CHAPTER I

BACKGROUND AND SIGNIFICANCE

1.1 Introduction

Older members of the population becoming the majority among the peoples of the world. The U.S. Census Bureau, Population Division (2000), has revealed that the proportion of people aged ≥ 60 years is growing faster than any other group. In the period 1970-2025, growth of some 694 million (223%) in the older population is expected. It is estimated that, by 2025, about 1.2 billion people will be aged > 60 years, and by 2050, 2 billion, with 80% living in the developing countries (World Health Organization [WHO], 2002a).

This increase in the number of older people is affecting the global population structure and having a considerable impact on elderly healthcare. This study was conducted and hoped the findings would be fruitful information to strengthening older population health and wellbeing. This first chapter, therefore, illustrated the information support why this study focus on the older population; social support and the elderly health, Thai elder's problems, possible entry of intervention, purpose of this study, also the study expected outcome.

1.2 Why the older population?

1.2.1 The number of older people is increasing rapidly and this growth has consequences

The elderly population is growing globally. Thailand, like other developing countries, has experienced an increase in the elderly population. Jitapunkul et al. (2000) noted that, in 1990, the proportion of the elderly population (i.e. those aged $\geq$ 60 years) was 7% (5.6 million), and this increased to 9% (6.2 million) by the year 2000. By 2020, the percentage of the elderly in the population should rise to 15%, at > 7 million (Jitapunkul & Chayovan, 2004).

One major consequence of an older population is an increase in the dependency ratio. In 1960, the total dependency ratio was 92/100 working population, of whom almost all were dependent children. As birth rates have declined, the child dependency ratio has declined, contributing to an initial reduction in the total dependency ratio. Similarly, during the process of population ageing, old age dependency ratios have increased. The combination of the trends has contributed to an initial reduction in the total dependency ratio, which will reach a nadir in 2010. Thereafter, the ratio will increase dramatically. According to United Nations' population projections, after 2026 the old age dependency ratio in Thailand will be higher than the child dependency ratio (Figure 1).

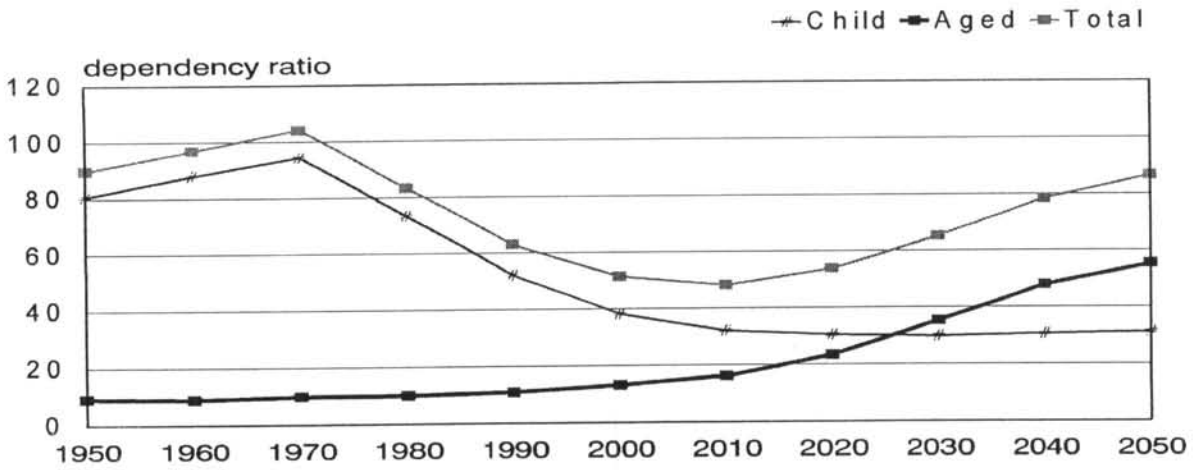

Figure 1: Total, Child and Aged Dependency Ratios per 100 populations, Thailand, 1950-2050

Source: Jitapunkul, S. & Chayovan, N. (2004). **National policies on ageing in Thailand.** Bangkok : Chulalongkorn University.

