

การดูแลผู้สูงอายุที่มีภาวะพึ่งพิงในชุมชน : กรณีศึกษาจังหวัดชลบุรี Care of Dependent Elders in the Community: A Case Study from Chonburi Province

สุริยา ฟองเกิด^{1*} พรรณปพร สิริโรจน์² และ ทิพาภรณ์ โพธิ์ถวิล²

Suriya Fongkerd^{1*} Phanpaporn Leewirot² and Tipaporn Photawin²

นักศึกษาหลักสูตรปริญญาตรีบัณฑิต สาขาวิชาการบริหารสวัสดิการสังคม มหาวิทยาลัยหัวเฉียวเฉลิมพระเกียรติ^{1*},

คณะสังคมสงเคราะห์ศาสตร์และสวัสดิการสังคม มหาวิทยาลัยหัวเฉียวเฉลิมพระเกียรติ²

Student in Social welfare Administration, Huachiew Chalermprakiet University^{1*},

Faculty of Social Work and Social Welfare, Huachiew Chalermprakiet University²

(Received: March 23, 2021; Revised: October 6, 2022; Accepted: October 17, 2022)

บทคัดย่อ

การวิจัยเชิงคุณภาพครั้งนี้มีวัตถุประสงค์เพื่อศึกษาการดูแลผู้สูงอายุที่มีภาวะพึ่งพิงที่บ้านของญาติที่ทำหน้าที่เป็นผู้ดูแลหลัก และศึกษาการบริการทางสังคม การช่วยเหลือและการมีส่วนร่วมของชุมชนในการดูแลผู้สูงอายุที่มีภาวะพึ่งพิงในชุมชน ผู้ให้ข้อมูลในการวิจัย คือ ญาติผู้ดูแลผู้สูงอายุที่มีภาวะพึ่งพิง ซึ่งอาศัยอยู่ในครอบครัวเดียวกัน และทำหน้าที่ในการดูแลผู้สูงอายุที่มีภาวะพึ่งพิงอย่างต่อเนื่องอย่างน้อย 1 ปี จำนวน 10 คน และผู้ที่เกี่ยวข้องในชุมชน จำนวน 10 คน คัดเลือกผู้ให้ข้อมูลแบบเฉพาะเจาะจง เก็บรวบรวมข้อมูลด้วยวิธีการสนทนากลุ่มเครื่องมือที่ใช้เป็นแบบสัมภาษณ์กึ่งโครงสร้าง ผลการวิจัย พบว่า

การดูแลผู้สูงอายุที่มีภาวะพึ่งพิงในชุมชน จำแนกได้เป็น 2 ประเด็น ได้แก่ ประเด็นที่ 1 การดูแลผู้สูงอายุที่มีภาวะพึ่งพิงที่บ้าน ประกอบด้วย การดูแลด้านร่างกาย การดูแลด้านจิตใจ การดูแลด้านเศรษฐกิจและสังคม ประเด็นที่ 2 การบริการ การช่วยเหลือและการมีส่วนร่วมของชุมชนในการดูแลผู้สูงอายุที่มีภาวะพึ่งพิง แบ่งเป็น 2.1) การบริการ การช่วยเหลือดูแลผู้สูงอายุที่มีภาวะพึ่งพิงในชุมชน และ 2.2) การมีส่วนร่วมของชุมชนในการดูแลผู้สูงอายุที่อยู่ในภาวะพึ่งพิงในชุมชน

การวิจัยนี้มีข้อเสนอแนะว่า การดูแลผู้สูงอายุที่อยู่ในภาวะพึ่งพิงโดยครอบครัว เป็นบทบาทที่เป็นภาระของผู้ดูแลหลักและสมาชิกในครอบครัว ควรส่งเสริมให้ผู้ดูแลหลักมีการเตรียมความพร้อม เพิ่มศักยภาพคนในครอบครัวเพื่อช่วยแบ่งเบาภาระและผลกระทบของผู้ดูแลหลักให้สามารถดูแลกิจวัตรประจำวันของผู้สูงอายุที่อยู่ในภาวะพึ่งพิงได้อย่างเหมาะสม

คำสำคัญ: การดูแล, ผู้สูงอายุ, ภาวะพึ่งพิง

*ผู้ให้การติดต่อ (Corresponding e-mail: suriya@bnc.ac.th เบอร์โทรศัพท์ 065-6279407)



Abstract

This research aimed to examine caring for the dependent elders that relied on their relatives' homes as the primary caregivers and to investigate the availability of social services, assistance, and community participation in giving care for them. The research informants were 10 family members of dependent elders who lived with them and gave direct care to them for at least one year as well as 10 community representatives. The subject selection was performed with the purposive sampling method. The data was collected during semi-structured interviews in group discussions. The research findings relating to caring for the dependent elders in the community could be divided into two main topics: 1) giving care to the dependent elders at home in the physical aspect, mental aspect, and economical-social aspects; and 2) the social services, assistance, and community participation which included the social services and assistance for dependent elders in the community and community participation in giving care for the dependent elders in the community.

