutional and community cares, which emphasize on rehabilitation and maintenance. So range of services of LTC is diverse depending on the adoption of a country's policies. May be the continuum of care extends from non - medical, personal services to highly skilled - medical care.

Despite the popular conception to equate long term care with residential or institutional care, the growing recognition of the importance of community based services and home care in providing the needed support and care has altered the current provision and long term policy development of elderly services.

Apparently, all countries in this study perceived and adopted LTC definition for practiced as it is defined above in the early of 1990s. Singapore advances other countries, the rest appear to envelop LTC in their policies for ageing population.

Differences in stage of development are found among countries seem to relate to their economic and political atmospheres. Economic bureaucrats have dominated major policy - making for the past 40 years. When economic grows better spending on elderly services are always generous. An example of affluent country , like Singapore , when ageing of population was becoming noticeable , they have become a priority target of national policy for security and well – being since 1984. In contrast to the other Asian countries with political instabilities and the economy have been in a recovery from the 1997 crisis like Thailand , of which up to today is still vulnerable to a recurrent crisis . The elderly population may not be a priority although a comprehensive policy for promotion of their well- being is already framed.

3.1 Changing Household Structure

Regarding family structure, country development have brought about changes in family where smaller family size and preference of nuclear family are replacing the expanded family structure and larger family size. Moreover, households of elderly living alone without caretaker is more prevailed especially in urban area, that appropriate living arrangement should be designed and put into action.

Changes have been brought by reduction of fertility and the out-migration of young population to urban areas, with the growth of female labor force participation. These changes put double and compound burden on effect as lack of caretaker of the elderly. Moreover it is evidenced that the elders in the rural of Thailand have to take responsibility or even earning for grandchildren due to loss of parents earlier by HIV/AIDs (Knodel et al, 2002, cited in Thailand paper).

The data of **Malaysia** reveal of increasing in nuclear household and a little decrease of extended family during the 1980 and 1991 with average household size, being 5.2 to 4.8 for total , 4.9 to 4.8 for nuclear family and 7.1 to 6.5 for extended family (Malaysian Department of Statistics , 1998, cited in Malaysia paper).

Singapore census of population 2000 is increase in "*elderly only*" households from 1.8% in 1990 to 2.8% in 1999. Parallel to this social trend , there was a decrease of extended or multigenerational household from 6.7% to 5.6% and the increase of one – person household from 5.2% in 1990 to 8.2% in 1999 (Singapore Department of Statistics , 2001, cited in Singapore paper). The increase of 3% in one - person

household is a matter of concern due to the problem of social isolation , vulnerability to depression and suicide.

The social - economic changes experienced by **Hong Kong** during the last two decades has also weakened the ability of the family to take care of their elders. The reliance on spouse for care is also a myth when elderly people age into older ages, more will become widowed or singled. Despite most of the elderly people in Hong Kong is poor and has to rely on social security payment, the reflection of diminishing family support is foreseen.

Thai elderly women are lacking of informal care by their families. The prevalence of widowhood-divorce-separation is much higher among the elderly women (Report of the 1994 Survey of Elderly in Thailand, cited in Thailand paper). Three percentage of the female elderly are single while only one percent of the male counterpart are. The difference is remarkable higher among elderly female living in urban areas and also increased with age. The very old persons living alone usually considered a high –risk group that are vulnerable to lack of appropriate caregivers. In Thailand, the older person aged 75 and over and women in particular , had high prevalence of living alone (6.5%) and living with a non- relative (5.6%) (Report of the 1994 Survey of Elderly in Thailand , National Statistical Office , Office of the Prime Minister, cited in Thailand paper).

3.2 Needs for LTC

When people gets older, one's dependent life expectancy increases while active life expectancy decreases. Data are presented by Korea and Thailand. The dependent period in the later part of old age is becoming an universal and normal life cycle. Not only do the elderly living a dependent life requires health care but they also need social care in their daily life.

Currently almost all ASEAN aged population are cared by informal systems mainly by families , relatives , neighbors and others in various circumstances. The certainty is that the proportion of those who utilize formal care services will increase. However, those who are cared for by the informal system will be out - numbered those who utilize formal care services in the future. In estimating the long term care needs of the elderly, the degree of mental impairment as well as physical impairment may have to be considered. The estimated number

and proportion of the elderly who need formal long term care is important for policy formulation. The reliable proportion of mentally impairment is not always available , prevalence of disability by level of dependency is preferable in order to estimate needs for formal LTC in a country.

While **Thailand** uses prevalence of disability by categories of home bound, bed bound, personal care dependent, and dementia among total elderly population to project the need for LTC. It is estimated 14.8% of aged people 60 years and over who may need for LTC in 2000(Jitapunkul, S., Kunanusont, C., Poolcharoen, W., and Suriyawongpaisal, P., 1999, cited in Thailand paper).

The LTC Policy Planning Committee, Ministry of Health and Welfare (2000) of **Korea**, estimated the number of those who need formal LTC in term of physical health is 19% of aged people 65 and over. The level of dependency measured by IADL and ADL, by types of LTC, whether it is institutional or community / family care are used by Korean team to estimate such needs (Policy Planning Committee, Ministry of Health and Welfare Korea, 2000, cited in Korea paper).

The need for long term care for the elderly in **Hong Kong** arises not merely as a result of the growing ageing population, but also reflects the interplay of multiple factors that affect the supply and demand for long term care in the long run. There is almost one in two elders suffering from depression in Hong Kong. On top of ailments, dementia, depression, and suicide will bring multiple problems including behavioral or personality changes, and inter-personal conflicts. For all these to be treated properly, a good deal of services has to come from long term care resources.

Table 9 Changes in household structure.

		1 person household	nuclear household	multifamily household	average household size
Singapore[1]	1990	5.7	81.0	10.8	…
	1990	5.2	84.6	6.7	…
	2000	8.2	82.1	5.6	…
Malaysia[2]	1980	…	55.2	27.8	5.2
	1991	...	59.9	26.4	4.8
Hong Kong	1996	…	59.2	…	…
	1999	…	63.6	…	…

Source: 1. Survey of Population Census, Singapore Department of Statistics, 2001.
2. Survey of Ageing population , Malaysia Department of Statistics, 2001.
3. Social Welfare Department, Hong Kong, 2000.

Change in household structure of the five countries are similar, such as Singapore, increase of 3% in one-person household is a matter of concern due to the problem of social isolation, vulnerability to depression and suicide, as well as lower possibility of immediate treatment at times of crisis faced by the elderly. Lonely persons, would require social networks to maintain their integration with the rest of the society. The well being of older persons is closely linked with the availability of social support, a key point which has been emphasized by many social researchers (Antonucci, 1990; Argyle, 1992, cited in Singapore paper).

Table 10 Living status by age and sex of the older persons according to the people they are staying with, Thailand.

Living status (%)					
	Alone	**With spouse +/- others**	**With children +/- others**	**With other relatives**	**With non relatives**
Male					
60-64	2.1	55.4	41.7	0.5	1
65-69	2.2	47.8	47.8	0.8	1.8
70-74	2.3	47.7	46.5	0.3	3.2
75+	2	36	58.4	1.6	2.2
Total	2.2	48.7	47	0.7	1.9
Female					
60-64	4.4	41.9	51.7	1.1	1.5
65-69	4	41.3	51.9	1.3	1.6
70-74	5.1	34.8	55.2	1.7	3.4
75+	6.5	27.2	57.4	3.3	5.6
Total	4.8	37.6	53.5	1.7	2.7

Source: Report of the Survey of Elderly in Thailand, National Statistical Office, 1995.

The need for LTC care would hinge on two main dimensions, the degree of the older person's physical and cognitive impairment and the availability of informal care for him/her (Deloitte and Touche, 1997 cited in Hong Kong paper). The needs of the older persons may change during the ageing process. It is hence essential for the government to develop a comprehensive long term plan which would cater for the changing needs of the elderly population. The elderly health centers, the community geriatric and psychogeriatric assessment schemes, and the gate-keeping (need assessment) mechanism recently developed are exactly geared to this.

