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SHORT REPORT

Strengthening self-help and mutual aid in Japan's community-based integrated care system based on the Thai health policy for the elderly

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Abstract

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Aging is a global issue not especially in the developed world. Governments of both developed and developing countries struggle with the financial burdens of aging populations. The Japanese government is implementing the Community-based Integrated Care System (CbICS) for elderly individuals to provide comprehensive up-to-end-of-life support services in communities. This system proposes four elements: self-help (Ji-jo), mutual aid (Go-jo), social solidarity care (Kyo-jo), and government care (Ko-jo); self-help and mutual aid are expected to be strengthened for successful policy implementation. Thailand, with the highest aging rate in Southeast Asia, has a successful system based on primary health care (PHC). The authors discussed ideas from the Thai health policy for the elderly to address the challenges in the Japanese system. For a data collection method, the authors conducted document reviews. Interviews with officers from the relevant ministries were conducted to verify the evidence to strengthen self-help and mutual aid in Japan's CbICS. Factors promoting the implementation of the Thai health policy for the elderly were extracted. Aging issues were influenced by the national strategy. The second National Plan for Older Persons focused on community-based care services following the PHC concept and tried to implement them comprehensively along with the ministries.

The factors promoting the implementation of the Thai health policy for the elderly included "Clear and adequate government role distribution", "Decentralization and authority of local governments", "Earlier preparation", "Empowerment and encouragement of preventive activities in the community", "Evaluation system", "Evidence-based", "Fit for global concepts and national issues", "Involvement of stakeholders", and "Solutions to fragmentation".

The results indicated that the Thai health policy for the elderly was characterized by a strong central government, with emphasis on well-being and the prevention of diseases, and involvement of multiple ministries. Japan's CbICS could provide more effective services when community activities adopt Thailand's community-based elderly care. Relevant ministries should be more integrated for better service provision, and Japan's PHC concept should be reconsidered for application to its peculiar situation.

Keywords: aging, long-term care, primary health care, universal health coverage

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การเสริมสร้างความเข้มแข็งด้านความช่วยเหลือตนเองและช่วยเหลือซึ่งกันและกันในระบบการดูแลแบบบูรณาการในชุมชนของประเทศญี่ปุ่นตามนโยบายสุขภาพของประเทศไทยสำหรับผู้สูงอายุ

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บทคัดย่อ

เคียวโก๊ะ ซูโด๊ะ จูน โคบายาชิ ชินนิชิโร๊ะ โนด๊ะ จิราพร ชมพิกุล โยชิฮารุ ฟุกุดะ และ เคนโซ๊ะ ทากาฮาชิ การเสริมสร้างความเข้มแข็งด้านความช่วยเหลือตนเองและช่วยเหลือซึ่งกันและกันในระบบการดูแลแบบบูรณาการในชุมชนของประเทศญี่ปุ่นตามนโยบายสุขภาพของประเทศไทยสำหรับผู้สูงอายุ ว. สาธารณสุขและการพัฒนา 2562;17(2):116-129

