MONASH University

Japan-Thai Collaboration to Address the Challenges of an Ageing Society: The dynamics of policy transfer

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A Thesis Submitted for the Degree of Doctor of Philosophy at
Monash University in 2022
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Abstract

The ageing of the human population is a global phenomenon that will affect most regions of the world in significantly different ways. Thailand too is likely to be acutely affected in terms of the scale and speed of this process. By the year 2025, Thailand is predicted to feel the full force of a rapidly ageing population, facing issues of labour shortages, poverty and shrinking resources. In order to tackle these challenges, Thailand looks towards a more 'senior' Asian neighbour, Japan to adopt policy ideas and best practices.

This study argues that the S-TOP program, as implemented between Japan and Thailand, is an example of policy transfer, occurring within the context of ageing societies. Based on fieldwork in Thailand, and using sources in Thai, English and Japanese, the study analyses the case study of S-TOP and addresses the follow questions:

1) What specific initiatives have been (are being/will be) pursued in policy transfer related to Thailand's ageing society?
2) How can policy transfer be viewed within a broader context of ageing population in Thailand?
3) What factors impede/enable this policy transfer?
4) What insights does this case study offer into Thailand – Japan relations?
5) How will the case study extend our understanding of policy transfer in general?

To date, policy transfer has predominantly been used as a tool in the field of education and has not been applied widely to policies in the field of ageing, or to intra-Asian transfers. This study marks a new direction in the study of policy-oriented learning. From the investigative findings, the study identified that the process of transfer involved both specific practices and culturally-driven assumptions to specific local settings. It also identified important actors overseeing the transfer and those receiving the implementing the policy in their own workplaces. The study uncovered a broad network of actors, involved in the transfer, both within the institutions formally, and across the wider community. Further, the case study of the Japan-Thai transfer offered a meaningful perspective into policy transfer, within which we are able to understand how wealthier countries like Japan may influence the transfer of policy to less developed countries through incentives. For Thailand, the findings have the potential to assist in setting the domestic agenda, where age-related policies are just beginning to take shape. They will inform the development of policies and programs for the benefit of the elderly and carers in various areas, such as health care, infrastructure, training and education, human resources and careers. Beyond the domestic context, this study opens up new directions in studies of policy transfer in global and regional forums.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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Publications during enrolment

1. Robson, Nalanda. 2020. “Japan-Thai Collaboration for Addressing the Challenges of Ageing Society: The dynamics of policy transfer.” In *「グローバル時代の日本学研究：GJS 講演会／セミナーの成果」[Japanese Studies in the Global Era: Results from Global Japan Studies Lectures/Seminars]. Institute for Advanced Studies on Asia 3,* 2020.

Acknowledgements

Having completed this study, I would like to express my gratitude to the following individuals and organisations:

To Ratchaphiphat Hospital and the medical staff for their hospitality in accepting my presence there as a researcher, allowing me to conduct interviews with them and observe their work. Many of the stories about their experiences with care were often personal and real, so that they have been fruitful not only for my research, but also for my own development as a person. My gratitude is also offered to Mr K, chief coordinator of S-TOP at the Japan International Cooperation Agency, who always willingly supported me by sharing his perspectives.

To Associate Professor Jeremy Breaden for his constant support, encouragement and patient guidance of my work throughout my time as his student. To Dr Jason Jones for his generous help in shaping my thought processes, and always challenging me to broaden my mind. I am extremely lucky to have had both individuals as my supervisor and co-supervisor, as they not only cared about my work but also about my personal growth.

To the Japan Foundation for providing me with a grant to travel to Japan for the Collaborative Research Workshop for Aspiring Scholars in 2019, and in publishing my work in their journal *Global Japan Studies* (2022). Thanks to them, I was given several opportunities to attend conferences, to improve my research and to make lasting friendships.

To my friends in Japan, Thailand, Australia and all over the world, for supporting and encouraging me.

And finally, to my father, mother, Tayut and Kichi for having encouraged me. Completing this work would have been all the more difficult were it not for my father's continual willingness to proofread countless pages, and my mother for having the patience to endure the ups and downs of my research.

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STYLE NOTES

ABBREVIATIONS

S-TOP	Seamless Health and Social Services Provision for Elderly Persons (2017 - 2022)
JICA	Japan International Cooperation Agency
MOPH	Ministry of Public Health
DOH	Department of Health
L-TOP	Long-term care Service Development for the Frail Elderly and Other Vulnerable People (2013-2017)
C-TOP	Community Based Integrated Health Care and Social Welfare Services Model for Older Persons in the Kingdom of Thailand (2007-2011)

TRANSLATION AND TRANSLITERATION

The English translations of Thai and Japanese phrases in the body text are all my own translations.

English terms are presented with single quotes. For Japanese terms I give a transliteration

followed by the relevant Kanji in square brackets. For Thai, words are followed by their

transliteration in round brackets.

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Chapter 1. Introduction

1.1 Background

The phenomenon of an ageing population has affected a number of counties around the world. For the majority of the world's population declining fertility and increasing longevity appear to be the central causes of the ageing population phenomenon. This means that the countries concerned will have a demographic profile characterised having more older people, fewer younger people, and an overall decline in the population. While in some countries the ageing of the population has been gradual, in others it has been more rapid and recent. In Japan the ageing population has been ongoing since the 1950s,[1] while in Thailand it started much later, in the 1970s and 80s.[2] Policymakers have long understood the consequences presented by an ageing population, namely the considerable implications for the economy, public health and welfare services demands, housing supply, household structure, labour supply and community behaviour. Without necessary preparations to respond to a changing society, the ageing population phenomenon will present complex challenges for the government to tackle. Some of these challenges are, namely, difficulties in maintaining pension payments, the provision of increased health care costs for aged care and other social welfare and services, and a stagnant economy due to a shortage of qualified workers. In response to the need to lessen or alleviate the impact of some of the challenges mentioned, governments are proactively learning from one another. Despite their different geographic and cultural contexts, most countries with an ageing population will face similar social and economic challenges. As a result, countries such as Thailand, with a more recent experience of ageing population, are looking toward countries with an advanced ageing population such as Japan for guidance, in the form of the adoption of ideas, policies and best practices. These ideas may then be adjusted to remedy the issues of their own

[1] Sagiri Kitao, "When Do We Start? Pension Reform in Ageing Japan," *The Japanese Economic Review* 68, no. 1 (2017): 26-47. https://doi.org/10.1111/jere.12135.
[2] Pramote Prasarkul et al., "Prospects and Contexts of Demographic Transitions in Thailand," *Journal of Population and Social Studies* 27, no. 1 (2019): 1-22. https://doi.org/10.25133/jpssv27n1.001.

ageing population, in the case of Thailand within the context of its own specific needs. The adoption or transferring of policies from one country to another can be studied using the framework of policy transfer. This offers an approach for studying the processes by which Thailand has been adopting policies from Japan in order to tackle the challenges of its ageing population.[3]

In this study, using the policy transfer framework, I explore the processes of Thailand adopting measures, policies and programs from Japan in order to address the challenges faced by Thailand's rapidly ageing society. I present findings based on the case study of a Japan-to-Thailand joint healthcare program, known as S-TOP, which was transferred by a Japanese government agency called the Japan International Cooperation Agency (JICA) into Ratchaphiphat Hospital in Bangkok, Thailand.

The World Health Organisation (WHO) describes population ageing as 'one of humanity's greatest triumphs'[4], as more people live longer and relatively healthier lives, with a high probability of giving birth to children in good health with limited frailty. However, this success does not come without its concerns. For many researchers this global demographic trend is also seen as one of the greatest challenges of the 21st century.[5] Where countries are experiencing a dramatic decline in both fertility[6] and mortality, governments must consider how to adapt their societal infrastructures and resources to accommodate the transition

[3] Various other social and economic factors such as class status, education level, urban, rural, age, race, population makeup and more, are all part of the picture of Thailand's fertility decline and ageing population. Other scholars have contributed to the discussion of these variables in detail. For more information see Whittaker, Andrea. "Empowerment or Control? Northeast Thai Women and Family Planning," in *Borders of Being: Citizenship, Fertility, and Sexuality in Asia and the Pacific,* ed. Kalpana Ram and Margaret Jolly. (Ann Arbor: University of Michigan Press, 2011). Muecke, Marjorie A. "Make Money Not Babies: Changing Status Markers of Northern Thai Women." *Asia Survey* 24, no. 4 (1984): 459-70.

[4] "Health and Ageing: A Discussion Paper," *World Health Organization, Department of Health Promotion*. 2001, Accessed March 5, 2019. https://apps.who.int/iris/bitstream/handle/10665/66682/WHO_NMH_HPS_01.1.pdf;jsessionid=E5B897818A71276575AEB695FE5996DA?sequence=1

[5] Sarah Harper, *How Population Change Will Transform Our World* (Oxford University Press, 2016).