Moreover, the WHO (2002a) has indicated that the overall decline in mortality rates has had a dramatic effect on survival into old age. Advances in public health and medicine, improvements in nutrition and the standard of living, together with the control of various communicable and infectious diseases, have resulted in a gradual but dramatic increase in life expectancy at birth. In the case of Thailand (Table 1.1), life expectancy at birth has increased for both males and females, from 55.2 years for males and 61.8 years for females in 1965, to 70 years for males and 75 years for females in 2001.

Table 1.1: Life Expectancy at Birth, Thailand 1965-2001

Year	Male	Female
	Years	Years
1965	55.2	61.8
1975	58.0	63.8
1985	63.0	68.8
1995	69.9	74.9
2001	70.0*	75.0

Sources: National Statistics Office [NSO]. (2006). **Reports the survey of population change.** Retrieved December 12, 2006, from http://web.nso.go.th/eng/en/stat/popchang/popchg.htm

Survey of population change, population gazette. *(2001). Nakhon-Prathom : Institute for population and social research, Mahidol University.*

The number of elderly is increasing and people are living longer in Thailand. This has resulted in an increase in the dependency ratio and life expectancy, with consequences for socioeconomic development and health resources, especially for serious health problems requiring timely and well-planned policies and programs to manage them effectively.

1.2.2 Ageing and Changing

The maximum human life-span over the centuries appears to be relatively constant, at approximately 100 years, but can be as high as 120 years (WHO, 2002b). The passage of time results in physiological, psychological and psychosocial changes in the elderly.

Physical change: the physical function reserve capacity (such as muscle strength, cardiovascular and respiratory fitness, skeletal integrity) of older

people declines with increasing age. Older people have to cope with an increasing "fitness gap" (figure 2), and this reduction in reserve capacity places older people closer to a threshold that will limit their functional independence and will reduce their capacity to adapt to new challenge by diseases, and social and environmental factors. Reduced adaptability makes elderly people vulnerable to increased risk of the complications of disease and more likely to suffer a "cascade of disasters" following an initial fairly trivial incident. Loss of adaptability also make atypical presentations of diseases more common, as thresholds for normal performance are so precarious that minor degrees of impairment, regardless of the organ system involved, results in more general physical and mental disturbance (Ebrahim, 2002).

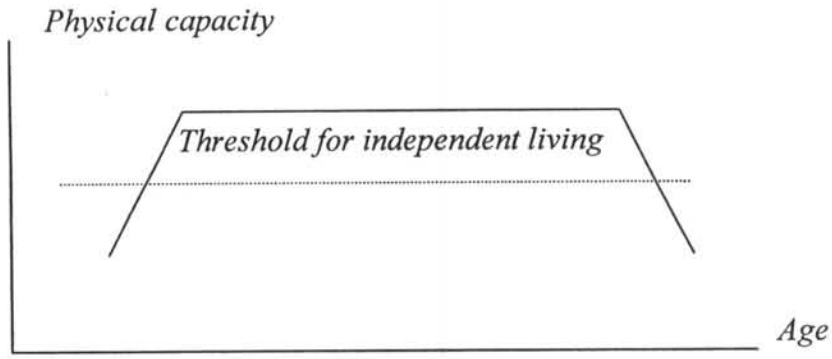

Figure 2: Relationships between Age and Physical Capacity Showing the Effect of a Threshold of Dependent Living

Source: Ebrahim, S. (2002). Health of elderly people. In Detels R, McEwan J, Beaglehole R, Tanaka H (Eds.). **Oxford textbook of public health.** (4th Ed.). (pp. 1713-1736). New York : Oxford University Press.