ความชราเป็นปัญหาระดับโลกไม่แต่เฉพาะในประเทศที่พัฒนาแล้ว รัฐบาลของประเทศที่พัฒนาแล้วและประเทศกำลังพัฒนาต่อสู้กับภาระทางการเงินของประชากรสูงอายุ รัฐบาลญี่ปุ่นกำลังใช้ระบบการดูแลแบบบูรณาการสำหรับผู้สูงอายุในการให้บริการช่วยเหลือที่ครบวงจรในชุมชน ระบบนี้เสนอองค์ประกอบสี่ประการ การช่วยเหลือตนเอง การช่วยเหลือซึ่งกันและกัน การดูแลความเป็นปึกแผ่นทางสังคม และการดูแลของรัฐบาล การช่วยเหลือตนเองและการช่วยเหลือซึ่งกันและกันนั้นคาดว่าจะได้รับการเสริมสร้างความเข้มแข็งสำหรับการดำเนินนโยบายที่ประสบความสำเร็จ ประเทศไทยซึ่งมีอัตราการชราภาพสูงที่สุดในเอเชียตะวันออกเฉียงใต้ซึ่งมีระบบที่ประสบความสำเร็จบนพื้นฐานของการสาธารณสุขมูลฐาน ผู้เขียนได้อภิปรายแนวคิดจากนโยบายสุขภาพของไทยสำหรับผู้สูงอายุในการรับมือกับความท้าทายในระบบของญี่ปุ่น สำหรับการเก็บรวบรวมข้อมูลผู้เขียนได้ดำเนินการทบทวนเอกสารที่เกี่ยวข้องและยังได้สัมภาษณ์เจ้าหน้าที่จากกระทรวงที่เกี่ยวข้องเพื่อตรวจสอบความถูกต้องของหลักฐานการเสริมสร้างความเข้มแข็งด้านการช่วยเหลือตนเองและช่วยเหลือซึ่งกันและกันแบบบูรณาการในชุมชนของญี่ปุ่น ยุทธศาสตร์ระดับชาติได้ครอบคลุมปัญหาด้านความชราภาพ แผนระดับชาติฉบับที่สองสำหรับผู้สูงอายุไทยมุ่งเน้นไปที่บริการการดูแลในชุมชนตามแนวคิดของสาธารณสุขมูลฐาน และพยายามนำไปใช้อย่างครอบคลุมพร้อมกับกระทรวงต่างๆ

ปัจจัยที่ส่งเสริมการดำเนินการตามนโยบายด้านสุขภาพของผู้สูงอายุไทย ได้แก่ การกระจายอำนาจและบทบาทของรัฐบาลที่ชัดเจนและเหมาะสม การกระจายอำนาจและอำนาจของรัฐบาลท้องถิ่น การเตรียมการล่วงหน้า การเสริมพลังและสนับสนุนกิจกรรมการป้องกันโรคในชุมชน ระบบการประเมิน บนพื้นฐานการใช้หลักฐาน เหมาะสำหรับแนวคิดระดับโลกและปัญหาระดับชาติ การมีส่วนร่วมของผู้มีส่วนได้เสีย และวิธีแก้ปัญหาการกระจายตัว

ผลการวิจัยชี้ให้เห็นว่านโยบายสุขภาพของไทยสำหรับผู้สูงอายุนั้นโดดเด่นด้วยรัฐบาลกลางที่เข้มแข็งโดยให้ความสำคัญกับความเป็นอยู่ที่ดีและการป้องกันโรคและการมีส่วนร่วมของหลายกระทรวง ระบบการดูแลแบบบูรณาการสำหรับผู้สูงอายุของรัฐบาลญี่ปุ่นจะสามารถให้บริการที่มีประสิทธิภาพมากขึ้นเมื่อกิจกรรมชุมชนได้นำการดูแลผู้สูงอายุในชุมชนของประเทศไทยมาประยุกต์ใช้ด้วย กระทรวงที่เกี่ยวข้องควรบูรณาการเข้าด้วยกันมากขึ้นเพื่อให้การบริการที่ดีขึ้น และแนวคิดด้านการสาธารณสุขมูลฐานของญี่ปุ่นควรได้รับการพิจารณาทบทวนใหม่เพื่อการประยุกต์ใช้กับสถานการณ์ที่แปลก แตกต่างออกไป

คำสำคัญ: ความชรา การดูแลระยะยาว การสาธารณสุขมูลฐาน หลักประกันสุขภาพถ้วนหน้า

Introduction

Japan is the world's most aged society, with 27.7% of the population aged over 65 years in 2017.[1] The main cause for the increasing population aging is attributed to the low death rate due to improved living standards, advanced medical care, and low birth rates.[2] Aging populations in Southeast Asian high-income countries such as Singapore are similar, but rapid aging is occurring even in low- and middle- income countries such as Thailand and Vietnam due to the same reasons. By 2050, the number of individuals above the age of 80 years is expected to double worldwide, and one quarter to one half of them will need long-term care (LTC) due to their reduced functional and cognitive capabilities.[3] The cost of LTC for the gross domestic product worldwide is also estimated to double by 2050.[3] Thus, most countries are facing an increasing need for human resources and funding to deliver appropriate services to the elderly.

