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ORIGINAL ARTICLE

The development of community care model of sub-district health promoting hospitals for older persons

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Abstract

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Thai government is improving public health service systems for better quality and efficiency by upgrading health centers to sub-district health promoting hospitals (SHPH). Healthcare service for older persons must be holistic service combining services for consistency with the needs and problems faced by older persons. This study aimed to investigate community care models of SHPH for older persons in order to manage and provide sustainable care for older persons by using limited resources with quality.

The study was using design as mixed method. Quantitative data were obtained via questionnaire from 104 healthcare providers for older persons of each SHPH who had worked more than one year and were selected by stratified sampling from all thirteen districts of Kanchanaburi Province.The qualitative data were collected from four focus groups of purposive key informants. Data analysis used descriptive statistics and content analysis. The model was examined by a consensus of persons involved in the local public hearing.

The results revealed the model called the community care model"SHPH for Older Persons" consist of collaborative work by four organizations from the government sector with agencies responsible for providing care for older persons. Every sector must set six strategies and ten factors of success to support SHPH operations in order to provide holistic care for every older persons. The importance of care, family members and communities must be willing to volunteer and participate in providing community care for older persons.

The results suggest that The government should set policies and support SHPH, local administrative organizations including related agencies to build community strength in providing care for older persons by developing the knowledge of community leaders, enhancing volunteer capacity, enable linkages in the work of every sector to arrange strong elderly service systems in communities.

Keywords: Community care model, older persons, sub-district health promoting hospitals

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การพัฒนารูปแบบการดูแลผู้สูงอายุในชุมชนของโรงพยาบาลส่งเสริมสุขภาพตำบล

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บทคัดย่อ

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รัฐบาลไทยดำเนินการปรับปรุงระบบบริการสาธารณสุขให้มีคุณภาพและประสิทธิภาพ โดยยกระดับสถานีอนามัยเป็นโรงพยาบาลส่งเสริมสุขภาพตำบล (รพ.สต.) การให้บริการผู้สูงอายุต้องเป็นการให้บริการแบบองค์รวมที่มีการผสมผสานการบริการสอดคล้องกับความต้องการและปัญหาของผู้สูงอายุ ปัจจุบันการดูแลผู้สูงอายุดังกล่าว ถือเป็นความรับผิดชอบหลักของ รพ.สต. ดังนั้น ผู้วิจัยจึงสนใจศึกษารูปแบบการดูแลผู้สูงอายุในชุมชนของ รพ.สต. เพื่อให้ได้รูปแบบการบริหารจัดการและให้บริการผู้สูงอายุที่ยั่งยืน โดยใช้ทรัพยากรที่มีอยู่อย่างจำกัดได้อย่างมีคุณภาพ

ลักษณะการวิจัยเป็นการวิจัยและพัฒนาโดยผสมผสาน ทั้งวิธีเชิงปริมาณและเชิงคุณภาพ ข้อมูลเชิงปริมาณโดยใช้แบบสอบถามเก็บจากกลุ่มผู้รับผิดชอบให้บริการดูแลสุขภาพผู้สูงอายุของ รพ.สต. 104 คน จาก 13 อำเภอ จังหวัดกาญจนบุรี แห่งละ 1 คน ซึ่งปฏิบัติงานใน รพ.สต.มากกว่า 1 ปี ข้อมูลเชิงคุณภาพเก็บโดยวิธีจากการสนทนากลุ่มแบบเจาะจงกับ 4 กลุ่ม วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนาและการวิเคราะห์เนื้อหา

ผลการวิจัย พบว่า รูปแบบการดูแลในชุมชน “รพ.สต.เพื่อผู้สูงอายุ” ประกอบด้วยการทำงานร่วมกัน 4 หน่วยงานที่รับผิดชอบดูแลผู้สูงอายุ โดยทุกภาคส่วนต้องกำหนดกลยุทธ์ 6 ด้าน และปัจจัยแห่งความสำเร็จ 10 ประการ เพื่อสนับสนุนการดำเนินการในการดูแลผู้สูงอายุในชุมชน สิ่งสำคัญในการดูแล คือ คนในครอบครัวของผู้สูงอายุและประชาชนในพื้นที่ ต้องมีจิตอาสาและมีส่วนร่วมในการดูแลผู้สูงอายุในชุมชน

ดังนั้น รัฐควรกำหนดนโยบายและสนับสนุนให้องค์กรปกครองส่วนท้องถิ่น หน่วยงานที่เกี่ยวข้อง และรพ.สต. สร้างความเข้มแข็งให้แก่ชุมชนในการดูแลผู้สูงอายุ โดยพัฒนาความรู้ของผู้นำชุมชน ส่งเสริมศักยภาพในด้านจิตอาสา เชื่อมโยงการทำงานทุกภาคส่วน เพื่อจัดระบบการบริการที่เข้มแข็งในชุมชน