It was acknowledged that giving care to the dependent elders at home was a hard job for the primary caregivers and family members. Caregivers should receive preparative knowledge to enhance the potential of family members to appropriately manage the daily routine of the elderly dependents.

Keywords: Caregiving, Elderly, Dependency

Introduction

The United Nations estimated the situation of global population that in 2001 to 2100 would be a century of the elderly as the size of older proportion would project to 10 percentage of world population due to the medical science and public health advance resulting in longer lives of human beings (United Nations Population Fund: UNFPA, 2017). Currently, various countries, including Thailand, have obviously entered the era referred as Aged Society. This can be noticed by the rapid growth of aged population from 8% in 1950 to 11% in 2009. The World Health Organization expected that by 2050 we will have a doubled sized of aged population from 605 million or 11% to 2 billion or 22%. That is, one fifth of the whole global population will be 65 years old or above (United Nations Population Fund: UNFPA, 2017). Likewise, the situation of aged society in Thailand revealed it's rapid growing trend in numbers of the elderly. In 1960, the proportion of the elderly and the whole population went from 5.4% to 11.5% in 2009. In addition, it was expected that in 2025 the elderly population would become 17.8% (Choonharas, 2011). This phenomenon is considered to be the social and economic challenges for countries because their people live longer but they are likely to face with the risk of chronic diseases which could result in the inability to depend on themselves and finally cause them to become the dependent elders in the community (Office of National Health Security, 2016).

One of the major health problems in many countries was becoming dependent elders. That is, aged people have to depend themselves on others due to their illness from chronic diseases and severe complications that caused disability (Phueaksawat, Cholanakul, & Rojanarak, 2016). Office of Policy and Strategy of Ministry of Public Health reported in 2013 that the most common health

problem in the elderly included hypertension, diabetes, renal failure, osteoarthritis, depression in disabled persons, and bed-bound patients (Office of Health Promotion, Department of Health, Ministry of Public Health, 2014). It also reported that the ratio of burden of the elderly for work-force age in 2015 was at 24.09%, in 2016 at 25.14%, in 2017 at 26.23% (Office of National Statistical, 2018); and in 2020 at 27.7% which was expected to increase in 2040 up to 56.2% to 100 work-force aged persons (Phichayan, 2020). It is obvious that the statistics of burden of the elderly annually rises, which agrees with the statistics of numbers of the elderly dependents. That is, in 2014 there were 1,023,000 elderly dependents. Moreover, it was found that the 960,000 elderly of dependency were bed-bound who could partially help themselves, while the other 63,000 could not help themselves at all (Office of National Health Security, 2017). In 2015, the number of elderly dependents went up to 1.3 million individuals (Department of Health Service Support, Ministry of Public Health, 2017). A report revealed the situations in Chonburi Province that there were 398 elderly dependents in 2016, 620 in 2017, and 987 in 2018 which accounted to be 0.58% of total 169,037 elderly in the area (Office of Public Health Chonburi Provincial, 2018). This statistics clearly suggested that Chonburi Province had more elderly dependents each year.

From the proportion of dependent elders mentioned earlier, Thailand government had to speed up the development of the social service system for the elderly especially those in the dependent condition so that they would have better quality of life (Chanwit, 2017). In doing so, the government increased more budget for the social service and medical treatment expenses (Sirikampeng, & Phosing, 2017). This was because the factor of labor became lowered as a part of work-force population had to quit their jobs to take care of the elderly dependents which were unable to help themselves and needed continuous and close care. Thus, it became such a burden for the main caregivers in the family who had to adjust their new role and provide sufficient time for the elderly dependents, or caused discomfort in their lives (Chunhabodee, Supanan, Upala, & Thongsai, 2013). In additionally, giving care to elderly dependents should cover other types of burden such as the caregivers' jobs or living costs, resulting in average daily expenses in a high level (Smith, Piamjariyakul, Yardrich, Ross, Gajewski, & William, 2012). It was also found that caregivers usually became distressed when they found they could not help the elderly dependents recover when their illness went worse (Jean-Philippe, Ranjit & Christopher, 2012). Moreover, the elderly dependents could have unstable emotions such as anger, upset, rage and did not cooperate with the caregivers which caused even more anxiety (Berg, 2002).