4. National Policy on Ageing

The session will review the national policy on ageing population, including philosophy, principal and social value which based behind the policy characteristics and strategies for policy formulation. Responsive plans, programs and financial scheme will be described along with its monitoring and evaluation system. The last part is summary of National policy for ageing population.

SINGAPORE

Expressed by words of Mr. Goh Chok Tong, the Prime Minister of **Singapore** illustrated succinctly the main philosophy of the government in regards to ageing issues, "*We want Singaporeans to age with dignity and to remain actively involved in society. We want them to be actively engaged in family and community life. And, in line with the Singapore 21 vision*, *We must maintain a strong sense of cohesion between the generations. Singapore should be the best home for all ages"*. (IMC Report on Ageing Population, 1999: 13, cited in Singapore paper). The government has clearly stated its stand that family is still the best approach, it provides the elderly with warmth and companionship of family members and level of emotional support that cannot be found elsewhere.

The "*Many helping Hands*" policy, the community and the government are expected help the aging families in order to reduce the stress of care giving for older members. This policy basically emphasizes that the government expects to work with civic bodies such as voluntary welfare organization, religious institutions, ethnic- based organizations. The support given is in form of funding, land leased at special rates, training of staff, and guidance in program planning.

A national policy of **Singapore** on ageing has taken shape after a number of successive policy reviews. Two characteristics in the policy formulation process have been noted as strategies and policy forming process. ***First,*** the various Committees have the benefit of representation from various sectors. Historically, cross- sectored representation has worked well in the local context and it is the standard feature in Singapore's government problem-solving approach. ***Second,*** the Committees were given much publicity. Public awareness of the issues was heightened especially when controversial recommendations were made. Public inputs thus become

an important consideration in the Committee' deliberations (Mehta and Vasso, 2000, cited in Singapore paper).

While the government of **Singapore** has to monitor carefully whether its safety net is effective in the midst of global economic changes. As such, a great deal of money is being spent on lifelong public health education. ***The recommendation on Health Care for the Elderly is the establishment of a national disability prevention program***. Another dimension of primary care, which the government is focusing on, is free health screening for senior citizens.

The importance of comprehensive health care system of *"step-down care"* after the patient is discharged from hospital. The hospital would provide professional leadership in the development of geriatric step-down care in each zone. This includes provision of professional staff e.g. geriatric nurse, social worker, physiotherapists on a rotation basis, training programs, development of quality assurance programs and sharing of resources. In addition, Ministry of Health would draw up guidelines and standards of care for step-down services, and would audit the providers to meet the standards.

The ***co-payment*** is a main principle for funding policies of **Singapore**. This applied to the Medisave scheme, which is a compulsory medical savings scheme under the Central Provident Fund. An individual may use his Medisave for his own or his parent's hospitalization expenses (including expenses incurred at a hospice). The implication of the system of co-payment is that individuals should not depend on the state, but rather be self-reliant as far as possible. When there is a need, the state would come in to assist. It should be noted that the co-payment principle preserves the self-dignity of the consumer and militates against abuse.

To summarize, five high level committees have been appointed to review the various issues and problems that are anticipated as an outcome of a rapid ageing population (Vasoo, Ngiam and Cheung, 2000:177 cited in Singapore paper). They have been very effective in crystallizing the issues and possible negative outcomes. The Inter-Ministerial Committee on the Ageing Population has proposed a more co-ordinated and comprehensive plan to deal with challenging issues of Singapore's ageing population in the 21st century.

A continuum of care for the sick Singaporean from acute to community-based to home care is the aim of the Singapore government's policy for the elders but this has yet to be achieved.

Malaysia

"Creating a society of elderly people who are contented and possess a high sense of self worth and dignity, by optimizing their self potential and ensuring that they enjoy every opportunity as well as care and protection as members of their family, society and nation" has been stated as National philosophy of **Malaysia** (GOM, 1996 p.571, cited in Malaysia paper).

The National Policy for the Elderly is a great step forward in preparing the Malaysian society for a transition into an ageing society. Although health care receives substantial attention, the financial aspect is not covered. The emphasis of the policy appears to be on social aspects, not denying that these too contribute toward the well-being of the elderly.

In line with the objectives of the national policy for the elderly, several action plans, several sub-committees, and monitoring system have been put in place to monitor the progress of all activities for the period 1997-2005. The formal social protection system includes: the Employees Provident Fund, the Social Security Organization established, Government Pension Scheme for Civil Servants, Old Age Benefit Scheme for Armed Forces, and private sector provident and pension funds.

Several action plans are initiated and several sub-committee have been set up to look into the various aspects related to ageing and the welfare of the elders. ***They include: social and recreational, health, education and training, religion, housing and research***. In 1995, the program is aimed at improving and maintaining health and functional outcome of the elders with the objective of promoting quality of life as well as forging productive ageing among the elders. Various primary and secondary health care have been identified and strategies formulated to achieve the objectives of the program.

In caring for the elders, both the family and the community have long been perceived to be of primary importance (Chow, 1992, cited in Malaysia paper). In the case of developing countries such as Malaysia where competing needs are varied and sometimes more urgent than the lesser priority issue of the elderly, family and community care seem to be the most

viable alternative than the welfare state approach. In addition the deeply rooted Asian culture that stresses *the importance of filial piety* dictates that care by family become an automatic old age security.

Apart from social security as the primary source of income for the aged, savings, personal life insurance and unit trust funds are alternative forms of sources of protection. The national investment schemes provide attractive returns with the aim to encourage wider participation, particularly, participation from the lower income group. All these are voluntary schemes and hence individual decision is critical in influencing participation. No specific insurance scheme is tailored for the elders before the year 2000.

The significance of financing has been appropriately acknowledged in the Eighth Malaysian plan (2001-2005) as ***one of the strategies for heath sector development: developing and instituting a healthcare financing scheme.***

The monitoring system (control mechanism) provides checks and balance as well as evaluates the progress of programs and activities. Various ministries and departments undertake action plans and activities for the elderly, but the agency that oversees all matters is the Department of Social Welfare. This will ensure that gaps and shortfalls are identified and corrective actions taken for future development of a sustainable national policy for the elderly.

KOREA

Korea's philosophy ***is a perspectives of economic-growth-then-distribution, perspective of reactive and piecemeal policy development and perspective of ageism, and value of filial piety have been observed , attempts are made to find a new approach.***

Responding to the problems, the government recognized the ageing as a social problem since the 1970s and has become increasingly serious since then. However serious one may think the issue is, if the people in key positions of the government do not pay sufficient attention, the issue will remain neglected.

A delay in policy decision making for elderly may partly due to their social and familial ***values of filial piety,*** familism and communalism.

Families, generally been safety nets for the elderly and culturally belief not to take them away to any institutional care facilities.

In the process of major revisions of the Welfare Law in 1989, 1993, and 1997, many interest groups and citizens' groups initiated suggestions to revise the law. Creation or improvement of some programs, many cases initiated by interest/citizen groups. The power of ***NGOs*** has grown over the past 10 years in the social welfare policy for the elderly.

Almost all of the national policies and program for the welfare of the elderly are currently planned and implemented by the Ministry of Health and Welfare. The National Policies for the Aged can be grouped into four categories according to the nature of the provision; income maintenance, health care, housing, and social services.

The government created the Elderly Persons' Welfare Division under the Bureau of Health and Welfare for Families, Ministry of Health and Welfare in 1990 and in 1999 the Elderly Persons' Health Division was created. The National Pension Law and the Older People Employment Promotion Law were enacted. In order to guarantee a minimum living standard, the existing public assistance law was re-codified into the National Basic Livelihood Security Law. Institutional care services became diversified with the revision of the Elderly Welfare Law. The home help services, adult day care and short-stay services are provided to the low-income elderly.

The end of 1990s, the general public and the government became aware of the importance of long-term care services. Two national surveys was revealed the increasing needs of long- term care (Lee et al., 1994; Chung et al., 1998 cited in Korea paper). In response to this need, the government established a policy planning committee. The first report of the committee (2001) recommends the government to set up mid and long-term policy development plans and some important basic research projects.

The budget for social welfare has increased in **Korea**, but it still remains less than five percent of the national budget and less than one percent of GDP. Most of the public policy programs for social services for the elders aimed at the low-income elders.