คำสำคัญ: รูปแบบการดูแลในชุมชน ผู้สูงอายุ โรงพยาบาลส่งเสริมสุขภาพตำบล

Introduction

Thailand has been rapidly transforming into an aging society since 2005. According to statistics, the older population in 2010 accounted for 8.0 million people or 11.9% of the national population comprising 67.3 million people whereby males have a mean age of 69.5 years and females have a mean age of 76.3 years[1], this figure is expected to increase to 16.1% and 19.8% of total population by 2020 and 2025[2]. In 2010, the number of newborn infants and children has been continually dropping, thereby resulting in a continually increasing rate of burdens created by the older population in comparison to the working age population. Dependency ratio among older persons have increased. One older person was cared for by six people of working age. Over the next twenty years (2010-2030), one older person will be cared for by only two people of working age1. Furthermore, many older persons are confronted with a number of problems in living with health problems caused by risk factors from the lowest to the highest levels, resulting in chronic illness or disability with economic and social problems. The government's current ageing policies encourage older persons to remain at home, allowing residential care to only the most frail and disabled[3,4]. Hence, older persons are living in poverty with escalating rising trends marked by living alone with self-reliance. However, most of them have had responsibility of their health by frequently observed and concerned their own health problem so they practice daily activity for promoting their good health and consult with practitioners and health volunteer immediately when they observed their health problems[5,6].

These conditions have prompted Thailand to raise awareness and preparations for the care of the older person population group. Health facilities in the public sector play an important role in health system to provide health services with good accessibility and coverage to the people in all localities[7]. The government is improving public health service systems for better quality and efficiency by upgrading health centers to be sub-district health promoting hospitals (SHPH),in order to convert defensive healthcare service to aggressive operations emphasizing health promotion, health risk factor management, disease control and prevention at the individual, family and community levels with diagnosis, preliminary treatments, rehabilitation, home health care, follow-up on treatment outcomes, refers in the system, coordination of necessary resources and empowerment of the public, communities, local administrations and related government and private parties to strongly participate in SHPH operations. Therefore, healthcare service for older persons of SHPH emphasizes in health promotion by enabling the older to perform daily activities as much as possible, enhance individual capacities, access to service systems and decreasing disabilities with the prevention and promotion of psychological, social and spiritual wholeness while building security in life, perceived self-value and pride leading to good quality of life for older persons[8].

The aforementioned healthcare service for older persons must be holistic service and combining services for consistency with the needs and problems faced by older persons in line with capabilities in performing duties, symptoms and existing illnesses divided into three main groups namely, the well-being, home bound and bed bound older persons requiring complex

care[9,10]. Hence, SHPH have been delegated the task of providing services for older persons to meet the following standards[8].

According to the literature concerning older person healthcare service models of SHPH, long-term community care system arrangements for older persons by various countries lacked emphasis on the true value of community care, service integration and insufficient resources[11]. Healthcare services are also lack of specific service systems, long-term and chronic care for older persons, healthcare services offer insufficient coverage and some older persons are unable to access healthcare services while private sector, government sector and communities are less cooperation in the care of older persons where family care trends are losing quality with a shortage of caregivers in the future[12]. SHPH staff must be the center of work with direct duties in providing basic care, planning and providing holistic care to prepare older persons for good health and quality together with joint mechanisms for working with networks at each level[13]. Furthermore, SHPH should be age-friendly services by having generous providers with good attitudes, knowledge and skills, generous service systems with service units using systematic processes covering the goals of every older person group and generous environments offering safety, accessibility and attention in service units, communities and homes[14]. Community-Based Care for Older Persons obviously continues to encounter problems in terms of management, healthcare service, resources, knowledge and care skills. At present, the care of the aforementioned older persons is the main responsibility of SHPH. Therefore, the researcher is interested in investigating community care models of SHPH for older persons in order to obtain clear healthcare service models capable of meeting the expectations of all healthcare provider of SHPH and clients must be able to manage and provide sustainable care for older persons by using limited resources with good quality.

Methods

Design: This study comprised research with mixed quantitative and qualitative methods.

Ethical Considerations: This study was certified for human research ethics by the Human Research Ethics Committee, Social Sciences, Mahidol University, Project Code: MUSSIRB 2012/261.2008 on 20 August 2012. The researcher explained the details of the research project to every research participant who were able to withdraw from participation in the research at any time without requiring advanced notification and with no negative effects on performance or service reception.

