PMAC
PRINCE MAHIDOL AWARD CONFERENCE 2026

Navigating Global Demographic Transition through Innovative Policy: An Equity-Centered Approach

HEALTH POLICY AND SYSTEMS RESEARCH TEAM RAMATHIBODI HOSPITAL

คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี
FACULTY OF MEDICINE RAMATHIBODI HOSPITAL

TWO DECADES OF **LONG-TERM CARE** UNDER THAILAND'S UNIVERSAL HEALTH COVERAGE: **Review of Evolution, Expansion, and Equity Challenges**

NATTHAWUT IANGTANARAT, PAWIN SRIWICHIAN, PIWAT SUPPAWITTAYA, THEPPITAK KHEMLA, PHARANYOO OSOTTHANAKORN, NUTTAPAT PROMMANUN

AFFILIATION:
Health Systems Research Unit

Department of Community Medicine
Faculty of Medicine Ramathibodi Hospital, Mahidol University

RATIONALE

- Health systems worldwide are facing immense pressure from two converging forces: rapid demographic aging and declining family caregiving capacity, which collectively strain the sustainability of Universal Health Coverage (UHC).
- Thailand presents a pivotal, yet underexplored paradigm—a community-based, tax-funded Long-Term Care (LTC) system integrated into UHC through decentralized governance. However, global policy lacks a synthesized, longitudinal evaluation (2002–2024) of how such community-driven models evolve, adapt, and sustain scalability in a middle-income setting.
- For LMICs confronting similar demographic pressures, policymakers currently lack a viable blueprint for integrating sustainable and equitable LTC into existing health coverage schemes. This research addresses that gap—offering transferable lessons from two decades of Thailand's experience.

OBJECTIVE

To trace and analyze the development trajectory of Thailand's LTC systems within the UHC framework from 2002 to 2024, examining the policy evolution, institutional mechanisms, and implementation approaches.

METHODOLOGY: SCOPING REVIEW

Systematic searches in international and domestic databases,

Scope
Data extracted on care models, financing mechanisms, service delivery, governance, and workforce structure

198
Documents Analyzed
Comprehensive literature base spanning academic publications, policy reports, and technical documents from 2002-2024

22
Years Reviewed
Two decades of LTC systems evolution under universal health coverage (UHC) framework in Thailand

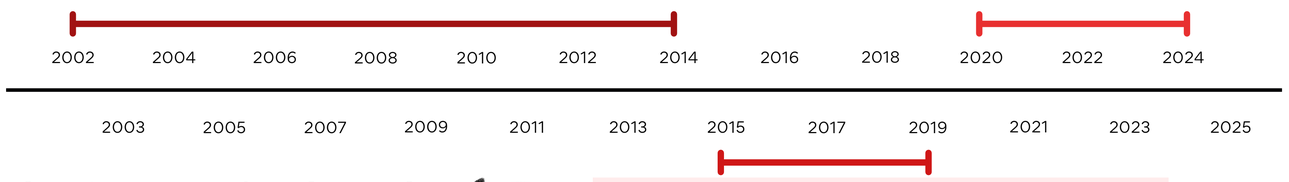
Key FIndings

Three Phases of LTC Evolution

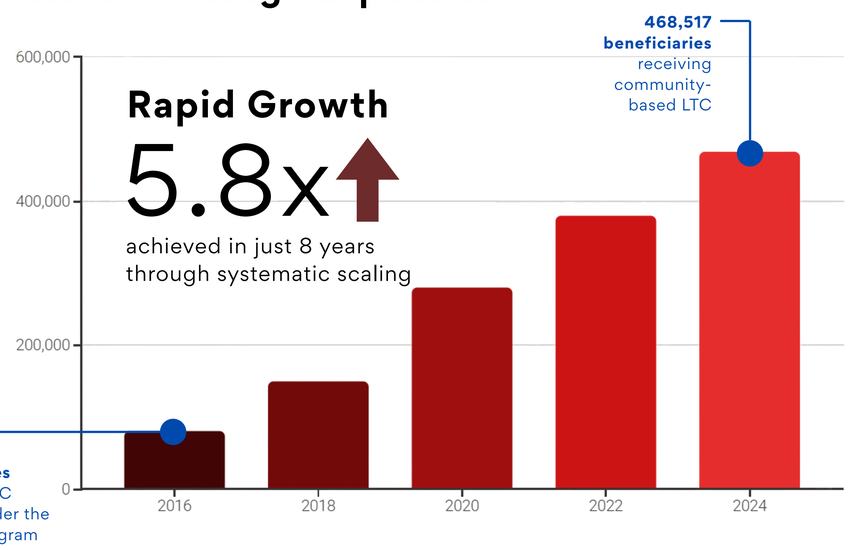
Phase 1: Foundations (2002–2014)
- UHC established, but LTC remained fragmented across sectors.
- Early pilot programs tested community caregiver models, revealing significant unmet needs among dependent older persons.
- This period laid groundwork for recognition that aging would require systematic policy response.