The government heavily subsidizes most of the voluntary social service organizations, however, subsidies are not sufficient to provide

quality services. On the other hand, they need to secure a substantial amount of funds from the general public to improve and develop services in response to the emerging needs of the elders.

HONG KONG

It has several major attempts in formulating policy. The ***coordination between different service departments*** is difficult so the issues become only the health and social services. The Colonial Government ‘s response to an increasing number of the elders by creation services presented by professionals and government departments. Under such a development, services are confined to within departmental efforts rather than cross-departmental. Service types, through broadly covered, have not been integrated and coordinated.

The Social Services Branch of the Government Secretariat drew up the first plan. It was then proposed in 1982, as a revised edition after five years of the Plan. ***The Central Committee*** functioned as an advisory panel on health and social welfare services on the elders. In 1989, this Committee produced the report contents were still very much the echo of the earlier plan. The Five-Year Plan review was responded to this Central Committee’s review. However, actual reforms remained slow for the following few years till 1997.

Living arrangement can be a significant for family support in **Hong Kong**. Primary healthcare service aims to maintain health and to compress morbidity. The recent introduction of family medicine is to support a holistic health incorporating physical and psychosocial domains. The messages for the elders have become loud and clear: ***be active, eat well and quit smoking.*** The health centers is promoting health education and to carry out health screening in prevention domain. Dental healthcare focuses on dental health education and prevention. The community health services are aimed at maintaining the elder people at home for as long as possible.

There is a whole range of services including community geriatric and psycho-geriatric assessment teams. They are multi-disciplinary teams conducting regular out reaching services in elderly centers and private nursing home. Their main task is to make accurate needs assessments and to provide the necessary medical and health support in maintaining for elderly patients to live in the community.

The health and social services of Hong Kong are coverage. These are easily accessible and almost free at the point of delivery. Health services can even be considered as universal, heavily subsidized for all who wants to use them. The social services are provided though the social centers, multi-services centers, home help services, and day care center and various types of homes for the elders was organized and managed mainly by the Social Welfare Department.

Most of the elders in Hong Kong are from lower status, the government are main source of financial support.

The Government has set up the Central Committee since 1987, which commented the problem in services after the first program plan implementation. The Social Welfare Department reviewed the programs and plans, then the elder services were well focused by Government planners. The governor set up a Commission for the Elderly Services and new initiating plans. The plan went so far as to indicate the inadequacies of services for the elders whilst at the same time pointed out the need for policy and service co-ordination amongst Government departments and between service providers. The Elderly Commission has achieved a comprehensive overview of policy and services, some innovations and new directive.

Until most recent, in the Policy Address 2000, though a lack in centrally directed and coordinated structure is observed, it echoes what the Chief Executive's advocates in promoting '*sense of security', 'sense of belonging', and 'sense of health and worthiness'*. Two principles guiding for all policy and services for elderly in Hong Kong are set for first time a clear directions, '*Ageing in place' and 'continuum of care'*.

THAILAND

The National Committee for the Elderly of Thailand developed the National Long-term Plan of Action for the Elderly (1986-2001). The plan gave support for the implementation of government policies on care of the elders and was used as a framework and guideline for elderly activities initiated by authorized and organization (National Committee on Ageing of Thailand, 1986, cited in Thailand paper). Therefore, the main features of this plan were based on recommendations of the International Plan of Action on Ageing, an output of the First World Assembly on Ageing (United Nation, 1983 cited in Thailand paper). Measures in the Plan are confined to health, education, income and employment, and social and cultural aspects.

The Government developed the *"Essence of the Long-term Policies and Measures of the Elderly (1992-2011)*"(Working Committee on Policy and Action for the elderly, 1992 cited in Thailand paper). This accelerated a progression of actions, particularly welfare actions of state organization. It also influenced the current Eighth National Economic and Social Development plan (1997-2001) to include a section providing social welfare benefits to the elders (Knodel, J., et al 2000 cited in Thailand paper). ***These welfare benefits include a living allowance to indigent elderly people, universal free health services, and discounted fares for public transportation.***

Since 1996, academic researchers and institutes with support from funding agencies have reviewed and conducted invaluable research toward this end. These works provide the factual situation of older persons and its impact in the near future, and provide essential data for developing a new national long-term plan for the elders (Working Group on Drafting of the Second National Long-term Plan for Older persons, 2001 cited in Thailand paper). During this period, some key persons, governmental and non-governmental organizations have motivated the Thai government to set up a national committee called the "*National Commission of the elderly".* A priority task of this commission is to develop the second National Long – term Plan for Older Persons of Thailand. This Plan was drafted and conceptualized mainly by the motivation and movement of the local institutions and individuals.

There was little progress in activities of Thailand between 1986-1991. Research and personnel training were the outstanding achievements of the elderly plan during this period.

In the last 10 years, after the announcement of the "*Essence of the Long-term Policies and Measures of the Elderly*", many major programs related to the elders have been implemented. The Department of Social Welfare, Ministry of Labor and Social welfare is the main organization responsible for social service provision, including both institutional and community care. In 1993, this Department set up a welfare fund, which provides 200 Baht per month to poor older persons. Since 1999, the monthly allowance has been increased to 300 Baht per month. In 1999, 200 "*Social Services Centers for older Persons in Temples*" has been set up. These community centers operated by communities' leaders are able to provide only the recreation activities and health promoting programs but not the community/home care.

Many ***NGOs*** provide community care for older persons, especially those in poor and remote areas. The International agency funds many projects on community services, including social and health services in several areas. ***Some NGOs run institutional care programs including homes for the elderly and nursing home***. Many acute-care private hospitals have turned their wards into long-stay care facilities.

In 1994, there were 3,487 registered senior citizen clubs in Thailand (Siripanich, B., et al., 1996 cited in Thailand paper). In 1992, the Ministry of Public Health started a free healthcare program for Thai elders.

Thai government has promoted seniority and family values by creating and "*Elderly day* " and a "*Family's day* " during the Songkran festival, a traditional Thai new-year day. Public train transportation gave 50% fare reduction from June to September. The educational and training for health personnel, caregiver, and older persons is available across the country.

The main supportive funding of **Thailand** is the government. Since 1997, the constitution of the Thai Kingdom clearly state that the government must provide assistance and welfare to the elder persons aged 60 years and over, particularly those who lack a subsistence income or are underprivileged. Under the Universal Health Insurance Scheme, Thai people will receive almost medical and health services with a 30 Baht co-payment. However, it needs to be stated that the elders have been eligible for free healthcare scheme provided by the Ministry of Public Health since 1992. Hence it is possible that this scheme may add only minimal benefits if special health care for frail and disabled elders is not under consideration.

5. Development of Long- term Care Policies

5.1 Policy on Long Term Care

Among five countries in this study, some countries have explicit policies on long term care, some have not. Principals and practices vary from country to country, however all of them depicting some infrastructures of long term care for the elderly.

The first is the government of Hong Kong, which has put the principle of "***ageing in place***" and "***continuum of care***" as a base of policy development, that is elders should live with their families or in the environment which they are familiar as they aged. This has been the foundation of social welfare policy since 1977 and was ascertained in the

1991 White Paper. The Policy Address 2000 is *'sense of security', 'sense of belonging', and 'sense of health and worthiness'.*

The interesting framework was presented by **Singapore** (1999) suggested a three-pronged approach in terms of *"Heartware"*, " *Software*" and "*Hardware*"**.** Heartware refers to the individual's and society's value, attitudes and perceptions of ageing and senior citizens. Software refers to development of policies, programs and services that constitute the community infrastructure. The third "Hardware" refer to the built environment such as housing infrastructure and the transport system. Ultimately, all three types of "ware" have to be aligned and coordinated to achieve the creation of an age-integrated society.

As part of the national planning process, the government produced a Five-Year Master plan of Eldercare Services. The three prongs of the plan are: (1) establishment of an appropriate infrastructure and a new service delivery system, (2) revamping of current funding policy, and (3) provision of a continuum of programs.