Sample: The population from three level of SHPH and the sample group size table of Krejcie and Morgan[15], the 104 quantitative samples were selected by stratified sampling from healthcare providers for older persons of each SHPH in all thirteen districts of Kanchanaburi Province who had worked more than one year. The qualitative samples were purposive sampling from two district areas (Wangsala and Nong Tak Ya) consisting of representatives from District Public Health Offices, SHPH administrators or professional nurses, municipality or sub-district administrative organization chairmen, community development personnel, community leaders, village

health volunteers and health care volunteers along with client groups comprising older persons, caregivers and older person leaders, etc.

Instruments: Two instruments were used for data collection. The quantitative instrument consisted of demographic data and healthcare service conditions of SHPH questionnaire in one set created by the researcher from the review of related documents, theories and researches. The questionnaire was tested for content validity by a panel of three qualified experts (CVI=0.86).

The degree of satisfaction towards service quality of front office personnel is set from 1 to 5 (5 is from the highest expectation/satisfaction, whereas, 1 is the lowest expectation/satisfaction)[16] The reliability was tested in thirty SHPH in Nakhon Pathom Provice and analyzed by calculating Cronbach's Alpha Coefficient (α =0.86).

The qualitative instruments were specified main questions in focus groups by researcher consisting of organizations or agencies with roles to help/support Community-Based Care for Older Persons, work integration, persons who successfully provided care for older persons, significant characteristics of persons who worked to care for older persons, important strategies, expectations of healthcare providers and clients, care models, existing problems and recommendations, guidelines and factors in successfully caring, etc.

Procedure: The researcher collected quantitative data by mail in October of 2012 and qualitative data by focus groups in the field using a period of 1.30 – 2 hours to discuss with each group. Audio recordings were made, result of discussion speaking and tapes were immediately removed after data analysis.

Data Analysis: Descriptive statistics were used to analyze demographic data and calculated mean scores of healthcare service conditions according to specified mean value levels such as 3.68-5.00 at high levels, 2.34-3.67 at moderate levels and 1.00-2.33 at low levels. The qualitative data was analyzed by content analysis. The researcher synthesized community care model of SHPH for older persons from quantitative and qualitative data and the model obtained was examined by a consensus of persons involved in the local public stages.

Results

Demographic Data: Most of the personnel in SHPH were public health officials (34.4%). Most of the SHPH were under the jurisdiction of district public health offices (55.3%), followed by hospitals under the responsibility local administrative organizations (33.0%). Concerning the responsibility for providing older person care, most of the older persons were found to be in the group entering older person hood aged 50-59 years (47.9%), followed by the 60-69 year age group (28.6%), the 70-79 year age group (16.2%) and the group aged eighty years and up (7.2%). Most of the respondents were in the high self-dependence group (80.4%), the moderate self-dependence group (12.9%) and the dependent/bed bound group (6.5%). Most of the caregivers of older persons were found to be relatives or primary caregivers (56.9%), followed by public health volunteers (27.2%) and older person care volunteers (15.7%).

Older Person Healthcare Service Conditions: From an overview perspective, SHPH offering older

person healthcare services in various category were found to be at moderate levels similar to one another ($\overline{X}$ 3.00-3.25, SD 0.63-1.05) according to category 4 Health Promotion and Disease Prevention having the highest mean value in a moderate level ($\overline{X}$ 3.25, SD 0.85). When the details of each healthcare service section were considered, according to category1 Sub-district Health Promoting Hospital Service on the topic of services in searching for abandoned disabled persons/persons in poverty/persons without opportunities who were left alone had the highest mean value at a high level ($\overline{X}$ 3.82, SD 0.95), according to category 2 – Older Person Family/Community Service on the topic of providing services in support of establishing older person clubs had the highest mean value at a moderate level ($\overline{X}$ 3.62, SD 1.21) while the topic of respite care to replace primary caregivers had the lowest mean value at a low level ($\overline{X}$ 2.26, SD 1.18), according to category 3 Refer of Older Persons with Problems on the topic of referring for recovery to achieve goals had the highest mean value in a moderate level ($\overline{X}$ 3.22, SD 1.14) and Section 4 – Health Promotion and Disease Prevention on the topic of providing mental health observation services and mental health problem consultation services for older persons had the highest mean value at a moderate level ($\overline{X}$ 3.49, SD 0.85).