[6] Fertility rate, or total fertility rate (TRA) is a term that many demographers use to measure the average number of children born to women aged between 15 and 44. Whilst fertility rate is a technical term, and has its limitations, the term is adopted for this study because it is widely used in academic literature. In a demographic context, fertility rate is an important factor in understanding population decline and population growth and should be distinguished from the term 'birth rates', which can be defined as the number of live births per 1,000 women in the total population of a country. "Total Fertility Rate (per woman)," The Global Health Observatory, *World Health Organization*, 2022, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/123

from having a younger population to an older population.[7] The crux of the issue here lies in finding feasible ways for a smaller cohort of working people to support a growing ageing population. Several researchers point to the negative effects of ageing population on economic growth, namely that a falling fertility rate brings about a decline in the working-age population, thus resulting in a decline in economic output. And while having fewer young people means that less income can be produced for the country, governments' payment for welfare provisions and pensions must also rise significantly, if they wish to maintain the current level of quality of life and financial security for the elderly.[8] All of this points to long-term fiscal deficits which imply a loss of welfare and diminishing support from government social security, which may lead to lower standards of living for future generations as they shoulder the burden of higher dependency.[9]

By tracing the demographic trend, we see some countries such as Thailand enjoying a window of opportunity in which preparations and economic adjustments can still be made. In other words, as while the proportion of workers is greater than the proportion of the elderly, there is still an opportunity for economic growth. This period of time is what demographers call the demographic dividend, that is, potential advantages where the proportion of declining youth is the same or greater than the increase in older persons, allowing countries to strengthen their economies and invest to offset the future effects of ageing on the country. The demographic dividend is time-limited and in all regions, except Africa, the working-age population will start to shrink within the next 10 to 20 years.[10] Today, the Thai government has recognised the importance of the demographic dividend as an essential period of time in which to prepare adequate economic, social, political and environmental measures to meet the challenges brought by the ageing of its population. The present situation gives time to explore and implement solutions for the difficult challenges mentioned above. These, if not fixed aggressively, will leave the future generation with

[7] George Leeson, "Prepared or Not, Latin America Faces the Challenge of Aging," *Current History* 110, no. 733 (2011): 80.
[8] Thach Ngoc Pham and Duc Hong Vo, "Ageing Population and Economic Growth in Developing Countries: A Quantile Regression Approach," *Emerging Markets Finance and Trade* 57, no.1 (2019): 108-22. https://doi.org/10.1080/1540496x2019.1698418.
[9] Rebecca Valenzuela, "The Economics of an Ageing Population," The Age. Accessed March 9, 2019. https://www.theage.com.au/education/the-economics-of-an-ageing-population-20150316-1m0g4a.html
[10] David Blood, David Canning and Jaypee Sevilla, *Demographic Dividend: A New Perspective on the Economic Consequences of Population Change* (Santa Monica, Calif: Rand), 37.

insurmountable problems. The time to act is short, but optimistically, many ageing countries are encouraged by examples among the forerunners[11], such as Japan, to prepare for some fairly clear, practicable future social and economic decisions.

It is true that different regions of the world have experienced the ageing of their population in significantly different ways, and there is no one-size-fits all policy to solve the challenges that each country faces. Europe first entered the demographic transition from the mid-19th to mid-20th century.[12] As the ageing transition lasted for more than 100 years, the region had the benefit of time to make societal and governmental adjustments. Elsewhere and more recently, demographers have turned their attention towards Asia, as the fastest ageing region in the world. The proportion of Japan's ageing population is higher than other countries: the proportion of over-65s is close to 30 percent and is expected to reach almost 40 percent by 2060.[13] Drawing on examples from Europe, Japan is pursuing a number of initiatives to aid the transition from younger dependence to older dependence,[14] including the development of a long-term care insurance system and the promotion of new industries to cater for the lifestyle and care needs of the elderly. Japan is viewing the prospect of their challenges from various angles: replacement

[11] Forerunner: A term used to describe countries that have experienced the onset of fertility decline before 1935, comprised of 18 European and 6 American countries. "Post-transitional Demography and Convergence: What can we learn from half a century of world population prospects?" in *Developments in Demographic Forecasting*. (Cham, Switzerland: Springer, 2020), 23.

[12] George Leeson, "Increasing Longevity and the New Demography of Death." *International Journal of Population Research* (2014): 6. https://doi.org/10.1155/2014/521523.

[13]「統計局ホームページ・令和元年・統計トピックス No.１２１統計からみた我が国の高齢者の人口・２０１９年９月１５日現在」(Statistics Bureau Homepage. Statistics Topics No. 121 Population of elderly people in Japan from the viewpoint of statistics as of September 15, 2019) Ministry of Internal Affairs and Communications. Accessed March 13, 2019, https://www.stat.go.jp/data/topics/pdf/topics121.pdf

[14] Young and old dependence refers to the share of the dependent population, calculated by taking the total elderly and youth population as a ratio of the total population. The dependency ratio indicates the population of those not in the labour force (aged 0 – 14 and 65 and above).

migration[15], changes to the pension regime[16], the use of robotics in care[17], elder employment[18], intermediate care programs for senior citizens[19] and more. At the turn of the century, demographers have now noticed the rapid decline in birth rates in middle-income countries (also known as low-income, emerging, or rapid-growth countries, such as the developing countries of Asia, Latin America, Africa and the Middle East as well as China and other transition economies in the former Soviet Union)[20] within Southeast Asia. Thailand is one of the fastest countries to age in Southeast Asia[21] and officially entered into an aged society in 2021.[22] At the beginning of 2017, the Thai government raised its ageing population as an urgent item on the national agenda and began to look at foreign approaches for potential adoption.[23]

Despite Japan being a world leader in population ageing, we still know very little about how Japan's ageing experience has influenced policy reforms of other ageing countries in the surrounding regions. There is little research on how countries have shared ideas in the past or have used other countries' experience as a point of reference.[24] Using the framework of 'policy transfer' (detailed below), my study helps to fill these gaps in knowledge of the transnational development of ageing policy in Asia.

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[15] Alexander Parsons, and Stuart Gilmour, "An Evaluation of Fertility- and Migration-based Policy Responses to Japan's Ageing Population," Edited by Baltica Cabieses. *PLOS ONE* 13, no. 2 (2018): e0209285. http://doi.org/10.1371/journal.pone.0209285.

[16] Akira Okamoto, "Welfare Analysis of Pension Reforms in an Ageing Japan" *Japanese Economic Review* 64, no. 4 (2013): 452-483. https://doi.org/10.1111/jere.12002.

[17] Hiroo Ide, Naonori Kodate, Sayuri Suwa, Mayuko Tsujimura, Atsuko Shimamura, Mina Ishimaru, and Wenwei Yu, "The Ageing 'Care Crisis' in Japan: Is There a Role for Robotics-Based Solutions?" *International Journal of Care and Caring* 5, no.1 (2021): 165-171. https://doi.org/10.1332/239788220x16020939719606.

[18] Arima Yukiyasu, "Status Quo and the Challenge in Research on Paid Employment and Sense of Meaningful Life for Elders in Japan," *Journal of Human Resource Management* 21, no. 3 (2021): 92 – 102.

[19] Takaaki Shimada, Yoshie Suzuki, Yuko Yada, Shinsuke Hori, Kenta Ushida, and Ryo Momosaki, "Community-Based Integrated Care Units: Intermediate Care Units for Older Adults in Japan," *Journal of the American Medical Directors Association* 22, no. 8 (2021): 1774-1775. https://doi.org/10.1016/j.jamda..2021.03.027.

[20] Robert E. Hoskisson, et al., "Strategies in Emerging Economies," *Academy of Management Journal*, 43, no. 3 (2000): 249-67. https://doi.org/10.5465/1556394.

[21] Dhanaporn Chittinandana, Nakanang Kulnartsiri, Jaree Pinthong, and Paphatsorn Sawaengsuksant, "Aging Population: Global Perspectives," *Bank of Thailand* 2017. Accessed March 16, 2019. https://www.bot.or.th/Thai/MonetaryPolicy/EconomicConditions/AAA/2AgingPopulation_GlobalPerspectives.pdf

[22] Kesara Phoyen, "สังคมผู้สูงอายุ: โอกาสของธุรกิจที่ยั่งยืนในอนาคต" [Aging Society: Opportunities for the Future Sustainable Business] *Journal of Management Science Review* 1, no.1 (2019)

[23] "รัฐบาลยกผู้สูงอายุเป็นวาระแห่งชาติ" [Government raises ageing population as national agenda], *Thaipost.* Accessed March 3, 2019, http://www.thaipost.net/main/detail/6739

[24] Eellen Minkman, Arwin Buuren, M. W., and Victor, Bekker, J. J. M., "Policy Transfer Routes: An Evidence-based Conceptual Model to Explain Policy Adoption," *Policy Studies* 39, no. 2 (2018): 228.