Singapore emphasis on ***family caregivers and care support centers***, it arises from the government's realization that the family responsibilities increase with longer life expectancy of ageing family members. The paradigm of services is a partnership of the state, community and family (Mehta, 2000, p.249 cited in Singapore paper). The "*Many Helping Hands*" policy upheld by the government is discussed earlier in the first part of National Policy on Ageing.

There is no explicit policy on long term care in **Malaysia** (2001). However, the absence of one does not reflect a total absence of infrastructure to safeguard the interest of the elderly, nor does it mean an absence of services necessary for long term care.

The government of **Korea** has no clear policy development plan for LTC in either the public or private sectors (2001). Almost all the elderly who need LTC are cared for by informal caregivers. There are a number of reasons for this. They are: lack for long-term care services, traditional values of filial piety and family responsibility, face-saving, cultural attitudes of being reluctant to use services provided by non-familial persons, and lack of understanding of in-home/community care services.

The debate on long term care for the elderly of **Hong Kong** (1999) has been focused on the existing gap between demand and supply which

requires much policy and program initiatives to meet the needs of the growing ageing population. In this regard, reforms in the funding source and structure and initiatives to promote continuum of care and enhanced home care are put forward. While these reforms and measures have aroused uncertainty and criticisms among the health and social service sectors, they have also started to move in a direction that long term care is to undergo some fundamental changes.

The main features of the Long-term care for elderly of **Thailand** is based in the First and Second National Long –term Plan for Older Persons of Thailand since 1986 (as discuss earlier in the National Policy on Ageing).

Generally, the public perceives LTC as long-term institutional care especially nursing home and residential home, but not the shelter service nor home/community care. The first National Long-term Plan of Action for the Elderly of Thailand mainly emphasized the informal care of the family; however, it ignored provisions needed to support the family.

The Second National Plan for older persons is implemented in 2001. It includes strategies on LTC provisions which cover a wide range from services both in home/community and institution, and developing shelter/accommodation services and environmental adaptation to suit with activities of the elderly. Moreover, under the universal coverage scheme in healthcare finance, which is currently implemented, primary care units must provide community health services. This will strengthen the formal LTC for elderly people in the future.

However, over-reliance on the family care and the current economic problems may suppress the progress of LTC development, particularly the home/community services and the state-owned nursing homes.

5.2 The Administration of Long- term Care

The administration of long term care facilities and services in each country are varied depend on their infrastructure of the governances. Mostly, the Social Welfare services are provided by Ministry of Social Welfare and institutional health and medical care facilities and services are rendering from the Ministry of Health. The problem is that services for aged are multidisciplinary and older people's issues are multidimensional. In Australia, the government has solved the problem by creating a Ministry for

Aged, while some countries have combined the Ministry of Health and Welfare under one roof.

In **Singapore,** most of the community-based social care facilities fall under ***the Ministry of Community Development and Sports*** while nursing home facilities, hospices, community and chronic illness hospitals belong to ***the Ministry of Health***. The Ministry of Health of Singapore is also responsible for monitoring quality of care in nursing homes, which include homes for dementia patients and their caregivers (Hartz and Splain, 1997; Burgio, Allen-Burge, Stevens, Davis, and Marson, 2000, p.242, cited in Singapore paper). The government established the ***Inter-Ministerial Committee on Ageing Population*** to be the co-ordinating body. This committee addresses some of the problem of co-ordination.

The main responsible organization for long term care in **Malaysia** is ***the Social Welfare Department*** under the Ministry of National Unity and Social Development. This Department and the Ministry of Health monitor the nursing homes those run by private organizations. The qualified care centers are licensed by the Social Welfare Department (The Edge, 19.2.2001). The other ***Welfare Department*** is responsible for selection the elderly residents for the Community Caring Village.

Community care services subsidized by the government of **Korea** are delivered through government agencies under the ***Ministry of Government Administration and Home Affairs (MGAHA)***. Currently social welfare policies made by the ***Ministry of Health and Welfare*** are implemented through the general administrative agencies of central and local governments under the control of the MGAHA. That is, the delivery system of social welfare services is fused with the general administrative system. With the current public delivery system of social welfare services, it is very hard to be professional and to utilize people with professional expertise and knowledge of social welfare and health care.

The ***Social Welfare Department*** of **Hong Kong** is responsible on long-term care, development of a policy to meet the public demand for better quality and quantity in service provision have been an attempt, and put into effect a number of innovative measures and programs. The public reliance on the private sector inevitably brings legislation to regulate these homes. The regulation of all nursing homes is now governed by the Nursing Home (Elderly) Ordinance implemented in 1996. The Ordinance puts the Director of Social Welfare Department as the ultimate authority in licensing all elderly homes in Hong Kong.

Co-ordination and integration of service policies have not been seriously discussed both within and across departments. So, the present ageing policy represents essential efforts from the Elderly Commission and the Health and Welfare Bureau. The Elderly Commission has so far developed guidelines mainly for the three executive departments, namely the Hospital Authority responsible for hospital treatments and rehabilitation, the Department of Health responsible for health promotion and disease prevention, and the Social Welfare Department responsible for personal social services. Other departments, depending on their own will, have implemented complimentary policy to improve the services for the elderly people.

The ***Social Welfare Department, Ministry of Labor and Social Welfare*** of **Thailand** is a major state organization responsible for the social welfare services. Nearly all of state-owned social services in Thailand are run by this organization. In term of formal LTC provided by the state organizations, social services are more advanced compared with health services. Recently, there is no information available to show the coordination between the social and health services of formal LTC.

5.3Facilities and Services in each Country

All of these five countries have defined the facilities and services into institutional/residential care and community based-care/home care. The facilities and services are quite similar, the different is the strategies and the owner type of whether they are state, private, NGO or voluntary, to enhance provision for accessibility, coverage and quality of the services.

Singapore

Singapore highlighted the need for ***multi-service centers*** so that services such as day care for children and elderly could be housed in one building. It is also referred to ***Neighborhood Links*** such as day activity centers for elderly living in the government housing flats, in order to provide a social support system as well as focal point for organizing volunteers and disseminating information on services and programs for the residents in the vicinity. The Maintenance of Parents Act of Singapore passed by the Parliament Legalizes the financial duty of adult children to look after their elderly parents in old age.

The institutional ***step down cares*** are community hospitals, nursing homes; and non-institutional step down care (community based care and home care) e.g. day rehabilitation centers (including centers for dementia patients), social day centers; and home care services such as home help, home nursing and home medical services (IMCa, 121, cited in Singapore paper).

The funding of health and social care services thus far has been a combination of individual (and indirectly his employer), the family, voluntary welfare institutions and the state. A safety net exists for those who do not have any family, in the form of Public Assistance from the government.

To encourage families to look after their older family members, ***tax incentives*** are provided in the form of Aged Parent Relief and also available for those who care for a handicapped spouse.

Housing grants are provided for adult children or parents who opt to live within the same housing estate. Known as the Reside Near Parents/Children Scheme, it encourages intimacy at a distance (Shanas, 1968, cited in Singapore paper). To overcome the accessibility services, the ***Ministry of Health*** recently announced the introduction of a Framework for Integrated Healthcare Services for the elderly, over the next 10 years.

Table 11 Current provisions for long term care in each country

	Singapore	Malaysia	Korea	Hong Kong	Thailand
A.Residential Long term Care					
Hospital for the chronically sick: for long stay patients	✓	✓	✓	✓	
Community hospitals: for rehabilitation after acute illness/nursing hospital	✓		✓		
Nursing homes	✓	✓	✓	✓	✓
Hospices	✓				
Home for dementia patients/Aged home	✓	✓	✓	✓	✓
Cluster Living (or studio apartments)	✓				
Joint HDB-MCDS housing project	✓				
Community caring project		✓			
Short stay care			✓		
B. Non-Residential Long Term Care					
Day rehabilitation centers	✓				✓
Social day care centers	✓	✓			✓
Day care centers	✓	✓	✓	✓	✓
Home care such as home medical care, home nursing care	✓	✓	✓	✓	✓
Carers' support center				✓	
Care-giving center					✓
C. Community-based Support Services					
Home help services	✓	✓	✓	✓	
Home modification service eg. Grab bars, non-slip tiles and leveled floors	✓				
Telephone hotline services: for crisis and counseling	✓				
Be friender service: volunteers matched with lonely elderly for home visits	✓				
Mutual help groups: neighborhood based small groups of about 10-30 elderly to foster mutual care and concern	✓				
Escort services: for volunteers to accompany elderly to clinics or hospitals	✓				
Bereavement and funeral service.	✓				
Alarm response service	✓				

Malaysia

With regards to medical and health services for long term illness, public hospital in **Malaysia** do play role. The most obvious effort by the government is to set up ***Homes for the Chronically Ill***. In terms of medical

services for long term care, ***public hospital*** do play role. It is the goal of the government to introduce geriatric care to all ***district hospitals*** by the year 2020. In line with this development, the geriatric training is become a priority for human resource development in the health care sector. In addition, training for caregivers is also being conducted.