Table 1 Mean, Standard deviation of Older Person Healthcare Service Conditions

Variables	healthcare services		Level of healthcare services
	$\overline{X}$	SD	
Older Person Healthcare Service Conditions (over all)	**3.13**	**0.69**	**moderate**
Category 1 Sub-district Health Promoting Hospital Service	**3.18**	**0.63**	**moderate**
1. Follow through on recommendations of Ministry of Health handbook of the health promoting for older person	3.36	0.63	moderate
2. Provide older person care giving volunteers database to classify dependent older person and care giving volunteers	3.63	0.76	moderate
3. Survey disabled persons, poverty persons, vulnerable people and living alone	3.82	0.95	moderate
4. Provide counseling team for community network and older person	2.83	0.98	moderate
5. Provide evaluation system to evaluate health care services every 3-6 month, Gantt Chart	3.10	0.98	moderate
6. Provide medical equipment and Prosthesis and Orthosis	2.78	0.99	moderate
7. Contracting Unit for Primary Care for older person care center	2.73	1.27	moderate

Table 1 Mean, Standard deviation of Older Person Healthcare Service Conditions (Cont.)

Variables	healthcare services		Level of healthcare services
	$\bar{X}$	SD	
Older Person Healthcare Service Conditions (over all)	**3.13**	**0.69**	**moderate**
Category 1 Sub-district Health Promoting Hospital Service	**3.18**	**0.63**	**moderate**
8. Training course for older person care giving volunteers and Public mind volunteers	2.73 3.36	1.27 1.10	moderate moderate
9. SHPH Center for training and education for medical personnel older person care giving volunteers, and public mind volunteers	3.10	1.31	moderate
10. Developing Home Health Care, Home visit, Home ward	3.12	0.95	moderate
Category 2 Older Person Family/Community Service	**3.00**	**0.82**	**moderate**
11. Screening older person according indicator of National Health Security Office by medical personnel and village health volunteer	3.21	1.05	moderate
12. Analysis data	3.04	0.96	moderate
13. Set up group and activities to enhance health promotion	2.97	1.06	moderate
14. Home visit and follow up older person as table operation	3.16	0.98	moderate
15. Respite care	2.26	1.18	moderate
16. Health service support: rehabilitation services by Physiotherapist	2.79	1.22	moderate
17. Health service support: established senior clubs	3.62	1.21	moderate
18. Support Senior clubs's activities every month	2.98	1.24	moderate
Category 3 Refer of Older Persons with Problems	**3.06**	**1.05**	**moderate**
19. Referral system	2.84	1.46	moderate
20. Assessment and care the patient, coordinate with other sections	3.13	1.20	moderate
21. Refer to the other departments involved: Rehabilitation Department, The provision of welfare allowances to elderly and disabled people living	3.22	1.14	moderate

Table 1 Mean, Standard deviation of Older Person Healthcare Service Conditions (Cont.)

Variables	healthcare services		Level of healthcare services
	$\overline{X}$	SD	
22. Mental health assessment and counseling mental health problem for older person	3.49	0.85	moderate
23. Counseling and provide activities to promote quality of life and rehabilitation for older person	3.20	0.98	moderate
24. Physical and mental rehabilitation	2.94	1.12	moderate
25. Exercise enhancement	3.19	1.07	moderate
26. Nutrition counseling in older person	3.38	0.99	moderate
27. Oral hygiene care in older person	3.29	1.12	moderate

Components/Factors Related to the Care of Older Persons in Communities by Sub-district Health Promoting Hospitals:

1. Organizations/Agencies/Persons Involved in Supporting the Success of Subdistrict Health Promoting Hospital Community-Based Care for OlderPersons: The organizations involved were found to be composed of government agencies such as municipalities, sub-district administrative organizations, district public health offices, provincial social development and human security offices and community group such as older person leaders, community leaders, senior clubs, village health volunteers, elderly care giver, health volunteers, families and relatives. Every sector requiresdistinct roles and duties in providing care for older persons (Table 1) and must integrate work at all levels (currently existing but not complete) with meetings to discuss and jointly layout work plans together with budgetary support in providing Community-Based Care for Older Persons. Older person societies/clubs/leaders must work to help and coordinate work at various levels for benefit and rights of olderpersons in communities. However, all parties agreed that family members and community members play key roles in participating in care for older persons to provide mental support, food support, traveling and livelihood, especially in engaging community volunteers, which will help improve quality of life among older persons if community volunteer levels increase. Furthermore, SHPH must provide impressive services with knowledge to provide exercising recommendations for older persons such as by walking on coconut shells, riding bicycles, stretching rubber, stick exercises, etc.Health care providers mention that “we must look from in the home to outside communities by beginning with home care”,

which concurred with public opinions that "the work will not be easy with only government agencies or organizations. People in communities, community organizations and homes should be directly responsible for providing care for older persons" and "We support children and grandchildren who take care of older persons together with supporting older persons who have no caregivers." in Providing Community-Based Care for Older Persons