Japan achieved universal health insurance coverage in 1961, when the proportion of the elderly population requiring massive medical care services was only 5.7%.[4] Free medical services for the elderly population were introduced; however, elderly persons are required to pay for medical treatment in the present super-aged society, while the national health insurance covers the residual costs.[5] In 2000, the LTC insurance system was implemented to cover elderly LTC and welfare services, which did not cover medical services. At that time, the introduction of formal home care services for daily living for elderly people in Japan lagged behind that in other high-income countries[6] and so the LTC insurance system greatly contributed to the socialization of care for the elderly. The Japanese government started implementing the Community-based Integrated Care System (CbICS) as a new care structure in 2012. The primary aim of the CbICS is to develop comprehensive services for elderly persons within their communities for supporting independent living and preserving their dignity until the end of life.[7] The coordination and integration of clinical care and welfare services are promoted by entrusting the responsibility to municipalities and establishing strong regional autonomy. The CbICS comprises four main elements: self-help (Ji-jo) engaged in by the individual and/or provided by their family, mutual aid (Go-jo) provided through an informal network of local health volunteers, social solidarity care (Kyo-jo) provided by organized social security programs such as LTC insurance, and government care (Ko-jo) provided by public medical and welfare services or public assistance funded by tax revenues (Figure 1).[7]

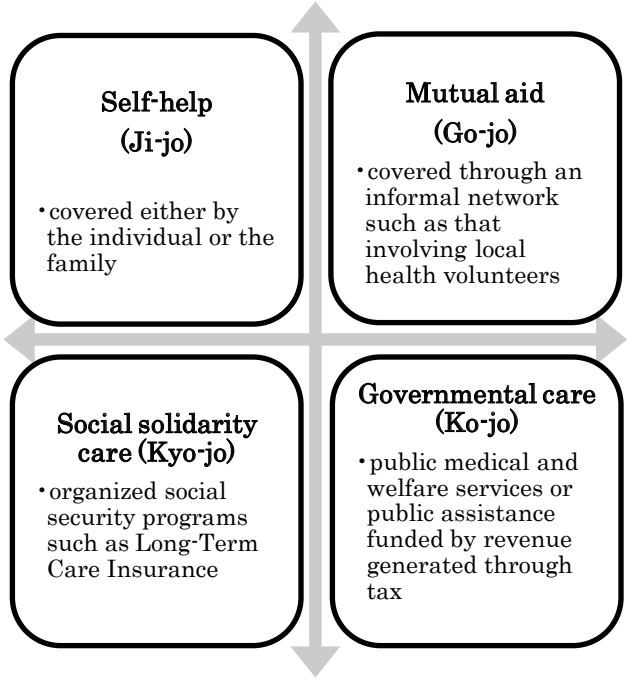

Figure 1 The conceptual four-part framework of Community- based Integrated Care System

A previous study showed that the CbICS faces three main challenges: accountability for financial benefits, interaction between the four CbICS elements, and CbICS applicability to communities.[8] In the CbICS, LTC insurance covers a part of social solidarity care, including services delivered both at home and in facilities, which are mainly welfare service facilities for the elderly population. The LTC insurance has helped to free families from providing home care for their elderly;[9] however, it simultaneously distinguished between welfare and medical costs and often hindered the integrated and continuous provision of medical and welfare services, which is the most important aim of the CbICS. This paradox is a pivotal point to be considered when addressing the challenges of the CbICS. Moreover, 50% of LTC insurance is funded by taxes.[5] The expenditure on social security in Japan is continuously increasing, with that on medical, LTC, and welfare services increasing by 1.5 trillion yen on average per year from 2000.[10] When the four elements of CbICS are analyzed in a financial context, self-help and mutual aid are expected to reduce the cost of elderly care for the government. However, evidence that self-help and mutual aid actually reduce medical and welfare costs has hardly been provided.[11] Nevertheless, self-help and mutual aid are crucial healthcare resources for community-dwelling elderly people,[12-13] and some evidence for this has been produced in Japan.[14-16] Activities to preserve or promote physical and cognitive functions of elderly persons are emphasized in the CbICS, which rely on self-help and mutual aid, while the LTC insurance does not pay much attention to preventive activities. Self-help and mutual aid in

the CbICS must be effectively implemented to reduce the burden of diseases, disabilities, and costs. These explanations suggest ways to address the challenges of accountability for financial benefits and interaction between the four CbICS elements. However, ideas from a different perspective are needed to address the issue of applicability of the CbICS to communities. The authors focused on the Thai health policy for the elderly.