1.2 Research Questions

As Thailand prepares for the challenges of an ageing society, it looks toward Japan as a model, leveraging the strong pre-existing bilateral relationship to incorporate Japanese policy approaches and welcome investment in new industries. This study's primary goal is to investigate the nature of the interaction between Thailand and Japan in relation to an ageing population. It does so by examining a case study of Japan-Thai policy transfer and addressing a series of questions:

1) What specific initiatives have been (are being/will be) pursued in policy transfer related to Thailand's ageing society?
2) How can policy transfer be viewed within a broader context of ageing population in Thailand?
3) What factors impede/enable this policy transfer?
4) What insights does this case study offer into Thailand – Japan relations?
5) How will the case study extend our understanding of policy transfer in general?

1.3 Significance

The ageing of the human population is one of the most significant social transformations facing the world in the twenty-first century. The efforts of individual countries and the actions of their governments to confront their ageing population challenges should be discussed and shared widely, as nearly all countries in the world will experience the effects of an ageing population. The current study brings to the fore Thailand and Japan's efforts to share solutions in the light of similar social and demographic challenges. Being informed about the struggles and achievements regarding the care, rights and best practices for elderly[25] citizens in other countries will serve to encourage policy-makers in other areas around the world,

[25] Demographically, those who are above the ages of 60 or 65 are taken to represent the term elderly or old age.

who are also confronted by the problems of the aged. The research will also foster a broader understanding of culturally specific concepts and practices of 'care'.

In addition, the study also contributes to the ongoing process of agenda-setting for various contemporary social issues in Thailand, such as aged care, health care, infrastructure and labour shortage. The study is one of the first to investigate the potential of policy transfer being used in this field. Internationally, the results of this investigation will help inform future policy implementations for various ageing countries. Domestically, the case study may reveal how Thailand can improve its policies internally, as well as in effectively adopting foreign ideas through risk-averse, evidence-based leads. Beyond this, the research may also inform future studies in the international dissemination of ideas and policy adoption in global and regional forums.

1.4 Conceptual Framework

Convergence theory is an overarching theory in this study that may help explain how two ageing countries, Thailand and Japan, share common societal characteristics and problem-solving decisions relating to an ageing population. Convergence theory postulates that industrialised societies become more alike in various aspects over time. One particular aspect of this is demographic trend, where convergence is occurring in two ways. Firstly, the converging demographic trend of Thailand's ageing population follows a trajectory in longevity, low mortality and decrease in childbearing similar to that of Japan's ageing population. This trend is realised by various factors, such as National Family Planning Programs, and other existing patterns in social structures, such as access to education, labour patterns, childbearing behaviours and family patterns. The theory provides contexts for a global convergence of countries transitioning in this way and demonstrating similar demographic and socio-economic changes, as seen in many regions of the world.

Rather than considering the ageing transition in terms of a demographic model, the study will apply the

notion of demographic convergence as its organising principle. In the world where countries are experiencing ageing population, with an overall similar trajectory in falling fertility and mortality, these trends urge us to observe that demographic convergence provides the rationale for policy transfer. The demographic trends confirm the understanding that different countries may be able to identify more as they share and learn from one another. Looking at trends in population is also of importance for a wide range of planning situations, as governments of many ageing countries are also converging to adopt similar solutions from other ageing countries, as a quick way of effectively tackling known issues and challenges relating to ageing populations. With this in mind, the study will investigate convergence as a theory within which demographic convergence can be understood, and could be used to help explain how Thailand and Japan experience similar demographic trends. An in-depth analysis of the convergence theory will continue in Chapter 2, section 2.1.

1.5 Thesis Structure

Building on the discussion in this chapter, Chapter 2 describes the methodology and key concepts applied in the case study, which begins in Chapter 3. Policy transfer as the principal framework of the study is reviewed through the literature of other scholars in various fields. While Chapters 1 and 2 present the wider social issues connected with ageing population and the theoretical framework through scholarly works, Chapter 3 provides extensive details of the case study. Chapter 3 primarily focuses on background information concerning the field site itself in Thailand and identifies actors involved in S-TOP from Japan and Thailand. Chapter 4 depicts the processes involved in the implementation of S-TOP, presented in three stages, highlighting the multi-faceted experiences of those involved by means of interviews. Drawing on data from Chapter 3 and Chapter 4, in Chapter 5 a discussion of key points will help answer the research questions, and will reveal what lessons can be learned from the policy transfer of a foreign program to Thailand. Finally, in Chapter 6, the study formulates a conclusion of the case study and reflects on the discussions offered in the previous chapter.

Chapter 2: Key Concepts and Methodology

In Chapter 2, the study examines convergence theory, the overarching theoretical concept used to explain how countries in various regions experience similar demographic trajectories. It explores the underlying macro social and economic forces of a changing demographic transition. An awareness of greater macro forces reveals the reasons why countries such as Thailand and Japan experience similar demographic patterns of ageing and declining populations. The study will then discuss the key conceptual framework: policy transfer framework. In this framework, the policy transfer continuum is used to qualitatively measure instances of transfers. When considering the processes of policy transfer, the study will employ the focused questions formulated by Dolowitz and Marsh to uncover what factors drive the transfer process. Finally, the study outlines the methodology used in collecting data for the case study.

2.1 Convergence and its Application

In this study, convergence will be used as an organising principle through which we can examine and interpret how Thailand and Japan addresses the challenges of ageing population. Convergence lies at the

heart of modern economic growth theory. However, in this study, applying the idea of convergence will help assess how two countries from different geographical locations can experience common demographic trends and societal tendencies.

Convergence theory postulates that industrialised societies become more alike in various aspects over time. Well-known convergence theorists, Kerr observed that initially societies differ in the early stages of industrialisation.[26] However, as that process advances, the influences of industrial technology and economy drive societies toward a common pattern with standardised features. In the long run, societies begin to possess similar features and have normative models, which exist to meet a range of basic social needs, such as social services, basic state welfare, enterprise welfare and other important elements.[27] Simply stated, as levels of modernisation increase, levels of structural uniformity also increase, regardless of how diverse these societies were in the original form in which change took place.[28] As a result of this structural uniformity, specific characteristics of a modernised society are detectable, in that they have people have a higher levels of adult literacy, less income inequality, mass political participation, changes in class structure, increasing urbanisation as well as similar demographic patterns, namely longer life expectancy and a decrease in number of children per household.[29] Thus, the key observation by convergence theorists is that there are fixed patterns which developing countries must pass through as they modernise.

Researchers of convergence have attempted to measure levels of convergence across industrialised societies. In one study, convergence was tested among cross-societal variables: technology, gender, demography, political democracy, health, capitalist market economy and particularism-universalism.[30] Results showed that there is rapid convergence across different societies in the areas of capitalist market

[26] Clark Kerr, *Industrialism and Industrial Man: The Problems of Labor and Management in Economic Growth*, (London: Heinemann, 1962)
[27] Ramesh Mishra, "Convergence Theory and Social Change: The Development of Welfare in Britain and the Soviet Union," *Comparative Studies in Society and History* 18, no.1 (1976): 31, https://doi.org/10.1017/20010417500008069.
[28] Robert Marsh, "Convergence in relation to level of societal development," *The Sociological Quarterly* 49, no. 4 (2008): 798, https://doi.org/10.1111/j1533-8525.2008.00136.x.
[29] Rostow, W. Walt, *The Stages of Economic Growth*, (Cambridge, Eng.: Cambridge University Press, 1960)
[30] Gerry E. Boyle., and Thomas G. McCarthy. "A Simple Measure of B-Convergence." *Oxford Bulletin of Economics and Statistics* 59, no. 2 (1997): 257-64, https://doi.org/10.1111/1468-0084.00063.

economy and political democracy.[31] In view of this, it seems that major sources of divergence among highly modernised societies still exist, and are caused by cultural traditions, heritage, and national history.[32] The underlying question here is how and why convergence occurs in the first place. One hypothesis explains that more developed countries, in contrast to lesser developed countries, have a greater emphasis on patterns of rationality and universalism as opposed to particularism and individuality, i.e., tradition and customs.[33] This idea lends itself to centralisation rather than decentralisation of advanced industrial countries, as societies become more reliant on generalised media of exchange and the market for economic growth.[34] With market-based interactions and interdependency becoming more important than self-reliance, communication between countries and their markets occurs more frequently.[35] As a result, we witness major cities becoming culturally similar, as people have access to global markets and choose to consume similar products. This then contributes to the increasing homogenization of goods, knowledge and ultimately the way we live our lives.[36] Some sociologists contend that this process is intrinsically related to globalisation theory and the spread of Western capitalism, with countries converging towards a market-based liberal democratic system.[37]