Table 2 Roles and Duties of Government Organizations, Community Members and Families

Organization/Person	Roles and Duties
1. District Public Health Offices	- Provide budget/material support and provide recommendations and training to be older hospitals for SHPH and public health volunteers.
2. Provincial Social Development and Human Security Offices	- Accept complaints; provide support in terms of benefits, equipment/ wheelchairs; build community strength; develop learning processes and provide training to increase income for families and communities together with providing training for older person care giving volunteers.
3. Municipalities/ Sub-district Administrative Organizations	- Set older person work plans and budgets. Provide health promotion support such as by procuring exercising equipment and facilities. Provide care in paying living allowances to older persons and support in traveling to SHPH.
4. Sub-district Health Promoting Hospitals (SHPH)	- Provide holistic healthcare for older persons. Aggressively provide healthcare services, health screening, arrange urgent channels in hospitals for older persons aged seventy years and up. Home visit, provide care in health promotion, health education, support, encouragement and follow-up on the work of public health volunteers.
5. Village Health Volunteers 6. OlderCare Volunteer	- Visit homes and provide health instruction and care in terms of food, medicine and exercise. - Visit homes to provide care and consultation in various topics for older persons in communities.
7. Elderly Clubs/ Leaders	- Coordinate with every group involved with older persons. Follow up on visits to older persons and reflect the problems of older persons flow -up to various organizations together with preparing activities for older persons.
8. Families	- Provide care concerning with food, psychological support, traveling and living conditions inside homes.

2. Important Characteristics of Persons Working to Provide Care for OlderPersons- 1) persons with good hearts and public minded, persons willing to devote time, energy and resources to help Community-Based Care for Older Persons 2) persons with good psychology in speaking and persons with good human relations who can help olderpersons feel good and happy in speaking with one another 3) persons with knowledge regarding care for older persons because care for older persons is complex 4) persons who live in the community because these persons have more time to provide care 5) persons were trusted and respected by people because trust will help older persons express their needs conveniently 6) persons with interest in food health who should at least have knowledge regarding healthy foods for older persons 7) persons with health knowledge capable of making accurate advices for sick older persons 8) persons who have friendly, cheerful faces with good verbal skills, which will make older persons happy as in the following statement: "Persons working to provide care for older persons should possess the following characteristics: Interest in health and food, persons with knowledge of health, persons who are good at speaking, persons who have friendly, cheerful faces with good verbal skills and persons who are willing to volunteer." (Older Care Volunteer)

3. Important Strategies in Providing Community-Based Care for Older Persons: Strategies were found to be very important as in the following statement: "If we have budgets and personnel while we don't have plans or strategies in providing care for older persons, the budgets and personnel will be wasted because we wouldn't know what to do with the budget oruse the budget for other purposes. Therefore, plans for supporting care are essential." Key strategies can be summarized as follows:

1) Growing roots by providing training and education for students and youths in the Community-Based Care for Older Persons as in the following statement of Municipalities Administrative Organizations: "We try to help children and youths have awareness to return to care for their parents, grandparents, uncles and aunts at home and in communities, which will help older persons feel warm acceptance and free from loneliness."

2) Building day care centers and establishing senior clubs or groups to ensure that older persons who live alone at home without caregivers have opportunities to participate in activities at this center by having children bring older persons in the morning and come back to take older persons home in the evening, which will make older persons feel happy with no depression and no loneliness in addition to having friends to talk with.

3) Building community strength to care for one another with support from the municipality as in the following statement: "We don't have enough people. The families of olderpersons have to take care of older person first. Community members will later help take care of older persons, visit one another and speak with older persons to generate happiness in families and communities.State by Sub-district Health Promoting Hospitals

4) Care for older persons in all aspects consisting of body, mind, food and living conditions by continually providing training for volunteer older person caregivers and villages health volunteer groups in providing care for older persons in the field along with providing knowledge for well-being for older

persons and home bound for older persons to ensure that older persons take care of themselves or become self-dependent first.

5) Care for every older person living in the area to **receive living allowances and 100% medical treatment rights** with quick access to services as in the following statement: "The older persons who can come will come to receive allowances/benefits. We deliver to home bound older persons."

6) Support the **Community Hospital for the Community Project** by having municipalities select local residents to study nursing and return to work in the community after graduation.