It was found that the effects from giving care to elderly dependents on the caretakers included feeling fatigue, lack of concentration, insufficient rest, difficulty in sleeping, poor self-esteem, and lowered social roles (Shiouh-Chu, Hengh-Sin & Shu-Yuan, 2012). Being a full-time caregivers for elderly dependents created tiredness, tension, and stress that could cause health problems, changes in lifestyles, financial problems, and personal problems as the longer time went by, the more daunting it would be for the caretakers (Kasemkijwattana, & Praisson, 2014). The government developed a long-term care system to establish continuity. The long-term care was a system of public health and social services to respond to the needs of assistance in elderly dependents and their families in formal and informal models. The mentioned social services were designed for the elderly dependents to have better quality of life and live happily in the society

(Sonnoi, Siripanumas, & Piyanukool 2016). To elaborate on, it was believed to relate the social, health, economic, and environmental dimensions to respond to the medical and non-medical needs due to the chronic conditions, physical infirmity, accidents, disability, and inability to help themselves in daily life. The idea of the system relied on the formal caretakers (health care and social service staff), and informal caretakers (families, friends, and neighbors) which also included services in families, communities, or facilities as the participation in giving care for the elderly dependents to emphasize on rehabilitation, treatment, and health care promotion consistently and continuously so that the patients could carry on their daily life autonomously on the potentials and basis of respected human dignity, and the quality of life of the caregivers (Saengsee, 2013).

The quality of life is highly important for the elderly dependents in living their lives and also a major factor that has effects on the quality of life of the caregivers such as income of caregivers, emotions, environment of caring the dependents, etc. Such factors could result in the stress of the caregivers and, later on, the negative quality of life of the elderly dependents. According to Prasartkul (2013), the national strategic plans had its target on offering training of health care management for the elderly at the community level in order to increase the potential of caregivers as fulltime community caregivers who could take care of the elderly dependents and bed-bound patients. It was estimated that this group of population included 188,298 persons nationwide. Observation on the policy implementation showed that the elderly had better health. 2,160 bed-bound patients could move back to their homes, while 7,677 dependent elders could return to the community. It could be accordingly said that increasing the potential of the caregivers could help improve the quality of life of the elderly dependents. Moreover, it was reported that the number of caregivers for elderly dependents was decreased and development of models with the community participation for giving care of the elderly dependents was widely presented (Office of National Health Security, 2016).

After reviewing the literature, it was found that Chonburi Province had started their work in developing the long-term care management for the dependent elders by implementing the policy into practice in the community by training volunteer caregivers for 72 hours in order to have sufficient knowledge to care for dependent elders. There are health partners such as Chonburi Hospital, Care Manager responsible for planning patient care together with the Sub-District Health Promoting Hospital, resulting in a concrete care model that is appropriate to the context of Chonburi Province. Therefore, this research topic became an interest for the researcher to acquire the data and understand the care provision for the elderly dependents at the community level in Chonburi Province and present the guideline of development for offering care for the elderly dependents and their family so that they would have the better/ higher quality of life with happy, stable, and sustainable living.

Objectives

1. To examine care provision for the dependent elders who resided at their relatives' houses as primary caregivers at Chonburi Province.
2. To investigate the social services and assistance and the community participation in offering care for the dependent elders in the community at Chonburi Province.

Methodology

This study was a phenomenological research to examine the care provision for the dependent elders at the community level in Chonburi Province. Therefore, the research data was collected with focus group to gather the information about characteristics and content which are described below.

Participants and Subjects

1. 10 current caregivers who are the relatives of the dependent elders and former caregivers whose dependent elders passed away,

2. 10 community associates including the chief executives of subdistrict administrative organization, subdistrict headman, village headman, village health volunteers, village volunteers, caregivers, nurse, care manager, medical personnel.

The subjects of this research were selected with purposive sampling, and they were willing to participate in this study. The focus group discussion was designed to divide the subjects into two medium-sized groups (8-10 persons per group) (Photisita, 2013).