It has been noted that the above analysis has often been contentious and deemed one-dimensional. This is because it ignores important distinctions between the development of communist and Western capitalist societies. And despite various attempts at modifying the original theory, modern versions of convergence theory have struggled to provide a well-defined explanation for the two radically different economic regimes.[38] Certain countries in South-East Asia have demonstrated that convergence theory may not be working in the way that is suggested in political terms. The shift towards military, authoritarian government

[31] Mishra, "Convergence Theory and Social Change: The Development of Welfare in Britain and the Soviet Union," 808.
[32] Marion J. Levy, Jr., *Modernization and the Structure of Society*: *A Setting for International Affairs,* (Princeton, NJ: Princeton University Press, 1966)
[33] Marion J. Levy, Jr., "Patterns (Structures) of Modernization and Political Development," *The Annals of the American Academy of Political and Social Science* 358, no. 1 (1965): 30, https://doi.org/10.1177/000271626535800105.
[34] Robert Marsh, "Convergence in Relation to Level of Societal Development," *The Sociological Quarterly* 49, no. 4 (2008): 799, https://doi.org/10.1111/j.1533-8535.2008.00136.x.
[35] Amos Hawley, *Human Ecology: A Theoretical Essay*, (Chicago, II: University of Chicago Press, 1986)
[36] Saskia Sassen, *Cities in a World Economy*, 3rd ed. (Los Angeles Sage. 1994)
[37] Alex Inkeles, *One World Emerging? Convergence and Divergence in Industrial Societies,* (London: Routledge, 1998)
[38] Jan Tinbeegen, "Do Communist and Free Economies Show a Converging Pattern?" *Soviet Studies* 12, no. 4 (1961): 333-41, https://doi.org/10.1080/09668136108410255.

in some countries, such as Myanmar, the Philippines and Thailand, suggests that the pathway for converging political change in the region does not fit within the conventional understanding of convergence theory. Hence convergence theory may be inadequate for understanding the relationship between a political trend and socio-economic change.[39]

To demonstrate the multifaceted nature of the convergence theory literature, the following is a non-exclusive summary of the directions in which convergence theory has been explored: Convergence theory in an economy (intra-convergence) vs. cross- (inter-convergence)[40], convergence in relation to growth rate vs. convergence in relation to income level, global convergence vs. local convergence (regional), deterministic convergence vs. stochastic convergence, income-convergence vs. total factor productivity convergence.[41] Within these numbers of directions, convergence is also regularly used in demography to explain the common trajectory of population growth and demographic transition in the ageing population discussion.

Often mentioned as demographic transition theory, convergence in this sense can be seen as occurring in two ways. Firstly, there is the convergence of the global demographic transition: the decline in fertility and mortality, experienced globally in almost every country at varying stages. Second, there is convergence of demographic trends among countries within the same region that is experiencing similar demographic changes. The first discussion falls under the search for a common path towards this convergence, that is to say, what was the impetus that sparked the fall in death and birth rates?

Although there are many theories as to what catalysed mortality decline, most scholars today agree that the mechanisms behind these demographic trends is a chronological sequence initiated by mortality reduction in the eighteenth century. This later brought about the onset of fertility decline. For the

[39] Maria Giovanna, *Asia Struggles with Democracy*. 1st ed. (London: Routledge, 2016)
[40] Nazrul Islam, "What Have We Learnt from the Convergence Debate?" *Journal of Economic Surveys* 17, no. 3 (2003): 312, https://doi.org/10.1111/1467-6419.00197.
[41] Ibid.

forerunners (made up of 18 European and six American countries from the 1850s to 1990s),[42] where particularly long sequences prevent us from knowing when exactly the fertility and mortality decline began, scholars agree that one thing is clear: mortality decline occurred first, before fertility decline. For more recently developed and developing countries, there is a clear starting point for mortality reduction, which suggests that *latecomers* (made up of Latin American and Asian countries) [43] experience the same pattern as that of their forerunners. Research by economists suggests that mortality decline is a shared characteristic seen elsewhere, and without exception it preceded fertility decline,[44] and other researchers concur: 'If there was a single or principal cause of fertility decline, it is reasonable to ascribe it to falls in mortality, which was a major cause of destabilization.'[45] Furthermore, results from global fertility research also reveal that regardless of economic wealth or degree of modernisation, nowhere in the world has fertility change taken place without significant prior mortality change.[46]

The cause and effect here is that death catalyses a response in fertility behaviour. It seemed that mortality was a mechanism that arrived even before the days of development and industrial economies. The expectation of child loss had been expressed in terms of insurance, causing an increase in fertility.[47] Fertility rates were seen to be higher than the mortality rate in order to compensate. In turn, for the family, improved survival brings the onset of fertility control. Fertility control in this way saw that birth rates could drop below mortality rates.[48] Thus, rather than being an attempt to decrease family size, fertility decline is really an attempt to maintain family size, creating an overall control in the population, in other words, population equilibrium.

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[42] David Reher, "The Demographic Transition Revisited as a Global Process," *Population Space and Place* 10, no. 1 (2004): 23, https://doi.org/10.1002/psp.313.
[43] Ibid., 23.
[44] David Reher, "Economic and Social Implications of the Demographic Transition," Population and Development Review 31, (2011): 24. https://doi.org/10.1111/j.1728-4457.2011.00376.x.
[45] Dudley Kirk, "Demographic Transition Theory," *Population Studies* 50, no. 3 (1996): 379. https://doi.org/10.1080/0032472031000149536.
[46] John Cleland, "The Effects of Improved Survival on Fertility: A Reassessment," *Population and Development Review* 27, no. Supp (2001): 60-92.
[47] Council, National Research, Education, Division of Behavioral Social Sciences and, Education, Commission on Behavioral Social Sciences and, Population Committee on, Cohen, Barney, and Montgomery, Mark R. *From Death to Birth,* (Washington, D.C: National Academies Press, 2000) 13.
[48] Ibid.

In many places around the world, the second wave of fertility decline started in the latter part of the nineteenth century, continuing into the early part of the twentieth.[49] Human economic activities typical of the modern age, including technological advancements, the development of medicine, industrial manufacturing, urbanisation, and economic activities, brought about a second phase in falling fertility. It was economic factors that motivated having fewer children, because if more children have to be reared and educated, then resources become fragmented. Demographers argue that these reasons come much later in the demographic transition.[50]

Countries of different regions with different economic statuses are experiencing the ageing of their population in various ways. Researchers such as Harper have divided countries broadly into three demographic profile types: *advanced economies*, countries with a 'low percentage of young people and a growing percentage of older people'[51]; *emerging economies,* countries consisting of a higher percentage of young and middle aged adults, and *least developed economies*, countries with a very 'large percentage of children, adolescents, and young people'.[52] Within the span of thirty to forty years (from 1970s to 2000s) Thailand's growth went from least developed economy to an emerging economy. During this same period of rapid economic change, the country also saw a changes in its demographic patterns from a high childbearing to low childbearing.[53] By the end of the 1970s, the rest of the world also went through substantial changes in its demography. Today, the transition that took two decades results in almost all countries showing a median total fertility rate of 2.3.[54] 'Two-thirds of the world's countries are now at or below replacement level – crudely defined as 2.1 children per woman of child bearing age.'[55] The converging of childbearing rates indicates a direct causal relationship between economic growth and

[49] David Reher, "Economic and Social Implications of the Demographic Transition," 12.
[50] Ibid., 26.
[51] Sarah Harper, *How Population Change Will Transform Our* World, (Oxford University Press, 2016), 2.
[52] Ibid., 2.
[53] Kua Wongboonsin, Philip Guest, and Vipan Prachuabmoh, "Demographic Change and the Demographic Dividend in Thailand," *Asian Population Studies* 1, no. 2 (2005): 245-56, https://doi.org/10.1080/17441730500317493.
[54] Chris Wilson, "On the Scale of Global Demographic Convergence 1950 – 2000," *Population and Development Review* 27, no. 1 (2001): 166, https://doi.org/10.1111/j.1728-4457.2001.00155.x.
[55] Sarah Harper, *How Population Change Will Transform Our* World, (Oxford University Press, 2016), 26.

childbearing decisions. Moreover, for countries belonging in an emerging economy as in the case of Thailand its patterns are similar to those of other emerging economies such as South East Asia and Latin America.[56]