Domiciliary care is the most common aspect of ***community based services*** to older people, which include basic care (help with daily living, mobility, self care), home nursing, and home visiting (Tester, 1996 cited in Malaysia paper).

Under ***the Central Welfare Council Malaysia*** (MPKSM), a scheme known as the ***Home Help Service*** is offered to the elderly. Services include home visits, hospital visits, occupational therapy, simple medical tests and counseling. This is an outreach program that brings care to the elderly. The ***residential homes*** and ***huts*** are provided by MPKSM. The huts is catering to elderly Malays who are reluctant to relocate and residential homes are mostly catered for those who have no major functional disability. In addition to the non-medical care services, district health centers provide the necessary medical care on a regular basis.

Another NGO known as ***Golden Foundation*** (Usiamas) provide ***nursing care*** and ***home visits*** to the elderly, in particular those who are newly discharged from hospital. In addition, visits to the elderly are also being carried out from time to time as a social activity for the elderly in order to lessen the feelings of loneliness among them. ***Day center service***, training for caregivers and a resource center for ageing are also provide by the Golden Foundation.

Institutional care are nursing home, day care center, home help, catering services (meals on wheels) and other services. Most of the nursing home are run by private organizations. These homes are available to those who have the means to purchase. Because of the lack of regulation and supervision by respective authorities, the quality of care provided by nursing homes is in consistent (The Edge, 19.2.2001, cited in Malaysia paper).

Day care centers offer a place for social interactions for elderly who are dependent. However, a day care center is also provided the elderly people who have a problem of performing some of the daily living activities. It is hoped that facilities for long term care will be greatly improved since MPKSM receives grants from the government for its operations, it implies

that more allocation of resources would have to channeled towards provision of care for the elderly.

It has been the Malaysia government‘s policy to assist and encourage voluntary bodies to provide care and shelter to the elderly, by granting. The ***National Council of Senior Citizens Organization Malaysia*** (NASCOM) was map out policies and implement programs in order to foster better intergenerational understanding and interaction. In term of health and medical services, NASCOM is attempting to urge authorities to plan and provide comprehensive health care facilities and services for the elderly, and advocate for more geriatricians, specialized nurses and health workers for aged care.

Most of the expenses for health care are usually borne by the individuals and their family in the form of out-of-pocket expenses. The private health insurance cannot be ruled out as an alternative or supplementary source of financing for health care. For long term care needs such as institutional services, the cost is the responsibility of the individuals and family.

Korea

Institutional care services are the elderly housing welfare facilities and elderly health care facilities. The elderly housing welfare facilities are home for the aged. The elderly health care facilities are ***nursing homes***, ***geriatric hospitals and nursing hospitals***.

There are four kinds of ***community care services*** in Korea: ***home help, adult day care, short-stay care and visiting nurse services.*** The home-help program was introduced in 1987 by a voluntary organization. Home help services are currently provided on a free-of-charge basis exclusively for elderly people residing in the community under the public assistance program. Non- profit agencies providing free and low-fee-charging services are subsidized by the government, and agencies providing full-fee-charging services are those which collect fees from users. The amount of government subsidy differs with a small scale of range according to the results of program evaluations.

LTC focusing on health care can be provided in ***geriatric hospitals***, ***nursing hospitals*** or ***health care institutions*** in **Korea**. Geriatric hospitals mainly deal with elderly patients. Most elderly Koreans are reluctant to use hospitals as the place for long term care because of high medical cost. In

addition with costs of institutional care are not reimbursed by health insurance (2001).

However, compared with other community care services, the utilization rate of ***adult day care*** seems to be higher. This increased trend can be seen with the results of a research study which showed substantial proportion of the elderly under LTC and their family caregivers were willing to use this service in the future (Lee et al., 1999, cited in Korea paper).

The ***short stay care program*** provides necessary services to the elderly who need care for a relatively short period of time staying at a certain place because of temporary absence of their caregivers. The period of time to receive services is limited up 45 days and a total time cannot be over three months a year. The utilization of this service is low.

The visiting nurse program provide nursing care, transportation of patients, medication, injection, health counseling, health education under the supervision of physicians, etc. Fees for services are charged with reimbursement from the National Health Insurance for their insurees, and free and low-fees are charged to those who are using visiting nurse services offered by community health care centers and community centers. Services provided by the Korean Nurses' Association is usually fully charged.

There are only gatherings of ***self-supporting family caregivers*** at a private level and no governmental support is provided at all. Presently only one private social welfare foundation provides some support for the self-supporting family caregivers.

Hong Kong

Under the directives for " *ageing in place and continuum of care*", elders in **Hong Kong** are encouraged to remain living in their homes for as long as possible, assistance with community support services is available when needed.

The ***residential care*** in Hong Kong is further subdivided according to the level of care it provides, ranging from ***self-care hostel, aged home, care and attention home to nursing home and infirmary*** which provides the highest level of care.

The current provision of various types of home/community- based care are ***community geriatric assessment team***, ***community nursing***

services, day care centers, home help team, home care team, meal service team, carers' support centers, day care center for demented elderly and day respite service.

Thailand

Almost all the elderly who need LTC in **Thailand** mainly received informal care provided by their families and relatives.

Residential home or " *Home for Older Persons*" is the most common and traditional service offered by the governmental and non-governmental organizations. The provision of services are lodging, food, clothes, other necessary consumer goods, religious activities, physical exercise and therapeutic activities for physical rehabilitation, occupational activities, recreation activities, traditional activities, medical services, social work services, and traditional funeral activities (Department of Social Welfare, 2001a, cited in Thailand paper). It provides service for the low-income elderly who cannot stay with their families or have no relative to stay with. Only the elderly who are independent in personal care and have no need for nursing care. However, when these elderly people get older, they turned frail and need personal or nursing care.

Most of ***day care centers***, attached to residential homes, are provide services to limited number of older persons living within the distance of 5-10 kilometers. Apart from the day care and basic rehabilitation programs, these centers also provide medical screening and treatment, counseling, recreation activities and mobile clinic.

A ***formal care-giving center*** is organizing caregivers to look after the elders and children in home setting. A majority of these caregivers usually work as paid caregivers in the homes of the elderly.

During the last decade, The **Ministry of Public Health** lunched a *"Home Healthcare"* outreach to visit patients in their homes in the community. The primary care units in the universal coverage scheme in healthcare finance have to provide community and home services. Therefore, these services, particularly the "*Home Healthcare*" service for the elderly, will be inevitably established in the near future.

Although the Department of Social Welfare has no concrete idea or policy on LTC, it developed the ***Social Service center*** for older persons. In term of LTC, these centers provide day care and basic rehabilitative

services. Other well established home/community services for LTC is not available.

5.4 Problems of long term care and solving scheme

Problems of long term care will be discussed, with references to structure of facilities, delivery of services, financial support, quality of services and manpower.

Problems observed in Singapore are fragmentation of services, lack of service to middle class, gaps in service provision due to cultural and linguistic differences, manpower shortage and lack of attention to standardization of procedures for geriatric assessment across the board.

The government of Singapore has addressed the solution introduced to solve the problem of fragmentation of services, a case management program. The ***case management*** is the service which involves the assessment of an elderly person's health, psychological and social needs and maximization of services to attain optimal and most cost-effective care of the elderly and their caregivers to prevent unnecessary institutionalization (SAGE, 1998, cited in Singapore paper).