4. Healthcare Provider and Clients Expectations towards Community-Based Care for Older Persons by Sub-district Health Promoting Hospitals: Healthcare providers and clients were found to have similar expectations towards the services by having SHPH as the main host on health issues. In addition, healthcare providers and clients wanted SHPH to be expanded into community hospitals with sufficient doctors, nurses and personnel for healthcare service as in the following statement: "Hospitals should have one or two more doctors specialized in treating diseases, one or two more nurses and complete pharmaceutical supplies." The government sector should provide more support and promotion of care and older person activities. Most importantly, healthcare providers and clients wanted district hospitals to check – up community health and have SHPHassertively provide immediately services, complete coverage and timeliness for situations with holistic care, training and lack knowledge in food, exercise, physical therapy in older persons, etc., and visit homes providing care for bed bound older persons such as the administration of intravenous fluids, changing uterine catheters, cleaning wounds and following up on treatments, etc., as in the following statement: "I would like SHPHto visit and care for bed bound patients such as by providing saline and changing various tubes," and "It would be good to have physical therapists visit well- being and bed bound patients because their visits are essential to providing care for olderpersons."

5. Problems and Recommendations in Providing Services for Older Persons in the Communities of Sub-district Health Promoting Hospitals: In terms of problems in providing Community-Based Care for Older Persons, current problems are on the rise in terms of the number of bed bound patients, some service providers who lack attentive healthcare service, incomplete primary care unit conversions to SHPH from government policies, problems concerned with community organizations having no older person groups or senior clubs in communities, a shortage of doctors to provide care in compliance with policies for establishing sub-district health promoting hospitals. The fact that sub-district health promoting hospital personnelare frequently occupied by training and meetings has resulted in many problems by healthy personnel has no time to provide care for patients and older persons. Social development and human security problems are composed of lack of lower level personnel to provide care, resulting in difficult coordination. Community leaders usually fail to provide Community-Based Care for Older Persons. Some village health volunteers do not show as much interest in providing care for dependent/bed bound older persons as they should. Some older persons fail to cooperate/comply with advices and refuse

the treatments provided by medical personnel as in the following statement: “Older persons went to be treated at hospital but were asked why they did not seek treatment at another hospital, thereby causing bad feelings.” The researcher would like the number of doctors and nurses to be increased sufficiently for home and community healthcare service. Travel support should be provided for distant areas with difficulties in traveling to receive treatment.

6. Factors Involved in Successfully Providing Community-Based Care for Older Persons: The factors were found to comprise the following: 1) strong community leaders accepted by community people and have good management skills; 2) participation by several community groups and members; 3) community readiness, group forming and volunteering as in the following statement: “In order to achieve success in providing Community-Based Care for Older Persons, communities need to be ready and form groups to cooperate and help to provide Community-Based Care for Older Persons in addition to readiness among healthcare providers”; 4) knowledge, encouragement and care from family members/relatives/neighbors/older persons in communities; 5) care/socialminded from related organizations, resulting in quick services; 6) knowledge and understanding of society/communities in older persons; 7) older persons’ understanding of their own problems; 8) sufficient budgetary support from the government sector; 9) sufficient officials/personnel to meet needs and 10) village health volunteers/older care volunteers/caregivers knowledge and skills in providing care for older persons.

Community Care Model of Sub-district Health Promoting Hospitalsfor Older Persons: According to the findings, community care model of SHPHfor older persons should consist of collaborative work by multiple sectors consisting of the government sector with agencies responsible for providing care for olderpersons such as municipalities/sub-district administrative organizations, village health volunteers, provincial social development and human security officers, community hospitals and sub-district health promoting hospitals, etc., community groups and members such as older person agencies/associations/clubs, which will participate in stimulating and supporting community activities, and village health volunteer, which will have duties in providing care for older persons. Most importantly, family members and communities must be willing to volunteer and participate in providing Community-Based Care for Older Persons. Every sector must set six strategies and perform duties with integration to support sub-district health promoting hospital operations in order to be able to provide holistic care for every older persons in terms of health promotion, disease control and prevention, treatment and rehabilitation with ten factors of success. This model is called the community care model **“SHPH for Older Persons” Model** in reference to the fact that SHPH must rely on four organizations, six strategies and ten factors of success to support operations according to Figure 1 in order to successfully provide care for older persons.