Other mechanisms that contribute to countries converging are social constraints, such as access to education, productivity of the labour force and the National Family Planning Program.[57] Global human population control and other similar family planning policies were implemented across various developing countries through the 1950s, 60s and into the 1980s.[58] Thailand is one example of a country that showed a rapid decline in births under its voluntary National Family Planning Program (NFPP), which was created by the Ministry of Public Health in the 1960s.[59] From five children per woman in the 1960s, the fertility rate dropped to 1.5 by 2017.[60] Thailand's family planning is often been credited as one of most successful family planning programs in the developing world. In the case of Thailand, various social and environmental factors played an important role in the 'precipitating and facilitative of reproductive change'.[61] Other scholars have directly identified that female employment and woman emancipation are the main factors impact both the GDP and fertility.[62] More recently, Thai couples, not their parents, are in control of their choice of a partner. The status of women's literacy is universal and Thai Buddhism, being the predominant religion that neither encourages nor prohibits the use of birth control, are some of the social and environmental dimensions behind fertility decline.[63] In India and more recently Spain, China and Iran, all

[56] George Leeson, "Prepare or Not, Latin America Faces the Challenge of Aging," *Current History (1941)* 110, no.733 (2011): 75-80.
[57] Allan Rosenfield et al., "Thailand's Family Planning Program: An Asian Success Story," *International Family Planning Perspectives* 8, no. 2 (1982): 43, https://doi.org/10.2307/2948087.
[58] Judith Seltzer, *The Origins and Evolution of Family Planning Programs in Developing Countries.* (Santa Monica, CA: Rand, 2002), 10.
[59] Ibid., 25.
[60] Kwanchit Sasiwonsaroj et al., "Fertility Decline and the Role of Culture - Thailand's Demographic Challenges for the 21st Century," in *Southeast Asian Transformations Urban and Rural Developments in the 21st Century.* 1st ed. Global Studies. (Bielefeld: Transcript Verlag, 2020), 131.
[61] John E., Knodel, Aphichat Chamratrithirong and Nibhon Debavalya, *Thailand's Reproductive Revolution: Rapid Fertility Decline in a Third World Setting,* Social Demography. (Madison, Wis.: University of Wisconsin Press, 1987)
[62] Kwanchit Sasiwonsaroj et al., "Fertility Decline and the Role of Culture - Thailand's Demographic Challenges for the 21st Century," in *Southeast Asian Transformations Urban and Rural Developments in the 21st Century.* 1st ed. Global Studies. (Bielefeld: Transcript Verlag, 2020), 131.
[63] Judith Seltzer, *The Origins and Evolution of Family Planning Programs in Developing Countries,* (Santa Monica, CA: Rand, 2002), 116.

contribute to a consequential convergence of falling births.[64] Globally, the funding of family planning policies by organisations such as US AID, the World Bank and the World Health Organisation to developing countries was intended to improve quality of life, by giving people more control over safe and voluntary reproduction.[65] As a consequence of this, shifting attitudes and behaviours around family formation also meant that countries converged in falling fertility, and in turn in a continued overall population decline.[66]

Other researchers have argued that education attainment of females is causing the decrease in fertility rates of industrialised societies.[67] The education of girls leads to their access to the labour market, allowing them to engage in other roles apart from marriage and childrearing roles, resulting in later marriage, which reduces the number of births.[68] Some argue that changes in the 'mindset' of the women and their communities are key, as this enables them to recognise the range of alternative choices they can make, choosing fewer children, when they should have children, and that this transmission of ideas is in fact the biggest factor in declining fertility.[69] This also demonstrates the effects of reproductive controls when placed within the purview of individual choice.

From the reasons presented above, we may be able to discern that demographic convergence is an eventual process. Harper identified that difficulties faced by *forerunners* (rapid population ageing, severe labour shortages, migratory pressures, and in sourcing welfare payments) are now being experienced by the *latecomers* that once had explosive population growth with extreme young populations.[70] It is not a question of if, rather a question of when.[71] And as a product of this, one can place countries at certain

[64] George Leeson, "Prepared or Not, Latin America Faces the Challenges of Aging," *Current History* 110, no. 733 (2011): 75-80, https://doi.org/10.1525/curh.2011.110.733.75.
[65] Sarah Harper, *How Population Change Will Transform Our* World, (Oxford University Press, 2016), 46.
[66] Tiloka De Silva and Silvana Tenreyro, "Population Control Policies and Fertility Convergence," *Journal of Economic Perspectives* 31, no. 4 (2017): 210, https://doi.org/10.1257/jep.31.4.205.
[67] Lutz Wolfgang, William P., Butz, and K.C., Samir Kumar. *World Population and Human Capital in the Twenty-First Century: An Overview,* (Oxford Scholarship Online. 2020)
[68] Sarah Harper, *How Population Change Will Transform Our World,* (Oxford University Press, 2016), 44.
[69] Ibid.
[70] Ibid.
[71] David Reher, "Back to the Basics: Mortality and Fertility Interactions during the Demographic Transition," *Continuity and Change* 14, no. 1 (1999): 9-31, https://doi.org/10.1017/s0268416099003240.

points along a trajectory, and observe that what has occurred to *forerunners*, can be used to warn *latecomers* of their own future.

Other scholars view this phenomenon quite differently. They argue that although much of the world's population live in countries with below-replacement fertility, this does not necessarily equal a world that is destined to converge to the same level of experience. The word 'global' in global demographic convergence may also be somewhat misleading, as in contrast to most regions, Sub-Saharan Africa shows very little sign of fertility decline. This gives rise to the question of whether demographic convergence is indeed a world-wide phenomenon, or whether there exists a divergence-convergence effect occurring simultaneously, where some countries are not experiencing low fertility, mortality and ageing of their populations, whilst most countries of the world are. The notion that countries are converging demographically with common factors mentioned above, such as work, education and family planning, is fundamental to the reasons why one country's policies are applicable to another's. Policy transfer can be used to alleviate or tackle common challenges that countries with an ageing demographic share through demographic convergence.

Overall, various studies have shown converging social patterns, resulting in negative demographic trends in various countries all over the world. Although the timing and speed of fertility decline vary greatly in the individual country's socioeconomic context, not only is there high cultural and ethnic heterogeneity within a particular region, but there are also differing rates of economic inequality within and between countries. However, there is strong evidence, as explained above, to suggest that a global convergence in demographic and socioeconomic change is occurring to the region, and that this requires a number of countries, in particular Southeast Asian countries, to focus on their low-fertility problem. Despite the controversies surrounding versions of convergence theory in the study of modernisation, it is clear that demographic convergence provides a useful and potentially powerful theory within which to conduct cross-national studies across a broad range of social phenomena. The perspective it offers provides useful points of departure for research on an ageing population. As there are various definitions for the many subsets of convergence, this study will refer to convergence theory by using the definition most commonly

understood, namely as a theory used to describe the increasing 'level of similarity between two or more units of different origin across one or more dimensions common to both'.[72] The two units could be assumed to mean systems, groups, units of organisations, including countries that are increasingly similar because one is changing to look similar to the stationary subset, or both are changing in a common direction.[73] For the current investigation, this definition of convergence provides a useful theory which we may draw on in the comparative research regarding the demographic transition between Thailand and Japan. Finally, it is important that we recognise convergence theory as a process of 'becoming' rather than 'being' similar, and that countries being alike demonstrates very little about convergence itself. The focus is thus on the trends and movement over time, and an awareness of such a transition has led governments such as Thailand and Japan to consider what they share in terms of policies in ageing to combat common issues.

2.2 Policy Transfer

Information and knowledge at various levels of government and non-governmental institutions is increasingly transferred and shared across national borders. This suggests convergence of ideas drawn by actors in a process known as 'policy transfer' in order to create change. In this section the study takes an in-depth look into academic studies on policy transfer and see how the framework is applied to the selected case study.