Moreover, aging is the maturation and senescence of the biological system, not only the true expression of senescence, but caused by the greater length of time older people have lived, and hence their greater period of risk and exposure, which produces health effects. More than likely, it is some combination of true senescence and a greater exposure to risk factors that is responsible for the changes we consider as aging. For example, the highest audible pitch people can hear declines with age, but it is also likely that long years of occupational exposure to noise, untreated ear infections during childhood, and an accumulation of minor injuries might contribute to loss of hearing in old age.

Psychological change, for example, cognitive decline caused by some physical illness and medication, can affect natural function and also reduce the energy available for cognitive processes (Scharlach & Robinson, 2003).

In addition, social-role change and the passage of time increase the experience of the elderly in every life stage, encompassing changes in social roles, and societal and self-definition of transition, which results in psychosocial change for the elderly.

Physical, psychological, and social changes result in loss of adaptability and increased risk of disability, so that the elderly are a high-risk group, which affects the costs of care.

1.2.3 Cost of Care

The WHO (2002a) stated that research in countries with aged populations has shown that the elderly *per se* are not likely to lead the increases in healthcare costs that are spiraling out of control, for two reasons:

(1) The major causes of escalating healthcare costs are related to circumstances that are unrelated to demographic aging of a given population. Inefficiencies in healthcare delivery, building too many hospitals, payment systems that encourage long hospital stays, excessive numbers of medical interventions and the inappropriate use of high-cost technologies, are key factors in escalating healthcare costs. In the USA and other developed countries, for instance, new technologies have sometimes been rapidly introduced and used where alternative and less expensive procedures already existed, and for which marginal effectiveness was relatively low.

(2) Chronic diseases exact a particularly heavy burden, because they contribute to disabilities, diminish quality of life and greatly increase healthcare costs. In the USA, for example, more than 65% of Americans aged $\geq$ 65 years have some form of cardiovascular disease, and half of all men and two thirds of women aged >70 years have arthritis. Nearly 40% (12 million) of seniors were limited by some chronic disease. Of theses, 3 million were unable to perform the normal activities of daily living (ADLs), thus placing caregiving demands on family and friends (Jacobzone & Oxley, 2002).

Therefore, the demands on public health, and on medical and social services, have been increasing. Currently, almost one third of total annual U.S.

healthcare expenditures, or $300 billion, is for older adults. By 2030, healthcare spending will increase by 25% simply because of the increased number of elderly, and this does not take into account inflation or the cost of new technologies (Jacobzone & Oxley, 2002).

However, in developing countries, within the current health services system, inequity of access to services and overuse of ineffective services, are evident. Older people who would benefit from specific interventions (such as coronary revascularization) do not receive them. Simultaneously, acute hospital beds are inefficiently used by patients on hold, waiting for transfer to a different care sector. Increasing the barriers to entry for older people into secondary care is an obvious, but inappropriate, response. It is necessary that both health and social-care costs are considered in economic appraisal, rather than just the costs of one system or another, to ensure that the balance of care is of net benefit to society and not simply in favor of one party instead of another (Ebrahim, 2002).

1.2.4 Global Ageing Policies

As mentioned earlier, population aging is one of humanity's greatest triumphs. In the 21st century, global aging will put increased economic and social demands on all countries. At the same time, older people are precious, oft-ignored resources that make an important contribution to the fabric of society. The WHO argues that countries can afford to get old if government organizations and civil society enact "active ageing" policies and programs to enhance the health, participation, and security of older citizens. The time to plan and act is now (WHO, 2002a).

The programs and policies related to the recommendations should be based on the rights, needs, preferences and capacities of older people. Programs also need to embrace a life-course perspective that recognizes the important influence of earlier life experience on the way the individual ages. Therefore, strengthening family and social supports for the elderly will directly support this policy, to enhance the quality of life of elder people.