Research instruments

The researcher is a research instruments which must be in close interaction with the informant. Build relationships with informants to build trust and get the most reliable information. Researchers passed a qualitative research course from Burapha University in 2007, after that they received a qualitative research workshop and through training in data collection and analysis of qualitative data from the National Research Council (NRCT) and passed training courses on qualitative research data analysis from the Researchers Association of Thailand. There are currently a number of qualitative research papers published in national journals. In addition, the researchers provided equipment and semi-structure interview for collecting data, such as a voice recorder, for recording during the questions leading the group discussion should be mentioned for validity testing. And the data record form for use in research and create lead questions for focus group.

Data collection

The data collection was carried out the by the researcher which were described as follows.

- 1) The community associates were formerly contacted by the researcher for assistance and support in performing this study. The participants of this stage included the subdistrict health promotion hospitals, community leaders, head of village health volunteers, and head of the elderly club. The objectives, procedures, and time duration of research were explained, and other relating persons to this study were asked for permission to participate in this research.
- 2) The researcher visited the research sites to establish bonding with the community and the subdistrict health promotion hospitals, and to create familiarity with the community leaders which included headmen of subdistrict and village, community leader, head of the elderly club, head of village health volunteers, whom were invited to participate in the research procedures formally and informally.
- 3) Directions were given to create mutual understanding between the researcher and the informants about the objectives, procedures, and time duration of the study.
- 4) Focus group discussion of the two groups of research subjects was observed with note-taking and tape recording until the procedure would finish, and
- 5) Data management was performed after the focus group discussion.

Data analysis

The qualitative analysis was performed with the collected data after each focus group discussion. The content analysis was carried out by determining data code, categorizing the data, linking the data in terms of storyline, summarizing the conclusion, and giving examples of conversation by the informants based on the data analysis concept of Colaizzi's method (Colaizzi.1978: 48-91).

Data validation, this is because qualitative research is highly flexible and researchers are important research instruments for data collection. To make the research reliable. Therefore, the researcher used a triangulation method to verify the accuracy of the data before analysis. In this research, the researcher has examined the following triangulation data: 1) Credibility is a confirmation of the information obtained from the study to be correct and true. And the interpretation of the researcher with different levels of reality in the mindsets of the informant and the researcher. 2) Auditability, The researcher has clearly written details of the data collection process and data analysis. Leads to the formation of conclusions and verifiable.

Research Ethics

The researcher realized the importance of data collection. This was because the research instrument required close interaction with the informants since the stage of bonding with the informants to establish familiarity and reliability in order to acquire accountable information. It was noticed that research procedures of focus group discussion and interviewing involved with access to personal information, feelings, thoughts, and observation which could inevitably violate privacy of the informants. Therefore, the researcher had to strictly consider about the research ethics to maintain the privacy, secrets, and safety. That is, this research did not have questions that could harm emotions, feeling, and self-respects of the informants. This study was granted approval for research ethics in human from Huachiew Chalermprakiet University with Certified Number 499/2563 on March 5th, 2020.

Results

Part 1. General information

The demography of the participants can be described in two groups; the caregivers and the community associates. First, the majority of caregivers of the dependent elders in this study was females and married. Most of them graduated in senior high school level and were employees. The expenses for taking care of the dependent elders were reported to be not enough and most of the caregivers were likely to be the patients' children. The average period of giving care to the patients was at 6 years and the average age of the patients was at 52 years old. The samples of this study were 10 caregivers which included 8 caregivers of current patients and 2 former caregivers of the patients had passed.

The community associates in this study included one chief executive of subdistrict administration organization, one village headman, one volunteer, one village health volunteer, two caregivers, one nurse or care manager, and one representative from elderly club which makes 10 samples in total.

Part 2. Giving care to dependent elders in the community

Giving care to dependent elders at their relatives' house in the community could be described into two aspects. First, care provision for the dependent elders at home included physical, mental, and economic and social care. Second, service and participatory assistance from the community for dependent elders care consisted of 1) providing service and assistance for the dependent elders in the community, and 2) the community participation in giving care to the dependent elders in their local areas.

1. Providing care to the dependent elders at home can be described into three aspects of physical, mental, and economic and social care.

First of all, as for the physical care, it was found that the dependent elders who could not help themselves relied on their family members as the primary caregivers throughout 24 hours and they also were visited by village health volunteers, their caregivers, and staff from Ministry of Public Health to check on their well-being and given activities such as knowledge about personal hygiene, nutrition, exercising, sleeping, and primary health care. The following conversations are examples of services which the patients received from the community.