The term 'policy transfer' on the surface suggests a straightforward process, although, in reality, most attempts at policy transfer are complicated and full of variables. The term is often used to describe the 'simple movement of a set of policies from one place to another with no (or limited) change of state, as the

[72] George G. Georgiadis, "The Convergence-divergence Debate Revisited: Framing the Issues," *Southeast European and Black Sea Studies* 8, no. 4 (2008): 313-23, https://doi.org.10.1080/14683850802556343.
[73] George G. Georgiadis, "The Convergence-Divergence Debate Revisited: Framing the Issues," 317.

policy can be clearly recognised as an import from another jurisdiction….'[74] The phenomenon of policy transfer is a deliberate and conscious process of learning and adapting, which creates a rather clumsy and messy process. Even though there is a consensus about what policy transfer is, that is, ideas from one system being moved to and used in other systems in order to solve similar problems[75], there are also various types of transfer that have expanded over the years, causing some controversy regarding the definition of terminologies that have been developed. The number of related terms used by scholars has increased concurrently, namely, 'lesson-drawing'[76], 'policy borrowing'[77], 'policy mobility'[78], 'policy diffusion'[79], and 'policy convergence'[80]. Other scholars have referred to the same phenomenon as 'emulation' and 'copying'[81], 'appropriation', 'assimilation', or 'importation'.[82] There are also distinctions between each term, as to how they are used and contextualised. For example, in the case of policy mobility, van Ewijk et al. examine the setup of LOGO, a program which is an explicit example of important policies from the Netherlands being exported to match the needs of other countries such as Benin, South Africa and Indonesia.[83] Policy diffusion is closely associated with the field of international relations, focusing more on empirical and quantitative analysis to investigate the spread of policies across a large number of countries. Typically, policy diffusion considers structural factors in how policies spread, namely governmental bodies, international regulations and institutions. And a more recent focus on actors of

[74] Sue Duncan, "Policy Transfer: Theory, Rhetoric and Reality," *Policy & Politics,* 37, no. 3 (2009): 453-58, https://doi.org/10.1332/030557309x458443.
[75] David Phillips, and Kimberly Ochs, "Processes of Policy Borrowing in Education: Some Explanatory and Analytical Devices," *Comparative Education* 39, no. 4 (2003): 451-61, https://doi.org/10.1080/0305006032000162020.
[76] Richard Rose, "What is lesson drawing?" *Journal of Public Policy* 11, no. 1 (1991): 3, https://doi.org/10.1017/s0143814x00004918.
[77] David Phillips, and Kimberly Ochs, "Processes of Policy Borrowing in Education: Some Explanatory and Analytical Devices," 451-61.
[78] Diane Stone, "Learning Lessons, Policy Transfer and the International Diffusion of Policy Ideas," *Centre for the Study of Globalisation and Regionalisation (CSGR) Working Paper* no. 69 (2001).
[79] David Marsh, and Sharman J.C., "Policy Diffusion and Policy Transfer," *Policy Studie*s 30, no. 3 (2009): 269– 88, https://doi.org/10.1080/01442870902863851.
[80] Diane Gibson, and Robin Means, "Policy Convergence: Restructuring Long-term Care in Australia and the UK," *Policy & Politics* 29, no. 1 (2001): 43-58, https://doi.org/10.1332/0305573012501198.
[81] Roger Dale, "Specifying Globalization Effects on National Policy: A Focus on Mechanism," *Journal of Educational Policy* 14, no. 1 (1999): 1-17, https://doi.org/10.1080/026809399286468.
[82] David and Kimberly, "Processes of Policy Borrowing in Education: Some Explanatory and Analytical Devices," 451-61.
[83] Edith Van Ewijk et al., "Capacity Development or New Learning Spaces through Municipal International Cooperation: Policy Mobility at Work?" *Urban Studies* 52, no. 4 (2015): 756-74, https://doi.org/10.1177/0042098014528057.

policy movement is 'policy entrepreneurs'[84], which investigates the motivations and roles of individuals as agents of policy transfer.[85] Overall, past scholarship has demonstrated that the varying terms explored above exist to create terminologies that encapsulate and categorise the broad nuances of the spread of policies.

2.2.1 Policy Transfer Framework

In this study, policy transfer is used to refer to the intentional process of learning and adapting ideas for the purpose of solving problems and for the improvement of other systems.[86] And while policy transfer studies often focus on the receiving end of the transfer, it may also be viewed as a collaborative process between the host and the receiver, working together in the process. The policy transfer framework is often used in the context of policy-related discussions that shape public debate, such as jurisdictions and international policies on immigration, environment and education. This study looks at the transfer of a Japanese healthcare system, in the context of an on-going public debate on ageing population in Thailand.

Prior to the discussion on policy transfer, it is important to first address 'policy'. Policy is a multifaceted term used to describe concepts in many ways. At its core, policy is an idea that flows through how we participate in and organise public life – by becoming an elected representative, activist, expert, government official and others.[87] We can often encounter policy in schools, hospitals, governments, non-government institutions, firms – being used in an attempt to shape and clarify activities within institutions. While policy seems to imply clarity and direction, the process of coming up with policy and implementing it is often characterised by conflict, ambiguity, struggle and resistance.[88] We must also remember that 'policy' itself is

[84] Michael Mintrom, "Policy Entrepreneurs and the Diffusion of Innovation," *American Journal of Political Science* 41, no. 3 (1997): 738–70, https://doi.org/10.2307/2111674.
[85] Youjung Shin, "A Policy Entrepreneur in the Information Society: Shaping the Interdisciplinarity of Brain Research in Korea," *Minerva (London)* 56, no. 2 (2017): 231-57, https://doi.org/10.1007/s11024-017-9328-y.
[86] Dolowitz and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," *Governance (Oxford)* 13, no. 1 (2000): 5-23, https://doi.org/10.1111/0952-1895.00121.
[87] Stuart S. Blume, "Policy as Theory: A Framework for Understanding the Contribution of Social Science to Welfare Policy," *Acta Sociological* no. 3 (1977): 247-62, https://doi.org/10.1177/ooo169937702000302.
[88] Ibid.

not simply a label but is also the process which it describes. Therefore, when examining policy, we must take into account how it is used by the practitioners and not only the observers. In turn, policy can also mean very different things for different people, depending on how policy is used, who benefits from the policy and from what perspective it is being observed. This explains how policy is concerned with the way in which different individuals are drawn together into an attempt to create stability and order, which comes to be labelled 'policy'.[89]

Policy exists in a wide range of fields of action, in different political and cultural contexts, in different circumstances and times and is, therefore, complex, widespread and difficult to define.[90] We are unable to ascribe a single meaning to policy. However, the most popular understanding of the term policy is its association with how it is used by the government and what governments want to do. As described so far, policy is a widely used term, which suggests that the idea of policy carries much symbolic power and force as a popular construct for groups and organisations to frame ideas, or to make sense of practices or situations in which we seek to have our opinions and concerns expressed.[91] For this study, 'policy' as used in the term 'policy transfer' is understood as the intent of an organisation or individual to identify, choose and implement different alternatives. The nature of 'policy' is therefore understood as being a managerial or administrative mechanism to achieve an objective. The term may apply to governments, private sector organisations, or groups as well as to individuals.

Historically, well-known cases of policy transfer have been documented as far back as the nineteenth century by mostly American and European scholars. And while there have been many studies of international policy transfer, much of the empirical work relates to high-income countries, such as the

[89] Stephen J. Ball, "What is Policy? Texts, Trajectories and Toolboxes," *Discourse (Abingdon, England)* 13, no. 2 (1993): 10-17, https://doi.org/10.1080/0159630930130203.
[90] Stuart S. Blume, "Policy as Theory: A Framework for Understanding the Contribution of Social Science to Welfare Policy 1," Acta Sociologica 20, no. 3 (1997): 247-62, https://doi.org/10.1177/000169937702000302.
[91] David Cohen and Deborah Loewenberg Ball, "Policy and Practice: An Overview," *Educational Evaluation and Policy Analysis* 12, no. 3 (1990): 233-239, https://doi.org/10.3102/01623737012003233.

policy diffusion in the European Union.[92] Waltman investigated the spread of policy among the Americans as far back as the time of the Civil War, where in order to finance the Union Army, the national income tax concept was adopted from the British.[93] In the Australian context, Bray et al. (2011) studied the history of Australian urban transport policy through the lens of policy learning, and it was inferred that similar transport reforms were adopted across cities and states with very minor differences.[94] Research on policy transfer relating to transfer from developed to developing countries tended to address the diffusion of trade and new public management policies.[95] Empirical investigation of policy transfer in other spheres, such as health, remains scarce.