1.3 Social Support and Elderly Health

Physiological, psychological, and socio-environmental changes put the elderly at high risk of disease and disability. Social support is one important factor that plays a major role in maintaining wellbeing and fostering the potential to transcend the physical limitations that accompany aging. The reasons are as follows;

(1) Social support involves meaningful social relationships; it reduces isolation. People with intimate companions in later life have higher levels of life satisfaction. They feel valued, and in turn, valuable. A study by McAuley et al. (2000) revealed that social relationships integral to the exercise environment are significant determinants of subjective wellbeing in older adults, such as satisfaction with life. Meanwhile, Zunzunegui et al. (2003) revealed that poor social connections, infrequent participation in social activities, and social disengagement, predicted the risk of cognitive decline in elderly individuals. In addition, McCulloch (1995) found that social support was a significant predictor of mental health outcome. Similarly, Van Baarsen (2002) indicated that elders who had lost a partner had lower self-

esteem, resulting in higher levels of emotional and social loneliness, i.e. perceptions of less support.

(2) Social support presents as caring, while a familiar other provides a flow of affection, information, advice, transport, assistance with meals and daily activities, finance and healthcare--all critical resources (Stephans & Bernstein, 1984).

(3) The social support system tends to reduce the impact of stressors, especially serious illness and depression, among the elderly (Murrell & Norris, 1991). The support system often serves to encourage an older person to maintain healthcare practices and to seek medical attention when it is needed. For some women, social support appears to have some relationship to length of time following treatment. Similarly, Koukouli et al. (2002) found that social support appeared to play a significant role in explaining differences in subjective functioning: people living alone or only with the spouse, particularly the elderly, seemed to be at greater risk of disability problems and should be more targeted for preventive programs in the community. McNicholas (2002) indicated that social support, self-esteem, and optimism were all positively related to positive health practices, and that social support was positively related to self-esteem and optimism.

(4) Social support affects quality of life

O' Hara (1998) supported the suggestion that optimism and satisfaction with social support are associated with better quality of life. In addition, several reports have confirmed the relationship between social support and quality of life. Keokum (2003) revealed that where the elderly had social support, QOL was high; social support for the elderly studied showed a significantly moderate positive

correlation with quality of life ($p<0.01$ $r=0.493$), but some elderly had not received social support and overall quality of life was low. The results of qualitative studies using focus groups and in-depth interviews showed that the social supports derived from the family, community, elderly club, government and private sectors, were unevenly distributed. The poor elderly were those who did not have a permanent residence, did not receive occupational promotion, had mental health problems, and did not receive any living subsidy from the government. The study suggested that elderly clubs should be involved in promoting the elderly vocation, with groups for mental development, providing useful information, and providing support with the needs of living, especially for the poor. Meanwhile, co-operation from the family, community, government, and private sectors is needed to increase social support and thereby improve QOL.

Very old people are likely to experience a decline in physical stamina. They may also have limited financial resources. Their value must be founded on an appreciation of their dignity and history of reciprocal caring. For very old people, especially women, the likelihood of living alone is quite high. After the death of a spouse, men and women must realign their social support system from among relationships that include their adult children, friends, relatives, neighbors and new acquaintances, in order to satisfy their needs for interaction and companionship. In addition, very old adults who are childless and those who have no surviving children or siblings, are especially vulnerable to ending their lives in isolation (Hays, 1984).

1.4 Thai Elderly Social Support

Yodpech et al. (1997) indicated that almost all Thai elders received and perceived social support from their families. Mostly, Thai elderly received financial support, material support, and information support from the family. Jitapunkul et al. (2000) found that young Thais had a positive attitude towards elder care, and recognized that care for the elderly was one of their greatest duties. Interestingly, daughters usually played the role of caregiver for elderly parents, with the youngest daughter being most commonly favored for this role (Wongsith & Siriboon, 1996). If the elderly had no daughter, the youngest son would stay and provide assistance. It is important to note that, even though the Thai elderly received family support, they received perceived emotional support from their elderly friends (Chayovan & Knodel, 1997).