Thailand is one of the countries with the highest aging rate in Southeast Asia,[17] and aging issues emerge as a priority in the national policy. Thai government formulated the first National Plan for Older Persons (1982-2001) influenced by the "Vienna Plan" endorsed by the United Nations General Assembly in 1982.[18] It has been amended into the second National Plan on The Elderly (2002-2021)[19] following the change in the social environment indicated in the amendment of Constitution of the Kingdom of Thailand and reorganization of the government.[18] Thai health policies are based on Primary Health Care (PHC) and appreciated for improving health conditions dramatically with the deployment of health volunteers since 1977 when the 4th National Health Development Plan was launched.[20] The public hospitals under the Ministry of Public Health (MOPH) deliver the medical care and ease of access to health through the community. Public hospitals also encourage medical care especially for the elderly people and prevention of non-communicable diseases. The Thai government has been promoting community-based care including home care across the country, and local governments have also aimed to financially support community caregivers to care for the elderly at home. This could be a reason why the Thai health policy for the elderly population relies on PHC. Moreover, they started providing the LTC program for the elderly people relying on their family.[21] There is no separation between medical and welfare due to existed comprehensive community-based care system. Community-based care makes be possible to deliver continuous care services for elderly people because PHC led by the health policy has been spreading in Thailand. Thai health policy for elderly is distinguished from that in Japan, which has developed institution-based care for elderly. The lessons learned from the community contributions to elderly care in Thailand may help to promote self-help and mutual aid in the CbICS in Japan.

The authors aimed to identify the characteristics of the Thai health policy for the elderly and the promoting factors affecting it. In this article, ideas to strengthen self-help and mutual aid in Japan's CbICS were discussed based on concepts from the Thai health policy for the elderly. This discussion may generate possible options not only for Japan but also for low- and middle-income countries dealing with aging in the future.

Methods

This study was part of an international comparative study between China, Indonesia, Japan, Philippines, South Korea, and Thailand on health policies for the elderly.[22] A research group with several countries was formed and a researcher represented each country. To clarify the health policy for the elderly in each country, the relevant policies, strategies, regulations, and decrees were reviewed.

The represented target documents in Thailand were the second National Plan on The Elderly,[19] the twelfth National Economic and Social Development

Plan,[23] The Act on the Elderly, B.E. 2546 (2003 A.D.),[24] the Constitution of the Kingdom of Thailand, and its official data,[25-29] and research sites[30-32] were used for supplementary information. Interviews with leading policymakers for elderly care were conducted to verify the researchers' ideas to strengthen self-help and mutual aid in the CbICS in Japan based on the findings of document reviews of Thai health policy for elderly. Two officers of MOPH and Ministry of Social Development and Human Security (MSDHS) were also interviewed individually in September 2017 and January 2018, respectively. The interviews involved semi-structured questions based on the Policy Implementation Assessment Tool,[33] including items such as "How extensive was the involvement of stakeholders during the process of formulating the policy?", "What have been the positive changes/barriers related to service delivery?", and "How well do you think the policy is being implemented?" The target policy for the interview was the second National Plan on The Elderly.[19] Interview data were analyzed using MAXQDA.[34] Meaningful sentences regarding factors promoting the implementation of the health policy for the elderly in Thailand were extracted as codes from the transcripts of audio data and categorized by similarity. Trustworthy and credible results were obtained through continuous discussions to achieve a consensus between independent researchers. The study was approved by the Ethical Review Committee of the National Center for Global Health and Medicine (NCGM-G-002136-00).