From the historical examples of policy transfer seen above, we begin to realise that policy transfer is in fact the circulation of frameworks, ideas and ambitions across empires and nation-states in the course of time. From a historical standpoint, policy transfer has continued throughout the various stages of history, from precolonial history to the post-colonial period, even into neo-colonialism and the market economy.[96] The subject of policy transfer is bounded within the discourses of nationalism and colonialism. Just as slavery was transnational, so were other later movements and ideas: from old age pensions, social insurance, child welfare measures, women's rights, labour unions and such progressive ideologies, that are adopted, remade and reimaged, demonstrating that countries have had a transnational history, that borders are porous and policies can be trafficked between them.[97] In short, we can consider that these policies do not belong to one single national history, but can be understood as a development of ideas throughout networks of transnational connections. As Rodgers states, while it is true that connectivity and communication play a role in policy transfer, stressing this too much runs the risk of only highlighting the

[92] Christoph Knill, "Introduction: Cross national Policy Convergence: Concepts, Approaches and Explanatory Factors," *Journal of European Public Policy* 12, no. 5 (2005): 764-74, https://doi.org/10.1080/13501760500161332.
[93] Jerold Waltman, *Copying Other Nation's Policies: Two American Case Studies,* (Cambridge, MA: Schenkman Publishing Co, 1980).
[94] David Bray, Michael Taylor, and Derek Scrafton, "Transport Policy in Australia – Evolution, Learning and Policy Transfer," *Transport Policy* 18, no. 3 (2011): 522-32, https://doi.org/10.1016/j.tranpol.2010.10.005.
[95] Richard Common, "Public Management and Policy Transfer in Southeast Asia," In *Policy Transfer in Global Perspective*, 1st ed. (England: Burlington, Vt: Ashgate, 2004), 143.
[96] Carina Schmitt, *From Colonialism to International Aid External Actors and Social Protection in the Global South.* 1st Ed. 2020. Ed. Global Dynamics of Social Policy. 2020.
[97] Daniel T. Rodgers, "Bearing Tales: Networks and Narratives in Social Policy Transfer," *Journal of Global History* 9, no. 2 (2014): 304, https://doi.org/10.1017/s1740022814000084.

voluntary side of policy movements, where the exchanges of ideas 'reinforces the ideology of contemporary neoliberalism – that it maps a world made up only of choice, possibilities, adaptations, and flexibilities.'[98] We must not understate the role and interests of non-concessional parties involved throughout history, and also consider how much of policy transfer has resulted from the effects of direct and indirect coercion.

The policy transfer framework is not limited to governmental spheres and has been extrapolated to fit various kinds of transfer; taking on ideological rhetoric, foreign concepts, strategies and inspiration can also be seen as a transfer and can be used in non-government areas, such as in non-profit organisations and self-funded entrepreneurship. The value of policy transfer here is significant in tracing individuals through whom policy moves across borders, giving insight into the motivations of local actors, and has the potential of uncovering micro-level contexts, issues that arise socially and culturally for individuals to initiate the process. When applied to the case study analysis, the framework helps uncover the roles of local actors in the healthcare system, such as doctors, nurses and carers who play a prominent role in implementing the policy transfer.

There are two main benefits for engaging in policy transfer, the first being practicality. In the practical sense, engaging in a search for best-practices assists 'decision-makers to respond more quickly and appropriately to crises' and improves policy making, especially with regard to 'new' policy problems that cannot be dealt with effectively through established domestic policy heuristics.'[99] As noted by Schneider and Ingram: 'Cross national policy comparisons contribute to innovation […] unless the examples of other countries are brought to light through analysis, changes will be incremental.'[100] The second benefit is at the

[98] Ibid.
[99] Diane Stone, "Learning Lessons and Transferring Policy across Time, Space and Disciplines," *Politics* 19, no. 1 (1999): 53, https://doi.org/10.1111/1467-9256.00086.
[100] Anne Schneider, and Ingram Helen, "Systematically Pinching Ideas : A Comparative Approach to Policy Design," *Journal of Public Policy* 8, no. 1 (1988): 67, https://doi.org/10.1017/s0143814x00006851.

scholarly level: the study of policy transfer contributes to comparative public policy, broadening the scope of what happens domestically, while taking into account the effects of globalisation.[101]

Additionally, it must be stated that policy transfer does not exist without its limitations and has been contested by some scholars. The official definition that is often encountered in the literature is the one that was developed by Dolowitz and Marsh. They define policy transfer as the process in which 'knowledge about policies in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system.'[102] It is precisely this broad definition that was critiqued as inadequately portraying the diverse and real-world examples of policy-making, on which various other definitions, terminologies and approaches were founded. The critique with such a broad definition is that real world policy transfer is not always rational and straightforward.[103] One such critique is of Dolowitz and Marsh's selection of cases that support their finding that policy makers increasingly rely on the policy transfer framework.[104] Upon evaluating these claims, other scholars showed that Dolowitz and Marsh sampled mostly positive instances where transfer is supposed to have happened, without a convincing survey of policies or jurisdictions over time.[105]

Despite common problems existing in international contexts for policy makers to pick and learn from, in reality why is the practice of policy transfer rarely heard of? Although the process of policy transfer seems to be systematic, evidence of its use in practical examples of professional and political contexts remains scarce. This is because the policy transfer framework is not intended to be used as a practical tool for policymaking, but rather is designed to be used by researchers in analysing instances of policy being adopted across borders. It could be argued that the real day-to-day job of policy-making does not allow

[101] Diane, "Learning Lessons and Transferring Policy across Time, Space and Disciplines," 53.
[102] Dolowitz, and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," 5-23.
[103] James Oliver, and Martin Lodge, "The Limitations of Policy Transfer' and 'Lesson Drawing' for Public Policy Research," *Political Studies Review* 1, no. 2 (2003): 179-93, https://doi.org/10.1111/1478-9299.t01-1-00003.
[104] Sue Duncan, "Policy Transfer: Theory, Rhetoric and Reality," *Policy and Politics* 37, no. 3 (2009): 435-58. https://doi.org/10.1332/030557309x458443.
[105] Oliver and Lodge, "The Limitations of 'Policy Transfer' and 'Lesson Drawing' for Public Policy Research," 183.

time for systematic transfers to take place.[106] While my current investigation into policy transfer framework is non-practice-based, the case study investigated and the fieldwork involved bridge this gap between theorising policy transfer, academic research, and the practical usages of the policy transfer framework.

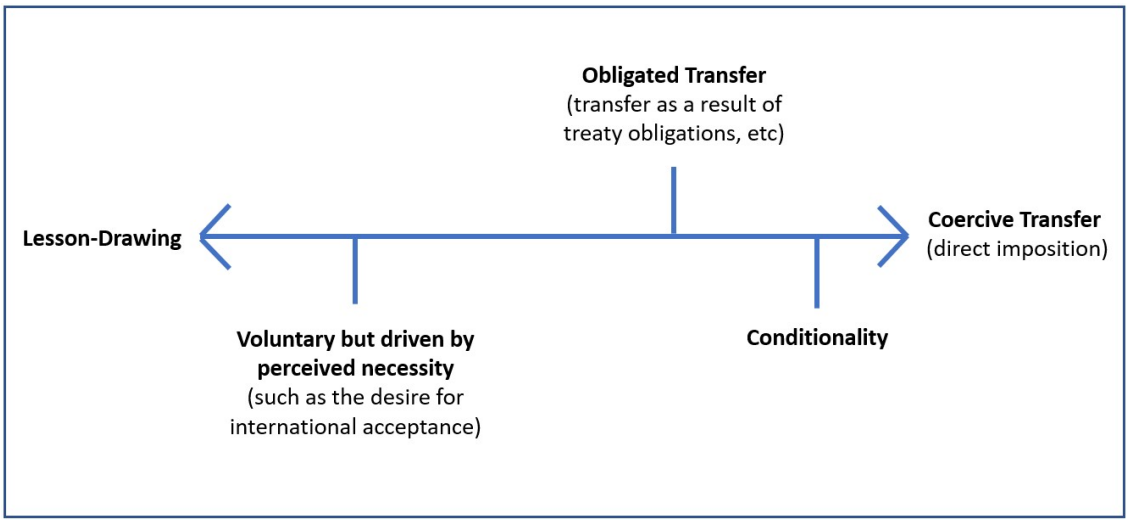
Considering this, the current study finds policy transfer to be a valuable framework for investigating the case study selected. Policy transfer is beneficial in its design by incorporating various occurrences of policy-making and classifying them as either: voluntary, coercive, temporal and spatial, as seen in the policy transfer continuum in section 2.2.2. Further, the way in which the framework is able to engage with a diverse array of topics allows policy transfer to hold a strong multi-disciplinary appeal and is an ideal framework in the analysis of my case study, which is multi-disciplinary in nature. Finally, the policy transfer framework is useful in that it allows for independent and dependent variables (investigating the process from various angles to explain the contextual factors of the transfer), permitting researchers to observe nuanced characteristics of the causes, impact and process of the transfer that has led to a particular policy outcome.

2.2.2 Policy Transfer Continuum

In order to avoid a one-size-fits-all oversimplification of the process, Dolowitz and Marsh (1996) have introduced the policy transfer continuum.

Figure 1. Policy Transfer Continuum: From Lesson-Drawing to Coercive Transfer

[106] Evans Mark, "Policy Transfer in Critical Perspective." *Policy Studies* 30, no. 3 (2009): 243-68, https://doi.org/10.1080/01442870902863828.