"...In the morning, we take him outside for breakfast and prepare what he needs beside him so that he can grab them by himself when we go out side for work. When we come back, we shower him, dry him with towel, then feed him. On weekends, we sometimes exercise his legs. But we do not normally do that because we do not have a lot of free time..." (FCG 01)

"...Mostly I would visit to check on him and monitor his sugar level. We give advice about nutrition for the most part. Daily care is the job for that patient's caregiver..." (COM 01)

"...As for caregiving mission, we start at 8 in the morning. We will visit the patients' houses to see if they correctly consume the food that could be sweet, greasy, or satly. Then, we will ask about their medicines and talk and have them exercise. If they refuse to, we would make them. There is one case. If we don't visit him, he won't take his morning pills. Sometimes we arrive his house around noon and find his morning pills...(COM 02)

"...Our assistance in order to help prevent complications can be done through innovations to keep complications away from happening again or prevent any complication at all. For some cases, we could not make it better, we try not to make it worse..." (COM 05)

"...When we receive a phone call from a patient or his family member, we will pack out back and rush out with the village health volunteers. We frequently go out when they have to change feed tubes, urinal tube, or wound addressing..." (COM 07)

The second was the mental care. It was found that the dependent elders receive support from their neighbors, village health volunteers, the elderly club, and staff from the government sector to cheer the spirit of the patients and their relatives up and fight with the conditions and suffering as they were facing. The following are examples of how the community provided mental for one another.

"...We talk and give them support so that they could accept their physical conditions. At the same time, we have psychologist team to assess the mental well-being too..." (COM 02)

"...We are family. We have to support each other no matter what the patient is going through..." (FCG 05)

“...but he doesn’t seem well and hopeless to live. So when we’re back from work, we always ask him questions and comfort him...” (FCG 03)

“...we plan our schedules to visit the dependent patients to support, talk, discuss about Buddhism, sometimes we sing so they would feel better and hopeful to live on...” (COM 10)

“...We, village health volunteers, visit the patients so give them support. Everytime we meet, they look happy and call us as we arrive “Doctor, you come again!”...” (COM 06)

The last aspect was the economic and social care. It was reported that there is assistance provided such as diapers, food, and transportation service. Moreover, the dependent elders are provided with social welfare from the government such as living allowances for the elderly and the disabled, and the State welfare card service. In addition to that, subdistrict organizations provided services and projects in taking care of the patients in their community as illustrated in the following conversations.

“ ...most bed-bounded patients are very old. They usually monthly receive the welfare services from the government such as elderly living allowance, depending on age. If you register as disabled, you will receive more. If you’re poor, you’ll receive the State Welfare Service for the poor as well...” (COM 08)

“...as for my mother, she has the golden card for treatment at the hospital. She’s an elderly so she receives the living allowance from the government. This quite helps. But it is a little because her expense is way higher than that...” (FCG 09)

“ ... We have officers to visit the patients. In the public health field, we have village health volunteers to do this job. Sometimes, the village headman is asked for a bed or any equipment, then we will contact the subdistrict administrative organization to send village health volunteers or doctors from subdistrict hospital. Our main job is coordination, but people will go to their community first after that it will be passed on to the subdistrict administrative organization later on...(COM 09)

“ ... They will send nurses to look after the patients. Then, they will do the part. If patients really need help, there will be village health volunteers to look after them. In fact, most of the time, they will coordinate with the community...” (COM 03)

“ ... Yes, we take photos of the patients, how they look like, or what they need. Then, we will the photos to group chat on Line of the subdistrict administrative organization staff....”(COM 07)

“...The subdistrict administrative organization supports diapers once a month, egg, milk, and rice. When we organize activities for the disabled, we will give them coupons so they’d use it for free stuff. Some live in rental houses, we will grant some money to support them. This money isn’t from the office, but from another foundation that gave fund to us....” (COM 01)

2. Social services, assistance, and the participation from the community for the dependent elders can be described into three aspects in the following section.

2.1 First, social services and assistance for the dependent elders in the community consisted of 1) village health volunteers who had experiences in taking care of patients with chronic diseases for over 30 years, 2) the caregivers which received over 70-hour theoretical and practical training, 3) the elderly club who were healthy and volunteered in consistently visiting and giving support to the dependent elders, 4) community leaders who played the role in coordinating requests from community members and providing the assistance for the dependent elders in the

community, 5) subdistrict health promotion hospitals which provided health care service, consulting, and giving proper care for the local patients, 6) subdistrict administrative organizations who provided social services by implementing the policy in giving care the dependent elders for the better quality of life, and 7) business entrepreneurs in the local areas who shared responsibility for their society by donating money to assist the dependent elders and consumer goods for the elderly in the community. Examples of conversation about this type of community assistance and services are shown in the following section.