However, social support for the elderly tended to decrease because the family structured had changed (Yodpech, 2007). In addition, previous studies of Thailand elucidated only social-support characteristics and sources of social support, and examined social support as a dependent variable related to stress or other disease situations. Thus, little was known about the factors influencing perceived social support and intervention programs to strengthen social support among Thai elders.

1.5 Current Intervention Programs

Health Services

The Thai government has implemented several projects to provide support for the Thai elderly (Ministry of Public Health [MOPH], 2001b), including a social

security scheme for the elderly, comprising a health card that entitles the holder to free medical treatment in public hospitals belonging to the Ministry of Public Health. In addition, the Ministry of Education and Culture (MEC) and the Ministry of Social Development and Human Security provide support for the Thai elderly in the areas of education and social welfare.

In the case of the Ministry of Public Health, health service supports for the elderly are not separated from other groups, and are divided into two levels: the institutional level, including hospitals, nursing homes, adult daycare centers, and the community level, including primary care units of community hospitals and health centers.

At the institutional level, the number of special clinics for the elderly in hospitals was inadequate. Only 44% of MOPH hospitals had a complete elderly clinic (Kamnuansilpa et al., 2000). However, Jitapunkul et al. (2000) found that care for Thai elders with illnesses not requiring hospitalization was high, with just over half using health services. Children had an important role to play in taking care of their parents. Despite the Thai government's wish to provide health care for the elderly, the rate of elderly people not using health services has increased from 39.6% in 1988 to 47.2% in 2000. One reason for this is that elderly people may receive inappropriate or inadequate care if they use the free healthcare program. Moreover, many prefer to buy drugs over the counter for the sake of convenience.

At the community level, primary care units of community hospitals and the health centers are responsible for providing services for elders, including home visits, health education, health promotion, prevention and disease control, and rehabilitation.

However, due to lack of staff, most activities result from MOPH policies rather than community-based problems (Sriruksa, 2001).

Non-government organizations (NGOs) also provide health services for Thai elders--private hospitals, private institutions, private health service centers, and private adult daycare centers. At present, the services are found only in towns and some urban areas (Sritanyarat et al., 2002).

Social Services

There are two social-service institutions that support the elderly; (1) government social services belonging to the Ministry of Social Development and Human Security, which provide 18 residential care facilities, support elderly social welfare funding, and other services; (2) non-government organizations, such as elderly clubs, the Senior Citizens' Council of Thailand, Thai Senior Citizen Great Wisdom Association, the Foundation for Older People Development (FOPDEV), and Help Age International (Sritanyarat et al., 2002). In rural areas, some elderly find services inaccessible, and receive only a monthly allowance for frail elderly or poor elderly.

In conclusion, health and social services for Thai elders have not been adequately covered. Some Thai elders did not access services, and government and non-government and NGOs had non-complementary or uncoordinated polices, with program mismatch and redundancy in some implementation areas in each organization (Sitthi-amorn & Somrongthong, 2000). Thus, an approach is necessary

that empowers the relevant community organizations working for the elderly, and which requires well-planned policies and programs.

1.6 Thai Elderly Policies

The WHO has argued that countries can afford to get old if governments, international organizations and civil society enact active aging policies and programs to enhance the health, participation, and security of their older citizens. The time to plan and act is now (WHO, 2002a). Program policies with the relevant recommendations should be based on the rights, needs, preferences, and capacities of older people. The programs also need to embrace life-course perspectives that recognize the important influence of earlier life experience on the way people age.

In the case of Thailand, in 1986, the first long-term plan for the elderly (1986-2001) was drawn up by the National Committee for the Elderly, to be used as a framework and guidelines for authorized and associated organizations. However, there was little progress or action by state organizations between 1982-1991. Active progress materialized after the passing of the National Long-term Plan of Action for the Elderly (1992-2011), in 1992 (Jitapunkul & Bunnag, 1999).