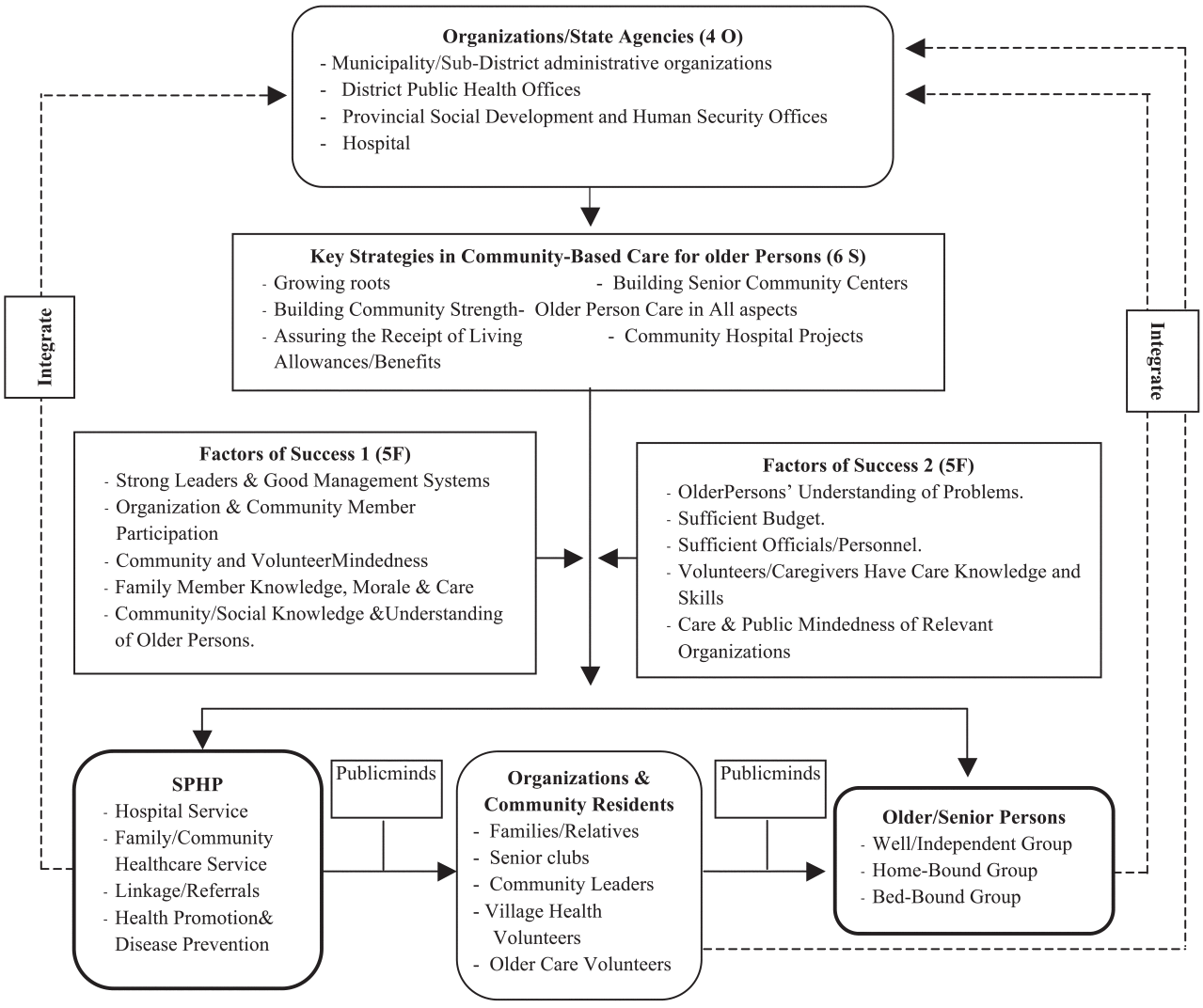

Figure 1 Community Care Model of Sub-district Health Promoting Hospitals for Older Persons (4 O - 6 S - 10 F "SHPH for Older Persons" Model)