The second issue regards the lack of affordable services for the middle class Singaporean. The subsidized services are made accessible to low income, and the upper classes are served by private services. Other issues is communication gap between foreign labor employed in nursing homes and the residents/patients. Cultural and linguistic differences cause such a gap, which would inevitably affect the quality of care adversely. Lack of information with regard to availability of vacancies in community hospitals, day care centers, rehabilitation centers, shelter homes and other long term care facilities causes frustration not only among potential clients but also service managers and providers.

Singapore government should address the pressing need for close co-ordination between the Ministry of Community Development and Sports, and the Ministry of Health, perhaps by appointing a senior official to administer his portfolio.

The problems of manpower shortage and lack of training for volunteers, pressure of time when services have to be arranged prior to client's hospital discharge, monitoring of quality and efficiency of services, and lastly difficulties in meeting the clients' ethnic preference of diet. Much

time is spent building rapport with family members since a family-oriented approach is applied. Manpower is a major issue that the voluntary welfare organizations face, since they work on a lean budget and volunteers are not easily recruited. There is room for fostering a culture of volunteerism in Singapore.

The last issue related to lack of attention to ***standardization of procedures for geriatric assessment across the board.*** A suggestion is Singapore could benefit by studying the Minimum Data Set-Home Care version 2 (MDS-HC) introduced by Hong Kong in 2000 as ***a gate-keeping mechanism*** for elderly applying to all residential and community-based services (Yuen, 2001, cited in Singapore paper). Another model is the Support Needs Assessment protocol used in New Zealand (Howe, 1996, p.222, cited in Singapore paper).

In **Malaysia**, the major issue that confronts is ***the scale and scope of services*** rather than the service per se. To further assess the types of services available, which is essence reflect the needs of the elderly, domiciliary is examined. There may exist latent needs but the needs that are urgent and have to be fulfilled are the expressed needs. Especially the home help service and home visiting are rather limited. In addition to the range of services outlined above, ***transportation need*** is strongly expressed by the elderly, both in the rural and the urban areas, as one of the most important type of assistance needed.

The ***traditional value of filial piety*** of **Korean** emphasizing its practice at familial level greatly hinders the development of formal LTC services. This perspective of family responsibility may contribute to the maintenance of face-saving attitudes toward caring for elderly parents. Thus most Koreans still think it shameful to have their parents cared by non-familial members and to have them institutionalized in homes for the aged and nursing homes. So, the utilization of all kinds of LTC services is still very low.

The level of services provided in low-fee-charging institutions are not satisfactory because their residents expect much higher level of services than their managers think appropriate to the fees paid. The nursing homes of **Korean** elderly is not well provided because of a ***lack of experienced professional social workers*** in these institutions.

Most elder institutions tend to be of a large size, accommodating more than 100 residents. Large sizes are good for the economy of size, however

they are likely to lose the benefits of the ***home-like environment*** together with other disadvantages.

Currently there is ***no housing policy*** for the elderly who require LTC. The ***public delivery system*** of LTC is fused with the general administrative system. With the present public delivery system, it is very hard for policy planning and service delivery to be conducted in a professional manner and to utilize people with professional expertise and knowledge of social welfare.

The recent community care services with only include ***adult day care, short-stay care and home-help services*** should be expanded to include visiting nurse services, and expand their target population to include all classes of elderly Koreans. In addition, the ***quality of their services*** should be improved so that the general elderly people will be willing to use them. As a provisional measure, it would be desirable for the National Health Insurance Program to pay for nursing home services up 6 moths per year, and to reduce the proportion of co-payment from 20% to 10% for the elderly.

Almost all of the social welfare programs have been developed as reactions to the problems which have already developed and as piecemeal reactions to these problems. Social welfare policies in general have been reactive, short- term and of a piecemeal nature, and have not really considered a mid and long term perspective.

Despite the **Hong Kong** government's emphasis on family care and community care as the core theme and policy direction of elderly services, the provisions of services in this respect are often ***discrete*** and ***lack of overall strategic planning.***

Adequate provision of services is partly dependent on ***an accurate and meaningful assessment*** of both existing and projected needs. Worse perhaps is that there are about one third now residing in residential homes should be able to live independently at home (Deloitte and Touch Consulting Group, 1997, cited in Hong Kong paper).

Not until recently reviews done on long term care provisions have indicated that there is a need for encouraging community care and in revamping residential care. Then greater emphasis has been put back on the role of ***community support services*** in maintaining the elders in the community for as long as possible. At the same time, residential care types

have been looked at in matching the residents' levels of dependency hence the development of a more refined ***system of need assessment*** and ***integrated service delivery***.

The principle form of LTC in **Thailand** is an informal care provided by family. Recently is uncertain whether the present level of family support persist or ***quality of care-giving*** will remain the same.

Although the main policy direction of the Second National Plan for older persons of emphasis on home and community-based services to enable older persons to continue living in their own homes or in the community (Working Group on Drafting of the Second National Plan for Older Persons, 2001, cited in Thailand paper), the provisions of the services in this respect are very limited at present. State organizations paid little attention on developing home/community services to assist the older persons and their caregivers. Thus, the availability of community-based services to ***support caring-capacity of family*** is very limited.

Non-profit and private sectors have been major contributors for nursing home services during the last decade (Jitapunkul, S., 2000b, cited in Thailand paper). The major contributors are private hospitals and religion-linked non-government organizations. Since there is no specific ministerial regulation for nursing home, the nursing home can be registered under the ministerial regulation of hospital for acute treatment; and private hospitals with facilities to treat acute illnesses can convert some beds for long-stay care service immediately. ***Quality accreditation*** of nursing home services is currently crucial. Now, there is no regulations or assurance for the ***training standard of the care giving***.

However, the home healthcare service did not happen as anticipated. The only existing activities in some area are community curative care for people with chronic disease, and these not include rehabilitation or maintenance. Moreover, data from the survey for assessment of the Thai Government's health services for older persons showed that less than one-third of older persons have ever been visited by a healthcare worker in their homes (Kamnuansilpa, P., et al., 1999, cited in Thailand paper).

6.Future challenge in long term care planning

Suthichai Jitapunkul et al (1999) has projected that in the next 20 years the number of disabled and dement older persons in Thailand will be more than 700,000 persons which need some forms of long term care services.

Addition with the expanding of morbidity and disability among Thai population will be continue for at least 50 years are evidenced , unless appropriate actions are taken. The number of the elders in need of special care will be higher than projected trend. This burdens have exerted substantial pressure on the demand for long term care to be put properly in place to assure the quality of life of Thai elders in need for their physical , mental and social functioning.

The practice issues and procedures of implementation of policies need to be improved in **Singapore**. The concept of co-operatives is attractive for the middle-class Singaporean long-term care services. The government provides subvention (grants in aid) to voluntary welfare organization that operate nursing homes and sheltered homes. It has been unspoken policy of the state that the number of nursing homes should be controlled in order not to encourage family members to turn of them as first resort.

If the government policy of *'ageing in place'* is to be upheld, more day care centers will have to be set up in all the housing estates with relevant support services, so that ageing families' needs are met in a comprehensive way.

Challenges Of Singapore government directly related to long- term care delivery are manpower shortage, lack of relevant training, ethnical issues pertaining to care of terminally ill patients, provision of interesting social programs in residential and nursing homes and lastly transparency to the public about vacancies in long term care facilities.

To further assess the types of services available in **Malaysia**, which in essence reflect the needs of the elderly, domiciliary care is examined. The future needs are expected to be different. In addition to the range of services outlined above, the transportation need is strongly expressed by the elderly, both in the rural and the urban areas, as one of the most important type of assistance needed. Especially in the area of medical care, which has an impact on long term care, the issue that needs to be addressed is the

determination of minimum acceptable standard of care that should be accessible to all.

The informal care by family requires the *strengthening of our value system that stresses on filial piety* and responsibility of children towards parents should further cultivated through publicity and fiscal incentives that reinforce such virtues. The *media* can be crucial for awareness creation and the dissemination of information. The *education system* can be used to instill and reinforce the culture of filial piety among the young.