The National Long-term Plan of Action for the Elderly (1992-2011) was prepared to support implementation of government policies for the care of older persons. The objectives of the plan were: 1) to provide the elderly with general knowledge on ageing and environmental adjustments, including health care, 2) to provide the elderly with the protection and care of their families and the community through other welfare services, as deemed necessary, 3) to support the roles of the

elderly in participating in family and other activities, and 4) to stress the responsibility that society has for the elderly (Ministry of Public Health, 2001).

In addition, Jitapunkul & Bunnag (1999) recommended that future state actions for the aging population should include: 1) provide welfare of all kinds, particularly a pension for every Thai elderly person. Social security and the promotion of private pension insurance are unavoidable strategies for the future, 2) strengthen family values and sustain family support for the elderly, 3) strengthen community participation in both social and healthcare sectors, 4) provide welfare and support schemes for care-givers of dependent elderly and disabled persons, 5) provide community care in both health and social sectors, especially at the primary healthcare level, 6) although institutional care is inevitable, these services should be provided only for the elderly in need. Geriatric assessment is essential for evaluation prior to placement, 7) improve self-care ability among the elderly; this should cover not only health promotion and prevention, but also simple curative care and rehabilitation. Alternative medicine is also invaluable, 8) strengthen information about care, which is also an essential domain of care for Thai elderly. Religious organizations, senior citizens' clubs and other non-governmental organizations are important resources of informal care, 9) provide continuous formal and informal education programs for the elderly and younger people nationwide (preparing people for old age), 10) provide education and training for both health and social service personnel.

The Thailand Health Development Plan, under the 9th National Economic and Social Development Plan (2002-2006), focuses on human-centered development with a holistic approach to strategies for sustainable development. The main strategies are

to improve the quality of life of the Thai people (The Bureau of the health policy and planning, 2001). Thai elderly policy has focused on health and social aspects, especially strengthening individual and family participation in the community, and other levels. Family and community social support among the elderly is a common important issue supported by social policy at both Thai and global levels.

1.7 Problems of the Thai Elderly

The problems of the Thai elderly are closely related to the impacts of Thai economic change, changes in the Thai social structure, and non-communicable diseases.

(1) Fewer caregivers for Thai elders: impact of Thai economic change

In 1970, Thailand entered a period of economic transition. Business organizations have initiated, transformed and encouraged self-sustaining developmental economic policies and legislation. The growth of business has resulted in a number of young people migrating to urban areas (Warnes, 1992). People in the countryside, who work in agriculture and experience the impact of inadequate rainfall and low prices for their products, seek and find employment in the cities. In earlier times, young villagers left home for the cities only after the harvest season. The situation was temporary and they would return in the wet season. Therefore, children used to be able to care for their elderly parents.

In 1985-1990, the economy of Thailand grew rapidly. The demand for labor rose and wages increased sharply. A large number of unskilled agricultural workers moved into the manufacturing and service sectors. Both male and female

laborers migrated from rural areas. They wanted high incomes to support their families back home. As a result, many old people were left at home alone with their grandchildren (Caffrey, 1992). Since the migration of young people to the cities tended to be long-term when the economy was growing, financial support was offered to elderly parents rather than traditional direct personal support and care.

In 1990-1995, the Thai economy grew dramatically, with a large influx of foreign investment and growth in exports (Warr, 1997). Thailand was becoming a newly industrialized country. Employment opportunities with attractive wages influenced a great number of rural laborers to migrate to urban areas, particularly Bangkok (Choowattanapakorn, 1999). The boom economy drained a vast number of youths, men and women from rural villages to the cities and abroad. Several hundred thousand Thais migrated to work in the Middle East, Japan, Taiwan, and Singapore. In addition, 7 of the 10 major export industries powering economic growth in Thailand were staffed overwhelmingly by women (Pongpaichit & Baker, 1996). Although village laborers were able to support their parents financially, the majority of older persons were at home, supporting themselves physically and psychologically. This situation has been shaped by some separate conflicting traditions: (1) children who had traditionally cared for their parents moved into the labor market, (2) married women were away from home working in the cities with no guarantee that they would be able to return home with adequate funds to support an improved standard of living for their elderly parents and their own children (Jane-Aubron, 1991).