Results

Health policy for the elderly in Thailand

Aging issues had been influenced by the National Economic and Social Development Plan as a national strategy.[23, 35-37] The Ninth National Economic and Social Development Plan had commenced when the second National Plan on The Elderly (2002-2021) had launched. The nation had faced the challenge of eradicating poverty and solving the economic gap at that time. In 2009, when it seemed to be in the end stage of completing this challenge, the second plan was revised according to the tenth National Economic and Social Development Plan that aimed to achieve "Green and Happiness Society". In the twelfth National Economic and Social Development Plan, four objectives were shown in Strategy 1, Strengthening and Realizing the Potential of Human Capital: to (1) transform people in the Thai society to enhance the acquisition of values that are deemed acceptable by social norms, (2) prepare the Thai people of all ages to acquire the skills needed for a suitable quality life in the 21st Century world, (3) promote the lifelong well-being of the Thai people, and (4) promote and strengthen social institutions to serve as foundations for both the country and human capital development. Aging issues became a high priority for developing a national strategy, and so the second National Plan on The Elderly was its complementary plan.

The first National Plan for Older Persons (1982-2001), which the Thai government initially formulated, had focused on emphasizing dedicated co-residence of elderly people and their families, and the promotion of social support for them. It was amended into the second plan with an increased focus on well-being and community-based comprehensive care service for

the elderly. According to the objectives of the plan (Table 1), the necessity to involve the community as a support resource was found. The second plan has focused more on lifelong health and the "Healthy Thailand" plan was announced in 2005.

To achieve comprehensive implementation of the plan, it has been implemented by both the local administrative offices and hospitals in such level as the provincial, district, Tambon (sub-district), and village throughout the county under the supervision of MOPH, MSDHS, Ministry of Interior (MOI), and Ministry of Education (MOE).[38] The plan exactly defined the role of each ministry; especially, medical treatment and LTC was assigned to the MOPH, LTC to the MADHS, forming "elderly club" to the MOI, and "elderly school" to the MOE.

Factors promoting the implementation of Thai health policy for the elderly

The factors promoting the implementation of the Thai health policy for the elderly were extracted from the key informant interviews (Table 2), categorized as follows: "Clear and adequate government role distribution," "Decentralization and authority of local governments," "Earlier preparation," "Empowerment and encouragement of preventive activities in the community," "Evaluation system," "Evidence-based," "Fit for global concepts and national issues," "Involvement of stakeholders," and "Solutions to fragmentation."

"Clear and adequate government role distribution" indicated the role of the central government that was effective in promoting the policy. The central government distributed roles between several ministries in charge of age-related issues because the plan involved several aspects of aging.

"Decentralization and authority of local governments" was recognized to help increase individuals' participation. Old-age allowance included in this category indicated one of the features of decentralization as this was managed locally, which is that local governments were independent because of an appropriate distribution of revenue.

"Earlier preparation" was a consequence of officers' consideration of the financial limitations of the government to deal with aging and aging speed.

"Empowerment and encouragement of preventive activities in the community" refers to daily activities in the community for elderly people, rather than clinical treatment. Especially, the plan recommended preventive activities in the community: "We try to encourage "elderly club" to give more opportunities of reemployment for older people because workplaces or small enterprises in the community can provide them with more friends and more social life with colleagues"; "Elderly schools offer some health and social activities, they are very popular. We, the department for older people, provide technical support and conduct useful training."

"Evaluation system" refers to a system managed mostly by the central power, which was paramount to implement the plan.

"Evidence-based" practice was recognized as necessary in an aging society, as shown in the following quote: "The plan must be grounded on geriatrics and gerontology concepts as well as new knowledge and innovation."

"Fit for global concepts and national issues" refers to Thailand's international commitment and plan regarding global aging, which have helped to

Table 1 Objectives of the Thai health policy for the elderly

1. To encourage the elderly well-being where they can lead their life as an asset to the society with their dignity and individual independence and autonomy under the reliable security.
2. To raise social conscience on the respect for and recognition of the elderly valuable contribution to the society whereby their valuable experience shall be promoted as longest possible.
3. To raise all people's awareness regarding the necessity for readiness preparation for their quality ageing.
4. To encourage the people, family, community, local, public and private sectors to realize and take part in the actions involving the elderly.
5. To formulate the frameworks and guidelines for good practice on the elderly for all concerned parties to observe aiming at an integral and comprehensive implementation on the elderly missions.