Community based services should be further expanded. Grants and incentives should be designed by the government in order to promote the development of these services for the elderly. The government may even consider encouraging corporate to contribute towards community care through fiscal incentives. Innovative methods of delivery of community care should be explored. The emphasis on health promotion through *healthy lifestyle campaigns* is most appropriate.

Perhaps it is time to examine the role of private corporations in contributing towards care for the elderly. Assistance and care to the elderly are mostly shown during festive seasons in the form of donations in cash and kind. It is about time for corporate citizens to initiate more organized programs that require greater commitment.

The government of **Korea** is conducting a LTC needs survey and in the process of developing ADL/IADL measurement scales. Also the government needs to recognize the fact that caregiver support service is a key to determine the success or failure of long term care services.

In developing LTC policies, what is most important is to work out the financing mechanism. In this regard, in the long run, Korean society may have to institute a social insurance system for LTC of the elderly citizens. The government is planning to develop a public LTC insurance from a mid- or long-term perspective. In addition to the LTC insurance plan, this report (Ministry of Health and Welfare, 2001, cited in Korea paper) contains plans to increase long-term care facilities and to activate visiting nurse services.

Therefore, citizens groups and gerontologists as well as interested elderly groups need to monitor government actions and apply pressure to government bureaucrats and political parties concerning their implementation.

In view of the policy directives from the **Hong Kong** SAR government on elderly services and the growing public demand for better quality and quantity in service provision, the Social Welfare Department has put into effect a number of innovative measures and programs.

Not until recently reviews done on long term care provisions have indicated that there is a need for encouraging community care and in revamping residential care. Then greater emphasis has been put back on the role of community support services in maintaining the elders in the community for as long as possible. At the same time residential care types have been looked at in matching the residents' levels of dependency hence the development of a more refined system of need assessment and integrated service delivery.

To deal with the changes and the challenges ahead, the government has considered, under the principle of capping expenditure at the present level, new sources and methods of financing long term care. The new model can be described as a mixed economy of provision elderly services will be delivered by a mixed economy of public, private and voluntary providers, with increased charges for selected items or selected user groups. In order to maintain the present level of services quality and quantity, methods of funding the services are linked with a quality assurance process, user choices and reasonable pricing.

6.1 Some trial on formal long-term care programs

The Thai Red Cross Society developed a shelter project in 1997 with occupancy of only 20%. It appears that the project criteria for eligibility is not appropriate for requirement of elder persons.

The Department of Social Welfare set a Social Service Centers for Older Persons in Temples in 1999. However, the result was not impressive. The success rate was under 10%. The reasons of the failure were inadequate community participation, a rigid of service package of which did not suit with need of the community, and a lack of continued financial supports. In 2001, a Social Service Center for Older Persons located in Bangkok started a trial respite service. The project was aimed to support middle-income families, which were providing care for the elderly. Each family was requested to pay 5,000 Bath a month for the service.

6.2 Long term care programs recommended for Thai

It is crucial that the policy and programs dealing with the Thai elder, need to be more clarified in LTC needs, health and social service, and integrated systems especially for the old, frail, and dependent elders.

If the government policy of *'ageing in place'* is to be upheld. Then greater emphasis should be community support services in maintain the elders in the home/community for as long as possible. So that ageing families' needs are met in a comprehensive way.

Most of the elders' needs for LTC received informal care provided by their families and relatives. The policy direction is how to support the informal care system in order to keep the elderly in their homes. Although the Department of Social Welfare has no concrete idea or policy on LTC. So, the establish of home/community service for LTC is challenge for Thailand.

The primary care units in the universal coverage scheme in healthcare finance have to explore the feasibility to provide community/home care services. Therefore, the primary care services, particularly the "Home Healthcare" for every elderly in needs, will be inevitably established in the near future.

The new initiative of LTC services should target at elders with moderate level of impairment. The Thai elders and caregivers are supported in home help service, personal care activity, nursing and allied health services. Under these service, the mechanism of assessment used an international standardized assessment tool (MDS-HC) to determine the care need of the elderly and match them with the appropriate services.

As a guide for the future development of a long-term care policy, certain principles are essential. An adequate system of long-term care must include some basic elements (Estes and Harrington, 1985, cited in Malaysia paper):

1) It must be comprehensive, including a full range of health and social services covering long term care continuum from community-based care to institutional care
2) It must provide incentives for providers to keep cost at a reasonable level, to prevent over-utilization, and to promote the usr of appropriate services

3) It must have a financing system that provides protection from impoverishment to individuals who need long-term care and that allows for combining private and public resources to assure protection for individuals before they become ill.
4) It must ensure access to those who need the services regardless of financial ability to pay or other characteristics.

7. Conclusion, Lesson Learned and Recommended Research

The profile of ageing population in the five countries are similar. They have been undergone demographic transition and most recent economic changes. Low fertility and mortality have been observed with longer life expectancy. Advance in medical and health technology have brought the World on unprecedented volume of elderly people. Parallel to modernization and urbanization, migrations of young people to cities or urban center seeking for employment have been a phenomenon of today world. Changes in the roles and structures of family, life styles, economic constraints make move women entering the formal workforce, meaning that fewer people are available as care-giver for the elders.

The rapid growth of aged population is demonstrated by sheer number and proportions to total population. Approximately it will be double in growth rate within the next 20 years. The projected rates in 2020 are 13% in Hong Kong, Korea, and Singapore, 9.5% in Malaysia and 16.2% in Thailand. The increase of most vulnerable group, females of old-old age group are evidenced in every countries, reflecting the increasing diversity in the elder's diseases and health risk factors. This trend indicates requirement of varied and diversified health care services, particularly long- term care services in the near future.

With respect to long-term care policy, apparently all countries in the study adopted LTC services to include the full range of health, personal care and social services provided at home and in community for a continuous period to adults who lack or have lost the capacity to care fully for themselves and remain dependent. The continuum of care may extend from non-medical, personal services to highly skilled medical care, depending upon the stage of development, economic and political atmosphere of the countries.

Three groups of elder are classified regarding needs for LTC, healthy and independent, functional dependent and sick people whether acute or

chronic. Policy in every country for the first group is for them to live with their adult children or relatives at home as long as possible and external help will come when changes occur to them. The second group needs social welfare services in daily living and services related to health and health risk surveillance. The needs for the last group may range from primary medical care to highly skilled institutional medical care.

The deeply rooted Asian culture that stresses the importance of filial piety dictates that care by family become an automatic old age security. The family and community care seem to be the most viable alternative than the welfare state approach.

Although, the traditional value of filial piety seems to be still relatively well upheld, but ways of realizing this value are changing, become more practical, reasonable and reciprocal. The individualism and a nuclear-family orientation is developing and expanding. All of these changes tend to weaken the consciousness of familial support and care for the elders by the family and within the family.

The informal care by family requires the strengthening of our value system that stresses on filial piety and responsibility of children towards parents should further cultivated through publicity and fiscal incentives that reinforce such virtues. The media can be crucial for awareness creation and the dissemination of information. The education system can be used to instill and reinforce the culture of filial piety among the young as well as to foster the sense of obligations of the young towards the elderly.

Promotion of active and reproductive ageing through lifestyle approaches recommended by WHO appear to be wel accepted by all countries under study.

The assumptions of productive ageing reflect today's reality that elders are repositories of wisdom and experience and important assets for society. They are healthy with the potential for maintaining that condition until late in life, capable of making economic and social contributions and in need of purposeful and meaningful roles and activities in life. A productive ageing activity model emphasizes involvement in paid work, volunteerism, education, fitness and exercise, leisure and travel, advocacy and political action, and consumerism.

To promote health in old age, we often forget that old people themselves, together with their families, relatives and friends, have a key

role in maintaining a good quality of life. The present challenge to community agencies and to health and other professional is to find a balance between actions designed to support (rather than under mind) the efforts of elderly people and their families to look after themselves, without at the same time neglecting their welfare needs.

Data for estimating needs for long term care of elderly is most superative for policy decision. The severity of mental impairment as well as physical impairment have to be considered. At the individual level, apart from the measure of ill-health in terms of burden of diseases, indirect measure that reflects physical independence in self-care activities, the ADL_s and prevalence and severity of long-term disability presented by Korea and, Thailand (national survey) and Hong Kong are good examples. It is estimated that 14.8% of Thai elders 60 years and over who need LTC in 2000. Korean estimated number of 19% aged people 65 and over in need of formal LTC in the same year.