The Thai economy slumped in 1997, due to excessive loans and reduced exports. Some investors were unable to repay their loans. This resulted in the closure of some companies and factories. At the same time as Thai people faced higher living expenses, an enormous number of laborers lost their jobs. Rural laborers suffered greater hardship and could not maintain financial support for their parents. Although some young people have now returned home and are available to provide care for their older parents, they now struggle financially due to unemployment.

In summary, the development of the economy and the modernization of Thailand, associated with a gloomy economic outlook, have resulted in many social changes that have impacted family structures and relationships. The Thai family has become smaller in size, with fewer children to take on the role of caregiver for their elderly parents (Choowattanapakorn, 1999).

(2) Decline in role, duty, and respect for the Thai elderly: impact of changes in social structure

Thai society is characterized by a hierarchical tradition, in which people occupy differently ranked social positions. Social relationships are marked by superiority and inferiority. Children are taught early to respect older people and people of higher status. One aspect of Thai culture may be called parent repayment. Children are expected to repay their parents for having borne and nurtured them (Choowattanapakorn, 1999). Therefore, the sense of obligation is very strong in Thailand. Thus, old people can expect to be valued and honored by their children. A study of the living arrangements of Thai elderly found that most Thais refuse to let their parents move to an institution for elderly people. However, because of economic

change and smaller families, an increasing number of old people currently live alone or with a spouse.

However, because of Thai social structural change, the dependence ratio of the elderly is rising, while the status and roles of the elderly are declining and those of the younger increasing. Society shuns some elderly because of negative attitudes, such as the perception that the elderly are group of people who are useless and live alone. In addition, some interactions between the elderly and other social groups may be negative, with some elderly receiving less care and increased neglect. Moreover, the passage of time causes the social environment of the elderly in each rural and urban community to change, resulting in reduced understanding between the elderly and younger people. Some families experience increased conflict between the younger and older family members.

(3) Health problems: impact of non-communicable diseases and disability

Elderly people may suffer due to the physical changes of aging, and also suffer decline in health status, particularly those in the old-old age group. The shift from communicable to non-communicable diseases among the elderly has already occurred in Thailand. Chronic illnesses, such as stroke, heart disease, osteoarthritis, accidents, blindness, deafness, and hypertension are fast becoming the leading causes of death and disability (Jitapunkul & Bunnag, 1999). However, AIDS, tuberculosis, malaria and various tropical infectious diseases still burden the nation. Therefore, the "double burden of disease" strains already scarce resources. With respect to the psychology of ageing, it may be said that Thai society is still stuck in an out-dated paradigm that considers old age as being associated with sickness,

dependence, and lack of productivity. Chayovan & Knodel (1997) found that 50% of elderly Thais experienced low levels of loneliness, indicating that elderly Thais have greater physical than mental problems.

In addition, the prevalence of disability among Thai older persons is high. Thai elderly women have a higher prevalence of disability and dependence than men in all age groups. The rate of disability increases with age, where very severe and severe disabilities contribute to chronic disability. Although elderly women live longer than elderly men, they also spend more years with disabilities. Thai men spend proportionally more time leading a healthy life than Thai women. While the importance of the gap between sexes in Disability-Free Life Expectancy (DFLE) seems to diminish with age, the proportional time of disability for both men and women increases with age. Unfortunately, there is evidence from recent research that suggests that Thailand is at a stage of "morbidity expansion", i.e. age-specific rates of chronic diseases and disabilities are increasing (Jitapunkul et al., 2000). AIDS and drug addiction are also serious issues for Thailand and definitely impact upon families and communities, national health and social services, as well as resource allocation, and hence the older population.