“...We separate our work into two groups; the public health care by doctors and nurses from subdistrict health promotion hospital, and village health volunteers, and the caregiving by us to work together when we visit the patients in the community ...” (COM 05)

“...I think the doctors from the health promotion hospital and village health volunteers visited us the most. So did the elderly club which now they are the elderly school or what they called themselves CG. They give us good care of us. Sometimes, they can look after the patients when I cannot be with them...” (FCG 04)

“...I think the community leader takes a very good care of us. When the community members had troubles or illness and asked for help and they came to me, I would report that to the chief executive from the subdistrict administrative organization who would send them team to take care of the problems based on the rights and welfare they deserved...” (COM 08)

“...Big companies and department stores around the community donated many things for the bed-bound patients, including money, through the subdistrict administrative organization. And the subdistrict team and private sector would visit us at the site...” (COM 02)

2.2 Participation from the community for the dependent elders can be described as follows.

It was found that the community participated in giving assistance to the dependent elders two main aspects. First, the health care team included village health volunteers, caregivers, subdistrict health promotion hospital, and community hospital visited, screened, and checked up the patients. They also coordinated with other related government departments in helping, organizing meeting and training about the knowledge for taking care of the elderly dependents such as health enhancing, prevention, and rehabilitation for the elderly. Secondly, participation from the community was carried out through networking such as community leader, private sector, and foundations. When requests from the community members were accepted, site visit would be performed to check on the patients case by case. The government sector also organized meeting, projects, and activities for the solutions in taking care of the elderly dependents by determining plans and assigning work for the team who were related to the job in implementing, setting funds, and receiving donation from private sector as another way to support the patients in the community. Examples of conversation were given below.

“...This community welfare fund mostly has a meeting with community committee and community leader once a month. Then, they will come to us like this. The chief executive will contact the private sector. Some of them offered like 50,000 or 100,000 baht...” (COM 02)

“...When we have one patient, the public health care department will come to take care together with village health volunteers. Most of the time, we received coordination from the community...” (COM 03)

“...The subdistrict administrative organization supports diapers once a month, egg, milk, and rice. When we organize activities for the disabled, we will give them coupons so they’d use it for free stuff. Some live in rental houses, we will grant some money to support them. This money isn’t from the office, but from another foundation that gave fund to us...” (COM 01)

“...Doctors from the health promotion hospital and the main hospital visit many patients. There are not enough doctors for our need. They often also organized training projects to educate for the village health volunteers and caregivers so that we could help our patients...” (COM 05)

“...the doctors from the health promotion hospital visit us and evaluated everything. Sometimes he comes to help change the feeding and urinal tubes without having to call for appointments. He remembers when he has to come visit us...” (FCG 08)

Discussion

The qualitative aspect of this research about caring for the dependent elders in the local community were classified into two topics which were providing care for the dependent elders at home and the social services and assistance from the participation of the community of the dependent elders could be discussed below.

The first topic is providing care for the dependent elders at home. The dependent elders in the community received physical, mental, and economic and social care which was done by their relatives, village health volunteers, caregivers, the elderly club, and staff from the government sector. In doing this, the government also provided policy in developing and extending the long-term service of health care (LTC) for the dependent elders in the areas with care manager who could be nurses, physical therapist, or social workers, or even with registered caregivers who had received training. This proactive care for the dependent elders ratio was 1: 10. The caregivers received allowance from the Health Care Insurance at Local or Area Level that was normally run by the local administrative organizations. Every part of the community would join altogether in order to giving assistance in offering knowledge and plans in taking care of the dependent elders together with the team from Ministry of Public Health who also visited the dependent elders in the community so that the patients would feel supported. As for the patients’ family, they had direct role in giving care for the dependent elders in terms of daily routine care and expenses such as transportation to the doctors, or medical equipment. This finding is similar to that of the study by Boonlert, Phromarak, & Khowphia. (2016) which showed that village health volunteers played an important role in visiting the bed-bound patients and taking care of the patients’ need. The volunteers also worked to plan and maintain the system for caring the dependent elders which directly connected to the government officers. This was also in accordance with the research by Phakdeeamnat, & Likitthamaroj. (2014) which stated that providing health care for dependent elders should cover services such as giving knowledge with brochures, allocating welfare and allowance for the poor elderly, providing housing and clothes, and encouraging them to exercise as the community network. This idea was also similar to the research by Sawatphol, Phengpinit, Senanikorn, &

Srisuraphon. (2017) which revealed that the proper way for local community to take care of the dependent elders could be materialized through having driving mechanism for the elderly in the community which required participatory work from community network and subdistrict administrative organization in setting plans and giving the proper care to patients from the community itself.