Table 2 Factors promoting implementation of Thai health policy for the elderly perceived by policymakers

Clear and adequate government role distribution · *Each Ministry invites their municipalities to join the plan and we let them focus more on new activities for older people.* · *Clarify the role of central, regional, and local governmental functions.* · *After establishing the Bureau for empowerment of older people under the Ministry of Social Development and Human Security, the plan for the elderly was transferred from the Prime Minister Office to the Bureau.*
Decentralization and authority of local governments · *Empowerment of local governments such as municipalities and sub-district Administration Organizations and decentralization results in a higher quality of participation of individuals in the community.* · *According to the Act, every municipality has to pay an old age allowance called social pension, so all municipalities in Thailand have the chance to be in charge of all Thai people who are over 60 years of age.*

Table 2 Factors promoting implementation of Thai health policy for the elderly perceived by policymakers (cont.)

Earlier preparation · *The government thinks that older people consume a large amount of the healthcare budget.* · *The national plan initiated in 2001 has not kept pace with the current rate of population aging and people's needs. Measures and action plans should deal with the frail elderly, functional limitations caused by geriatric syndromes, and their future burdens.*
Empowerment and encouragement of preventive activities in the community · *We try to encourage the elderly clubs to give more opportunities of reemployment for older people because workplaces or small enterprises in the community can provide them with more friends and more social life with colleagues* · *Elderly schools offer some health and social activities; they are very popular. We, the department for older people, provide technical support and conduct useful training.* · *Regional and local parties should work together for different needs of older people in practice using people's resilience and participation to achieve a truly community-based service.* · *Elderly centers can be community places to encourage their participation and make them more likely to enjoy their time during the day. We assign those voluntary caregivers to take them out and engage them in more activities.*
Evaluation system · *Central parts should exercise national authority and conduct standard monitoring and evaluation, academic and technical support, and data and resource management.* · *The monitoring and evaluation system is really important in the planning cycle to identify achievements, and gaps or failures in the plan that prevent achieving the objectives. Then we can re-plan again in order to solve the problem.*
Evidence-based · *The plan must be grounded on geriatrics and gerontology concepts as well as new knowledge and innovation.* · *We have enough information by using situation analysis before making a plan.*
Fit for global concepts and national issues · *International commitment and globalization influence people's needs regarding care standards and quality of life; policy is implemented powerfully to facilitate an increase in people's awareness.* · *The key area of the plan has already been responding to the international plan of action on aging that includes development, health and wellness, supportive environment, and follow up and monitoring systems.*

Table 2 Factors promoting implementation of Thai health policy for the elderly perceived by policymakers (cont.)

Involvement of stakeholders · *The policy should be monitored and evaluated by the outer sector as a third party.* · *The cabinet is composed of all ministers from all ministries and they fill each role. All ministers have to collaborate and correspond in the 5-year cycle to monitor the plan. We ask them to report what advancements have been made according to the measures and they respond during the monitoring process.* · *We have a lot more collaboration and work with our related stakeholders because aging is not a single issue to be managed by one ministry; we need more involvement and participation of stakeholders.*
Solutions to fragmentation · *The Ministry of Labor, Ministry of Social Development and Human Security, and Ministry of Public Health are separate, but the three ministries are working on the aging issue. We have a focal point to seek more than health, more than labor, so we need more help and involvement from each other. We need support from the Ministry of Interior in controlling municipalities to contribute more to the community.* · *They actually are multi-factorial, but the main barriers would be in administration systems and ineffective decentralization, while the situation is gradually better regarding the strong encouragement from policy-makers. The effectual participation of relevant stakeholders needs to be accentuated.*

increase individuals' awareness.

"Involvement of stakeholders" was similar to "Solutions to fragmentation," but referred to ministries and outer sectors such as non-governmental organization and private company to implement the policy.

"Solutions to fragmentation" was an issue perceived by officers and involved increased mutual help among, involvement of, and effectual participation by ministries while maintaining a "Clear and adequate government role distribution" as mentioned above.