In summary, in Thai culture, elderly people are respected and honored by their children. People follow the Buddhist doctrine of reciprocity for older parents' goodness. Thai society is being confronted by socioeconomic changes and an increased number of elderly people. Young people struggle to find employment in the new society and the migration of rural laborers to cities separates family members and communities. These changes jeopardize the customs of reciprocity for parent

goodness. Young people today experience conflict between their obligations to care for their parents and the hardships of life. In effect, family support is often different from what it was in the past. Moreover, non-communicable diseases and disability are having a marked effect on the Thai elderly. In the Thai healthcare system, there is no particular hospital or ward for elderly people, but few projects are being introduced to ensure appropriate care and support for the elderly. To solve these problems, support from other individuals and from society at large is important. Therefore, elucidating the various aspects of social support for the elderly, and related factors, is crucial, as the results will lead to a better understanding of Thai elderly social support and result in a strengthening of the social-support model of intervention for the better health and wellbeing of the Thai elderly.

1.8 Possible Interventions

Khon Kaen is located in central-northeast Thailand. Like the trend nationwide, the proportion of the Khon Kaen population aged >60 years has been increasing. In 2003, 10.94% of the total population were elderly; this increased to 11.54% in 2004 and 12.6% in 2005. In addition, the proportion of old-old people (≥ 70 years of age) increased from 4.3% in 2003, to 4.7% in 2004, and 5.1% in 2005 (Khon Kaen Provincial Health Office, 2006).

Sriruksa (2001) revealed that 70% of the elderly sample in Khon Kaen depended on medical aids and needed someone to care for them and take them to hospital and to the health-service system. The quality of life of the elderly in Khon Kaen was at a medium level and family support influenced elderly quality of life.

Unfortunately, little has been done to study social support and its factors/or model development to strengthen social support among the elderly in Khon Kaen.

In Khon Kaen Province, there are various organizations, including government organizations, non-government organizations, schools, religious organizations or community workers for elderly health and elderly activities. However, most of these organizations set their own objectives and work independently of each other. Consequently, there are gaps, fragmentation, and redundancy among the organizations.

While there was good cooperation between Khon Kaen University, Khon Kaen Provincial Health Office, the Community Hospital, District Health Office and Sub District Administrative Organization regarding social support for the elderly and their problems, no study had reported on social support and its factors, or cooperative intervention programs between local organizations in Khon Kaen. Thus, Khon Kaen Province was prompted to study and develop an intervention program focused on strengthening social support for the elderly.

1.9 Purpose of the Study

The purpose of this study is to develop a plan to strengthen social support for the elderly in Khon Kaen Province, Thailand. The study focuses on the area of Khon Kaen, the characteristics of the elderly, levels of perceived social support and related factors, and explores the social network of the elderly--perspectives, needs and problems--and compiles and analyzes the findings to develop a plan for strengthening social support for the Khon Kaen elderly.

1.10 Study Approach

The study approach consists of three phases. Phase I: to gather baseline data regarding the elderly characteristics, levels of social support and related factors, social support needs and problems, and their social network perspectives through a literature review and rapid survey, to develop a data collection instrument. In Phase II, qualitative and quantitative data will be collected and analyzed. Phase III includes the development of an intervention strategy, a plan of action, and evaluation.

1.11 Expected Outcome

It is expected that the results of this study will elucidate the characteristics of the elderly and their social network, the level of perceived social support among the elderly, social support behaviors in respect of the elderlies' social network, and identify factors related to social support among the elderly that can be used in developing strategies to improve social support among the elderly.

This study will provide useful information to inform and support recommendations for stakeholders and policy makers. In addition, the findings will be useful for the Thai elderly; although the recommendations are based on the results of studying only the Khon Kaen Province community, they are important for strategic planning and delivery of appropriate and effective services to strengthen social support in other, similar areas.

It is hoped that the impact of this study will enhance the life satisfaction of the elderly and lead to better elder access to resources and material goods related to their physical and mental health and better quality of life.