The second topic is the social services and assistance and the participation of the community in giving care to the dependent elders. It was found that the social services and assistance were offered to the dependent elders through the participation of the community which consisted of 1) the village health volunteer, 2) caregivers, 3) the elderly club, 4) the community leaders, 5) the subdistrict health promotion hospital, 6) subdistrict administrative organizations, and 7) private sector together with the community itself. This overall participation can be described into two parts of work which are the work from the government health care departments and that from the participation from community network. To elaborate on, the work started with participatory planning for long-term community development for the dependent elders. This stage consisted of three steps which were establishment of the knowledge, guideline for development, and guideline for practice. Working together of every part of the community could instill the foundation of strength in the community and sustainability. This idea agreed with the work by Pongsaengpan, & Rodjarkpai. (2014) which found that the community participation for providing health care of the elderly through brainstorming by group discussion in the community to analyze the problems in promoting and caring among the elderly club, village health volunteers, household representative, elderly caregivers, and officers from Ministry of Public Health as the leaders for promoting and encouraging the importance of health care promotion for the elderly under the idea of community networking. It was also emphasized by the research of Monklang, Phosing, & Kanaphum. (2016) which claimed that community participation and support from the related departments with the leadership from the municipal office in providing services for the elderly and their family and facilitating their quality of life such as the elderly allowance, or services for the elderly, disabled etc. Similarly, the study by Sirirak, & Suriyo. (2017) showed that participation from the community, family members, health volunteers, and local administrative organizations could be successfully performed through working together, realizing the importance of the issues, or granting fund for the better quality of life of the elderly dependents in their community.

Suggestions from research finding

1. Providing care for the dependent elders by the family is resulting in the burden for the primary caregiver and the family members. Therefore, it was suggested that caregivers should be prepared to increase the potential of care in order to ease the hard work and to give the proper care.
2. There should be more research about social driving process in assisting the relatives of elderly dependents in terms of means and operation. This is because this study explains only about caring for the elderly dependents. It was not aimed to provide any data about helping the caregivers who were the patients' relatives or providing them any welfare services for the caregivers. Accordingly, there was still the gap of attention on the caregivers has not been highlighted yet.

References

- Berg, D. (2002). The Hidden Client' Women Caring for Husband with COPD: Their Experience of Quality of life. *J Clin Nurs*, 11(5), 613-21.
- Boonlert, P., Phromarak, T., & Khowphia, S. (2016). Continuous Health Care Model Development for the Elderly with Bed-Bound and Home-Based Patient Groups at Ban Dong Man Health Promoting Hospital, Singkhok Subdistrict, Kaset Wisai District, Roi Et Province. *Journal of the Office of Disease Prevention and Control* 7, Khon Kaen Province, 23(2), 79-87. (in Thai).
- Chanwit, W. (2017). *Long-Term Care Insurance System: a System Suitable for Thailand*. Bangkok: Vitoon Karnpok Printing Co., Ltd. (1997). (in Thai).
- Choonharas, S. (2011). *Report on the Situation of the Thai Elderly in 2009*. Bangkok: Foundation of Thai Gerontology Research and Development Institute. (In Thai)
- Chunhabodee, A., Supanan, T., UPala, R., & Thongsai, S. (2013). Stress and Needs of Caregivers of Stroke Patients at Home. *Journal of Phrapokklao Nursing College*, 26(1), 53-63. (in Thai).
- Colaizzi, P. (1978). *Psychological Research as the Phenomenologist Views it*. In Existential – Phenomenological Alternatives for Psychology (Valle R. & King M. eds), Oxford University Press, London. pp 48-71.
- Department of Health Service Support, Ministry of Public Health. (2017). *Statistics on the Elderly in Bed Sickness*. Nonthaburi: Department of Health Service Support Ministry of Public Health. (in Thai).
- Jean-Philippe, R., Ranjit, N., & Christopher, C. (2012). Caregiver Burden among Nocturnal Home Hemodialysis Patients. *Hemodialysis Int*, 16(2), 214-9.
- Kasemkijwattana, S., & Praison, P. (2014). Family Caregiver of Chronic Patients: Risk Groups That Should Not Be Overlooked. *Journal of Nursing Council*, 29(4), 22-31. (in Thai).
- Monklang, R., Phosing, P., & Kanaphum, S. (2016). Factors Affecting Achievement Policy Implementation of Elderly's Health Service in the Local Administrative Organization. *Journal of Phrae Wa Kalasin, Kalasin University*, 3(2), 133-153. (in Thai).
- Office of Health Promotion, Department of Health, Ministry of Public Health. (2014). *Annual Report 2013*. Nontaburi: Health Promotion Agency, Department of Health, Ministry of Public Health. (in Thai).
- Office of National Health Security. (2017). *Health Security Building Report Fiscal Year 2017*. Nonthaburi: National Health Security Office, Ministry of Public Health. (in Thai).
- Office of National Statistical. (2018). *Demographic Statistics Report Population and Housing: Burden Rate 2010-2017*. Bangkok: National Statistical Office. (in Thai).
- Office of Public Health Chonburi Provincial. (2018). *Statistics Report on Elderly Bed Addiction*. Chonburi: Chonburi Provincial Public Health Office. (in Thai).
- Office of National Health Security. (2016). *Manual to Support the Management of the Long-Term Care Service System for the Elderly In the National Health Insurance System*. Nonthaburi: National Health Security Office. Ministry of Public Health. (in Thai).
- Phakdeeamnat, P., & Likitthamaroj, P. (2014). Guidelines for the Development of Welfare for the Elderly of Katong Sub-District Administration Organization, Yaha District, Yala Province. *Songklanakarin Journal of Management Science*, 31(2), 121-151. (in Thai).