Discussion

Characteristics of the Thai health policy for the elderly compared with Japan

The Thai health policy for the elderly was affected by the national strategy and strongly led by the central government. It is supported by the factor "Clear and adequate government role distribution" wherein aging issues have come to be handled by the central government. "Evaluation system" extracted from officers' views also indicates the government's role to conduct and manage monitoring and evaluation system clearly. Governance in Thailand is explained such that Government effectiveness and Regulatory

quality are comparatively high as shown in six Aggregated Governance Indicators by the World Bank.[39] Government effectiveness is reflected in the perceptions of the quality of public services, quality of the civil service and degree of its independence from political pressures, quality of policy formulation and implementation, and credibility of the government's commitment to such policies.[40] Regulatory quality captures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.[40] From this point of view, the Thai health policy for the elderly suggests being organized and managed well, led by the government. On the other hand, the factor "Decentralization and authority of local governments" was indicated as Thai's challenge of achieving health policy for the elderly. Japan's CbICS aimed to develop comprehensive support and services for the elderly within their communities, so the accountability by municipalities and strong regional autonomy is required. Decentralization may be one of the keys for elderly health care policy because both countries face the same challenge.

The Thai health policy for its elderly population focused more on well-being and prevention of diseases. Respect for elderly people has existed in Thai culture based on Buddhism.[41] Nevertheless, the factor "Fit for global concepts and national issues" showed the change in the Thai social environment following the global trend. Focusing on well-being and the prevention of diseases at this time reflects the nation's awareness that enabling elderly people's functioning is beneficial to society. Hence, "Earlier preparation," "Empowerment and encouragement of preventive activities in the community," and "Evidence-based" were extracted as factors promoting the implementation of Thai health policy for the elderly. The factor "Empowerment and encouragement of preventive activities in the community," especially fit to Japan's CbICS, was designed to lead by community-based. Thai's PHC experience helps to improve "Empowerment and encouragement of preventive activities in the community" in the elderly health policy.

The Thai health policy for the elderly is indicated a comprehensive policy that involves multiple ministries to implement and manage the policy. Community-based services focusing not only health but also daily activities were also characterized. Both points imply that the policy focuses more on well-being and the prevention of diseases as mentioned above. In case of Japan, the Ministry of Health, Labour and Welfare (MHLW) primarily considers aging issues to revolve around medical treatment and LTC; that is, it is difficult to capture the full scope of aging issues with only these ministries in Japan. In Thailand, MOH, MSDHS, MOI, and MOE were quoted as stakeholders of health policy for the elderly, which differs clearly from Japan's situation. Moreover, the integration of clinical care and welfare such as Japan's concept of integration, which is the most important to achieve CbICS, was not extracted as a factor promoting the implementation of the policy in Thailand. The result, which requires integration between medical and welfare services did not appear to promote implementing the health policy for the elderly, supports that the continuous care services for elderly people have been delivered.

Ideas to strengthen self-help and mutual aid in the Japan's CbICS

First, the MHLW of Japan centralizes its services in the CbICS, but service resources are not clearly stated. On the contrary, Thailand's approach invites relevant ministries to manage a "community-based" and "integrated" system despite the current challenges of decentralization and fragmentation. Japan's CbICS will not manage the preservation or promotion of the physical and cognitive functions of the elderly by relying on self-help and mutual aid without further involvement of several ministries.

Secondly, in the Thai healthcare context, health and welfare are not separated in service delivery. This indicates that the Thai health policy for the elderly population aims to meet healthcare and welfare needs, which emerge continuously in the natural course of life in communities. The PHC concept is also reasonable because it is based on the community's needs without separation between medical and welfare services under the idea of an "integrated" system.

Finally, the concept of PHC based on the Thai health policy for the elderly is surely "community-based," since it relies on community activities including elderly club activities. The "community-based" approach in the Thai health policy for the elderly can fit self-help and mutual aid in the CbICS, as it widely covers preventive activities in daily life.

Recommendations

Japan's CbICS could provide more effective services when community activities are adopted reflecting Thailand's community-based elderly care. The authors suggest strengthening self-help and mutual aid in the CbICS, greater integration among relevant ministries for better service provision, and that Japan's PHC concept be reconsidered for application to Japan's peculiar situation.

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