Discussion

Sub-district Health Promoting Hospital Service Providing Conditions for Older Persons: From an aggregate perspective, the healthcare service for older persons by SHPH in various sections was found to be at moderate levels similar to one another. The Health Promotion and Disease Prevention Section had the highest mean value at a moderate level ($\overline{X}$ 3.25, SD 0.85). This may be due to shortages concerning personnel, budgets and pharmaceutical/ medicine supplies.Therefore, health promotion and disease prevention operations are emphasized more than other sections because this section does not require much personnel or high budgets. The aforementioned finding concurred with qualitative data studies finding people to want sufficient numbers of doctors, nurses and personnel to provide services and want SHPH to visit and care for bed bound older persons more as a result of increasing numbers of bed bound older persons in communities while not having good care systems. This can be collaborated from the findings that respite care services for primary caregivers were provided at low levels ($\overline{X}$ 2.26, SD 1.18). Therefore, the burden of caring for this group of older persons falls to families and communities who require both care knowledge and skills.These findings were similar tothe study of Pagaiya and Sanya[12] and Wibulpolprasert[17] who studied healthcare labor needs in providing care for older persons and found the problem of healthcare service systems for older persons from the government sector to be deficient in terms of specific healthcare service systems for older persons with a shortage of long-term care and chronic care required for older persons with deficient coverage by existing healthcare services, the inability of some olderpersonsto access healthcare services, less coordination among the private sector, the government sector and communities combined with the fact that family care for older persons is marked by declining quality and future caregivers. Pagaiya and Sanya12provided policy recommendations asserting the need for unofficial labor support, arrangements of systems to link with medical treatment and service facilities, support for increasing manpower production, manpower management planning, emphasis on combining skills to arrange accessible service systems with quality and low cost, modified courses to produce healthcare personnel with knowledge and skills consistent with care for older persons, promotion for local administrative organizations to have roles in arranging healthcare systems for older persons along with promoting participation by the private sector to arrange services for older persons, build motivations in providing care for older persons by providing financial support for persons with burdens in caring for older persons and making legal preparations to facilitate labor operations, whether unofficially or privately, including the rights of older persons. In addition, education is important source of self-improvement, therefore, older persons and family need to have an accurate knowledge and right attitude in order to carry out correct health behavior practice[18,19].

Community Care Model of Sub-district Health Promoting Hospitals for Older Persons (4 O - 6 S - 10 F "SHPH for Older Persons" Model): According to the findings, Community Care Model of SHPH for Older Persons was found to be a model for integrating the work of at least four organizations to support sub-district health promoting hospital operations by having organizations, community members

and facilities participate in working with a service mind in line with six strategies and ten factors of success.The findings of this study concurred with the study of Srithamrongsawat, Bundhamcharoen, Sasat and Amnatsatsue[11] on long-term healthcare models for older persons by communities who found long-term community care system arrangements for older persons by various countries to be deficient in terms offocus on the true value of community care with inadequate service integration and insufficient resources. Principles for developing healthcare systems for older persons by communities comprised the following: 1) promotion and development of older persons' capabilities in living with pride in communities; 2) promotion and support for family caregivers to be at the core of care for older persons; 3) provision of quality healthcare services for older persons in communities with coverage and integration of health and social aspects; 4) local administrative organizations must have the capacity to manage healthcare service systems in communities and the public sector must have management roles with support from government agencies and 5) healthcare service systems for older persons in communities must be able to develop and operate with sustainability by using strategies to develop community strength, local administrative organization capacity, plan and develop manpower in terms of health and society including developing models for providing long-term healthcare services to older persons by communities. This study was similar to the findings of Holmesand Joseph[20] which showed that the formation of Senior clubs and older persons associations promoted greater social contact, social support, opportunities for learning, increased and easier access to health and social welfare services, better self-management of chronic conditions, greater participation in the community with inter-generational benefits, better relationships within families, greater visibility and increased influence.

The aforementioned was also concurrent with the findings of Moopayak, Rattanathanya and Foungfoo[13] in terms of community healthcare models that sub-district health promoting hospital personnel must be mainstays in working together to prepare older persons to have good health and quality of life by employing mechanisms for clearly designating the roles and duties of networks at each level, using Thai culture as a reinforcing mechanism and driving force in the care of older persons and using learning processes as mechanisms for building community awareness of older persons' values. Furthermore, the findings are also consistent with the findings of Sritunyarat and Damrikarnlerd[14] who presented a generous sub-district health promoting hospital model to provide for older persons consisting of facilitating service providers, service systems and environments with systematic work processes covering goals of every older person group including the study of Jitramontree, Thongcharoen and Thayansin[21] on a Good Model of Elderly Care in Urban Community, which found good factors in promoting care for older persons to consist of community capacity, good support from multiple sectors, strong leaders, ability of older persons to access services, receive health and social services along with databases which have coverage. Developing health care services system for older persons[8] within conceptual framework : Accessibility Continuity of care Integrated care Holistic care Co-ordination of care and Community empowerment.

Recommendations

1. Policy Recommendations: The government should set policies and support local administrative organizations and related agencies, including SHPH to build community strength in providing care for older persons by developing the knowledge of community leaders in providing care for older persons to ensure volunteer capacity, realize the value of older persons, enable linkages in the work of every sector to arrange strong service systems for older persons in communities.

2. Increase health care personals position such as doctors, nurses and physiotherapist for SHPH.

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