Phase 2: Institutionalization (2015–2019)
- NHSO launched dedicated LTC Fund channeled through LAOs, marking shift from pilots to formal programs.
- Standardized caregiver training curricula, competency frameworks, and supervision models developed.
- Shared data systems between caregivers, LAOs, and health facilities began integration.

Phase 3: Expansion & Integration (2020–2024)
- Rapid scaling of LAO-led LTC across Thailand.
- Consolidation of decentralized governance structures with clear roles and accountability.
- Expansion of coverage to nearly half a million dependent elderly, representing mature, integrated system.



Remarkable Coverage Expansion



The Community-based Service Delivery Model

Thailand's LTC system operates through a distinctive multi-level governance architecture that distributes responsibilities across national, provincial, and local tiers.

Multisectoral Collaboration:
- **National-local governance linkage:** The National Health Security Office (NHSO) provides strategic planning, financing, and performance monitoring, while local administrative organizations (LAOs) exercise implementation authority as elected governments with constitutional mandate over social services
- **Local-community partnership:** LAOs contract directly with village-based community caregivers (CGs), embedding service delivery within existing community structures and local accountability mechanisms
- **Health-social care integration:** Healthcare teams at primary care units and district hospitals provide clinical supervision, technical support, and quality assurance for CGs—bridging medical care and daily living support through regular supervision meetings, case conferences, and continuing education sessions

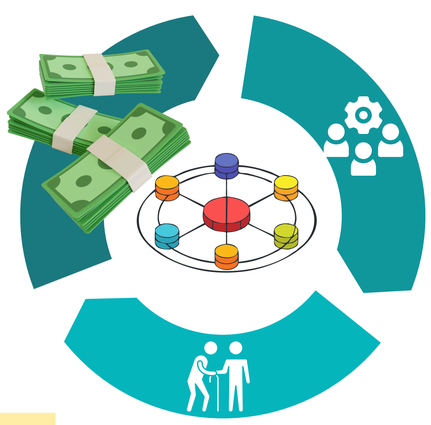
Village-Based Paid Caregivers Provide:
- **Basic ADL Support:** Assistance with activities of daily living including bathing, dressing, feeding, and mobility
- **Home Visits & Monitoring:** Regular check-ins to assess health status and identify emerging needs
- **Care Plan Follow-up:** Implementation of individualized care plans developed with clinical teams
- **Coordination:** Liaison with nurses and primary care providers for integrated care delivery

By leveraging existing local government capacity, integrating with primary healthcare systems, and developing community-based caregiver workforces, Thailand has created a model that is **contextually appropriate, cost-effective, and scalable.**

From National Strategy to Local Implementation

NHSO Allocation
National Health Security Office allocates dedicated LTC funding through annual budget cycles

$45.6M
Annual Program Cost
Total investment in 2024



CG Contracting
Community caregivers contracted and compensated for service delivery

LAO Distribution
Local Administrative Organizations receive and manage funds based on local dependency burden

Integrated digital reporting between CGs, LAOs, and health facilities supports quality assurance, resource allocation, and local monitoring, creating a cohesive ecosystem of care.

Implementation Challenges and System Constraints

Community Caregiver Workforce Shortages
- Burnout risks persist due to high caseloads, emotional demands, and limited support structures
- The lack of structured career pathways and professional recognition undermines retention and recruitment efforts

Financial Sustainability Concerns
- Reliance on annual budget cycles creates uncertainty and limits strategic long-term planning.
- The current funding model lacks mechanisms for automatic adjustment to demographic changes or inflation, risking erosion of real service capacity over time.

Variable LAO Capacity
- Significant differences exist in LAO budgeting capability, governance strength, and managerial capacity.
- These variations create geographic inequities in service quality and accessibility, with under-resourced LAOs struggling to deliver consistent care.

Limited Professionalism
- The caregiver workforce lacks formal career ladders, standardized accreditation systems, and robust supervision frameworks.
- This limits quality improvement potential and undermines the professional identity of this critical workforce.

Lessons for LMICs (design features appear particularly transferable to similar contexts))

Political Commitment

Thailand's success reflects sustained political leadership and multisectoral collaboration across health, social welfare, and local governance agencies. Building this consensus required years of policy dialogue, pilot demonstrations, and evidence generation.

Decentralized Governance with Local Empowerment

Empowering local governments with implementation authority and accountability creates ownership and enables contextualization while maintaining national standards and equity goals

LTC-UHC Institutional Linkage

Linking LTC explicitly to UHC frameworks and health financing systems positions it as an essential health and social services rather than a residual welfare program, enhancing political commitment and resource mobilization

Incremental Expansion

Rather than attempting immediate national coverage, Thailand pursued phased scale-up, allowing time for learning, adaptation, and capacity building. This pragmatic approach enhanced sustainability and quality.