Age-specific prevalence of dementia and suicide death rate among elderly are used for determining size of mental impairment and community mental health status. Moreover it gears towards specific intervention of health and psychological care.

Age-specific prevalence of senile dementia in Thailand is quit similar to Singapore around 3-4% , while Korean rate of this respective condition is estimated to be higher at 8.2% of elderly 65 years and over in year 2000. The differences may due to diagnostic means and cohorts in the survey.

Hong Kong elderly suicide rate of 28 per 100,000 is presented as opposed to 12 per 100,000 among general population, of which is lower than Singapore rate (50 per 100,000). The respective rates for most advanced countries are 20 in USA, 16 in Australia and 12 in New Zealand. In contrast to Thailand where elderly suicide rate remains lower than 10 per 100,000.

Lesson Learned for Thailand

Culture and religion

The Asian culture of filial piety dictates that care by family become an automatic old age security. Especially, in the area that the communities has developed for a long time. Most of the elders are relatives or friends, such as in Singapore that the policy of many helping hands is initiated.

Thailand is a Buddhist society and a filial piety culture. Therefore, the needs and the problems of the elders is recognized as an individual not a society. Despite the elders in the urban area are confronted with the needs for services and caretakers especially among the middle and poor elders.

In developing country, the problem and needs are varied and some more urgent than the issue of elderly, so the government put less attention. Until recently, there is no explicit philosophy for the Thai elders.

National policy formation process

In line with the process of formulation of the National Policy for the elderly in **Singapore**, step of review was conducted for the last policy before the new one is putting into shape. Two important characteristics are the various Committees and the publicity. The Singaporeans give many inputs thus become an important consideration in the Committee' deliberations.

In response to the needs of long-term care from the survey, the government of **Korea** established a policy planning committee. The first report of the committee (2001) recommends the government to set up mid and long-term policy development plans and some important basic research projects.

In 1982, **Hong Kong** revised the first plan after five years of the plan. The Central Committee was set in 1987, function as an advisory panel on health and social welfare services with a special focus on the elderly people.

The National Committee for the Elderly of **Thailand** developed the First National Long-term Plan of Action for the Elderly (1986-2001). This plan were based on recommendations of the International Agency. There was a little progress in activities between 1986-1991. This may be logical for development of the "*Essence of the Long-term Policies and Measures of the elderly (1992-2011)*". The Thai government set up the "*National Commission of the Elderly*" to develop the Second National Long –term Plan for Older Persons of Thailand (2002-2021).

Academic research as evidence-based

The government of Korea was conducted two national surveys for assessment needs of long- term care. In response to these needs, the

committee was established and recommends to set up mid and long- term plans and research projects for the elders.

The Thai academic researchers provide the factual situation of older persons and its impact in the near future, and essential data for develop the Second National Long –term Plan for Older Persons of Thailand.

Monitoring system

A monitoring system of Malaysia has been put in place to monitor the progress of all activities for the period 1997-2005. This control mechanism provides checks and balance as well as evaluates the progress of programs and activities.

The monitoring system of the Thai Policy should be the most important part for the policy implementation. This will evaluate the progress of program and activities. The development of a coordinated, systematic and responsive database is essential for government to make informed decision for policy formulation and planning, to assess the impact, and to operate programs effectively.

The evaluation of the plans and programs of the elders, the senior club, the social service center and the Aged Home, will help to make decision and reform the roles of each sector. Some programs may be decentralized to the community organization or private organization or NGO and the government should set up a mechanism for control the quality of services.

Responsive Plans and Programs

The plans responsive to the policy of Thailand should be documented at the range of time, addition with the priority sets of the plan. The delegation of the authority and responsibility should be noted. Both the health and social plans must take action by the government, NGO, community, private and voluntary organizations in concert with a budget plan. Without a corresponding to policy programs and financing methods the policy plan cannot be properly implemented.

Education for ageing

Malaysia and T**hailand** seem to have pronounced education and training for the elders. They are orientation for approaching aged livelihood,

training for vocation after retirement and upgrade skills for gainfully employed, training for volunteers to assist in community outreach programs, with inclusion of training of caregivers specific for the elderly. These should be pursued with quality and audit mechanism put in place.

Living arrangement

Living arrangement and friendly environments including transportation are essential for elderly people with specific to those disabled. The government of Singapore is set up about housing, apartment and infrastructure that support to the elders, as well as **Hong Kong.** The government of **Malaysia i**s tried to do this such as a community caring village, the transportation of the elderly, both in the rural and the urban areas.

A continuum of care

A comprehensive system of geriatric step- down care after the patient is discharged from the hospital of **Singapore** is very interesting because it includes provision of professional staff, training programs, development of quality assurance and sharing of resources. In addition, Ministry of Health has a guidelines and standards of care and audit the providers.

The continuum of care for the sick Singaporean from acute to community-based to home care is the aim of the government's policy. It is recommended to conduct in-depth study to actually reform the primary care service at Thai PCUs to be holistic, continuous and integrated to cover whole range of social, psychological and health care for long term sick people.

Advocacy and Public awareness

The concept for promotion of healthy ageing should be clear and simple for publicity, for example: Hong Kong messages: ***be active, eat well and quit smoking***. So, the increase of public awareness of the issues is heightened.

The Chief Executive's advocates in promoting '***sense of security', 'sense of belonging', and 'sense of health and worthiness'.*** Two principles guiding for all policy and services for elderly in Hong Kong are set for a clear directions, '***Ageing in place' and 'continuum of care***'(2000).

The three-pronged approach of **Singapore** (1999) is very interested in terms of ***"Heartware", " Software" and "Hardware***". **Singapore set** a great deal of money is being spent on lifelong public health education. Public education is a key mechanism in implementing the "*Heartware*".

Lack of data

The major drawback for Ageing Policy in Thailand may have been the lacking of policy initiatives, a lack in policy- service delivery links and the implementation process that always are problems. The vision on the role of each sector in Thai society including comprehensive and operational plans that appropriate to the cultural and the Thais' life style are apparently less directive.

The recommended research

1. Research to explore the demographic, social and health profile of ageing population for every 5 years.
2. The study for assessment needs of the elderly by age-sex for long term care, for instance, to determine the degree of mental impairment as well as physical disability have to be conducted, for every 5 years. The estimated burden in number and proportion of the elderly who need formal long term care for 10 to 20 years is evidence-based input for policy formulation. Addition with prevalence of disability by level of dependency is preferable in order to estimate specific needs for formal LTC.
3. Periodical study to assess the essential health behaviors of the elderly.
4. The older women have a longer life expectancy, chronic illness, and sometimes coincide with an inadequate financial resources may accentuate the needs for formal long term care. The lack of research data on ageing women per se is a gap that needs to be addressed especially those of middle-class and poor in urban areas.
5. The screening test should expand from detection of disease to assess the functional capacity and social need, and the support systems after the test.
6. What is the balance between public sector involvement and private sector participation?
7. In the area of medical care, which has an impact on long-term care, the issue that needs to be addressed is the determination of minimum acceptable standard of care that should be accessible to all.
8. A monitoring and evaluation system is essential in ensuring quality

of service to the elderly and for continuous improvements in social service and health care. How to monitoring and evaluation of the LTC for Thai elder?

9. The model of lifelong public health education for preparation the Thai is essential for society in order to ensure that individual entering old age with an acceptable quality of life.

10.Comprehensive study on the elderly to provide information specific to physical, mental, social and spiritual functional changes with advance in age.

11. Study on legitimate boundaries of social welfare and health services for ageing population.

12.How to support the informal care system in order to keep the elderly who need to be placed in an institution as low as possible? It also has to assure that family and relatives can provide adequate care to elderly people.

13.Housing and town planning in anticipating the growth of an ageing population, planning for township should take into account the facilities for the elderly. In line with the advocacy for the elders to remain in the community, infrastructure for the mobility of the elders is important and should be incorporated into town planning.