- Phichayanon, D. (2020). *Thai Economy, Third Quarter of 2020*. Bangkok: Office of the National Economic and Social Development Council. (in Thai).
- Phueaksawat, P., Cholanakul, N., & Rojanarak, W. (2016). Problem Situation and Needs of Care for Chronic Patients with Bed-Bound and Home-Based Patient Groups in Community at the Municipality Surat Thani Area. *Nursing Journal of The Ministry of Public Health*, 26(2), 54-64. (in Thai).
- Photisita, C. (2013). *Science and Arts of Qualitative Research (Edition 6)*. Bangkok: Amarin Printing. (in Thai).
- Pongsaengpan, P., & Rodjarkpai, Y. (2014). Community Participation on Elderly Health Promotion in Eastern Thailand. *The Public Health Journal of Burapha University*, 9(2), 13-20. (in Thai).
- Prasartkul, P. (2013). *Situation of the Thai Elderly 2013*. Bangkok: Amarin Printing and Plub Shing Public Company Limited. (in Thai).
- Saengsee, K. (2013). *Social Welfare for the Elderly of the Local Government Organization of Buriram Province*. National Academic Conferences and Research Presentations Academic Rajabhat University, Nakhon Ratchasima Rajabhat University. (in Thai).
- Sawatphol, C., Phengpinit, T., Senanikorn, A., & Srisuraphon, V. (2017). Caring for Dependent Elderly in the Northeastern Region of Thailand. *Journal of MCU Peace Studies*, 5 (Special Edition), 387-405. (in Thai).
- Shiouh-Chu, S., Hengh-Sin, T., & Shu-Yuan, L. (2012). Social Support as Influencing Primary Family Caregiver Burden in Taiwanese Patients with Colorectal Cancer. *J Nurs Schol*, 44(3), 223-31.
- Sirikampeng, U., & Phosing, P. (2017). Long-Term Care for Dependent-Dependent Elderly in the Era of Thailand 4.0. *Thammathat Academic Journal*, 17(3), 235-243. (in Thai).
- Sirirak, W., & Suriyo, N. (2017). *The Participation of Network Partners in the Care of the Elderly in the Community at Tanya Subdistrict, Kamalasai District, Kalasin Province*. Research Report. Kalasin Provincial Public Health Office. (in Thai).
- Smith, C. E., Piamjariyakul, U., Yardrich, D. M., Ross, V. M., Gajewski, B., & William, A. R. (2012). Complex Home Care: Part3-Economic Impact on Family Caregiver Quality of Life and Patients' Clinical Outcome. *Nursing Economics*, 28(6), 393-414.
- Sonnoi, A., Siripanumas, P., & Piyanukool, S. (2016). The Development Model For Elders' Quality Of Life in Buriram Province. *Academic Journal of Buriram Rajabhat University*, 8(2), 153-169. (in Thai).
- United Nations Population Fund: UNFPA. (2017). *Ageing in the Twenty-First Century: A Celebration and A Challenge*. Help Age International (online). pp 4-5.