Source: Dolowitz, David P., and David Marsh. "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making." *Governance* 13, no. 1 (2000): 13.

Along the axis of the continuum, the mechanisms for the spread of policies can be grouped into five categories: lesson-drawing, voluntary transfer, obligated transfer, conditionality and coercive transfer. At one end it describes transfers that are driven by the desire to see where the best practices are, and learn from another system. At the other end of the continuum there are transfers that are driven by dominance, as one country applies force for the adoption and implementation of a certain regime or policy in another country. In the middle there are two areas to describe cases of transfer that can involve a mixture of 'both voluntary and coercive elements.'[107]

The lesson-drawing end of the continuum is based on the assumption that actors choose to transfer something rationally. This rational process can loosely be referred to as a 'learning' process, specifically describing the way in which policies are adopted by considering their advantages and disadvantages rationally. Lesson-drawing with perfect rationality involves 'full information about options in choice of strategies best to pursue goals.'[108] Lesson drawing is 'contrasted with bounded rationality, in which decision-making is restricted by human and organisational characteristics resulting in efforts to find

[107] Dolowitz, and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," 14.
[108] Oliver and Lodge, "The Limitations of 'Policy Transfer' and 'Lesson Drawing' for Public Policy Research," 184.

solutions that are good enough, rather than fully optional from a perfectly rational viewpoint.'[109] These could occur in ways such as international study tours, meetings, technical assistance, educational tours and travel between countries in order to convey knowledge about policies or programs.

Aside from the decision to borrow from another political system, the decisions of policy transfer can derive from a voluntary decision but are driven by a perceived necessity, where 'the actors within a policy-making system perceive their system as falling behind its primary competitors.'[110] The process of lesson-drawing[111] with bounded rationality[112] subscribes to a logical decision-making approach, while recognising the limits or scope of information that borrowers have to process information and make a decision.[113] Policy transfer researchers explain that much of the reasoning behind these decisions is a 'psychological' process, where 'incomplete knowledge of options and their consequence informs actors decisions and choices.[114] Policy transfer 'takes place within the confines of 'bounded rationality', and is typically influenced more by actors' perceptions and predispositions than by 'real-world' situations.'[115] Therefore, 'information about a policy may be inadequate or even inaccurate.'[116]

Obligated Transfer (transfer as a result of treaty obligations and so on) involves a certain level of pressure or power, which Hill describes as the 'ability to get another party by a range of methods including persuasion and direction.'[117] Examples of this may include 'when governments are forced to adopt

[109] Ibid., 185.
[110] David Dolowitz, and David Marsh, "Who Learns What from Whom: A Review of the Policy Transfer Literature," *Political Studies* 44, no. 2 (1996): 66, https://doi.org/10.1111/j.1467-9248.1996.tb00334.x.
[111] Ibid.
[112] Karen Mossberger, *The Politics of Ideas and the Spread of Enterprise Zone,* (Washington, D.C: Georgetown University Press, 2000), 28.
[113] Ibid.
[114] Herbert Simon, *Administrative Behavior: A Study of Decision-Making Process in Administrative Organisation*, (New York: Basic Books, 1957), 61–109.
[115] Simon Bulmer, David Dolowitz, Peter Humphreys and Stephen Padgett, "Policy Transfer in European Union Governance: Regulating the Utilities," *Journal of Common Market Studies* 45, no. 3 (2007): 16, https://doi.org/10.1111/j.1468-5965.2007.00735_16.x.
[116] Karen Mossberger, and Harold Wolman, "Policy Transfer as a Form of Prospective Policy Evaluation: Challenges and Recommendations," *Public Administration Review* 63, no. 4 (2003): 436. https://doi.org/10.1111/1540-6210.00306.
[117] C.J., Hill, "Paradoxes of European foreign policy: convergence, diverge and dialectics: national foreign policies and the CFSP," *Working Paper, Florence: European University Institute* 66, no. 97 (1997): 18–19, https://hdl.handle.net/1814/1544.

programs and policies as part of their obligations as members of international regimes and structures.'[118]

Conditionality in policy transfer is less forceful than direct coercive transfer, because there is a degree of choice involved, where the importing countries receive a condition that is involved in the agreement, and the importing country is obliged to return the conditionality. Cairney explains, when 'developing countries seek loans from the International Monetary Fund or World Bank in critical circumstances, they are effectively obliged to undertake 'good governance reforms in return.'[119]

Coercive Transfer (direct imposition) *r*efers to a situation when policy transfer results from external pressures and the influence exerted by an organisation, nation or supranational organisation on another country to adopt a policy. In most cases the importing country has a limited degree of choice. As Cairney defines it, coercion refers to 'the agenda for transfer being set elsewhere and the adverse consequences if the importing country does not cooperate.'[120] Coercive transfers may also take on softer forms, where moderate pressure is applied to adopt new policies, such as a funding agreement, ranging to hard forms where firm conditionalities are made in commitments and contracts upon policy change.

Ultimately, for researchers using the continuum to analyse what policymakers are doing (what choices are available to policymakers, what influences their decisions and actions and so forth), understanding the degree of transfer is required from the above descriptions formulated in the process.

2.2.3 Culture as Context in Policy Transfer

Policy making is inherently a collectivist activity where several actors may be involved in a collaborative process, requiring them to have social awareness, and to make decisions about policies in a social dimension. Cremaschi, Carlotta, Terri and Sergio state that 'the collective dimension raises the cultural

[118] Simon Bulmer, David Dolowitz, Peter Humphreys and Stephen Padgett, "Policy Transfer in European Union Governance: Regulating the Utilities," *Journal of Common Market Studies* 45, no. 3 (2007): 16, https://doi.org/10.1111/j.1468-5965.2007.00735_16.x.
[119] Paul Cairney, *Understanding Public Policy: Theories and Issus* (Basingstoke: Palgrave Macmillan, 2011), 255.
[120] Ibid., 256.

question. Cultural approaches focus on the interaction between the individual and the (social) environment; accordingly, motivations and preferences cannot be taken for granted, since they are constructed and stabilised within a specific social context.'[121] Dolowitz and Marsh acknowledge the importance of context, especially cultural context, and the role it has in facilitating or preventing the success of a transfer.[122] Dolowitz and Marsh explain that unsuccessful transfers are more than likely caused by instances when contextual factors – cultural, social, economic or political –of the settings in which policies are being adopted have not been taken into account, and thus transfers would likely lead to a policy outcome that misaligns with the purpose of its adoption. Dolowitz and Marsh have termed this misalignment 'inappropriate transfer'.[123] Dolowitz and Marsh also identified policy failures as either uninformed or incomplete or inappropriate transfer.[124] Uninformed transfer, also known as 'misfits', occurs when policies are transferred with insufficient knowledge of the reasons and logic of why they worked in the original setting, illustrating a failure to understand the differences in social, political, and ideological contexts between countries. The cultural, social and ideological concepts that have been discussed here can be subsumed under the broad concept of 'culture'.

For the purposes of this study, the approach used to conceptualise culture will be congruous with the Dutch sociologist Geert Hofstede's definition: 'the collective programming of the mind that distinguishes the members of one group or category of people from others.'[125] While Hofstede's definition of culture may be problematic and has been critiqued,[126] it corresponds with the commonly used definition among anthropologists and sociologists. He contends that every person has patterns of thinking, feeling and

[121] Marco Cremaschi et al., *Policies and Culture: Mind the Gap in Culture and Policy-Making: Pluralism, Performativity, and Semiotic Capital,* (Cham, Switzerland: Springer, 2021), 25.
[122] Dolowitz and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," *Governance* 13, no. 1 (2000): 5-23.
[123] Diane Stone, "Understanding the Transfer of Policy Failure: Bricolage, Experimentalism and Translation." *Policy & Politics* no. 45 (2017): 59.
[124] Dolowitz and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," *Governance* 13, no. 1 (2000): 17.
[125] Geert Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions and Organizations across Nations,* 2nd ed. (Thousand Oaks, California: Sage. 2001), 9.
[126] Brendan McSweeney, "Hofstede's Model of National Cultural Differences and Their Consequences: A Triumph of Faith – a Failure of Analysis," *Human Relations* (New York) 55, no. 1 (2002): 89-118, https://doi.org/10.1177/0018726702551004.

behaviour that are acquired throughout one's lifetime from the social environmental structures that surround them. These patterns are equated to 'culture' as a kind of universal 'software of the mind' that belong to different groups of people, and are a collective phenomenon.[127] Culture, as an assemblage of values, norms and practices is a significant feature of the way in which new lessons are chosen to be adopted and has a decisive influence on the transfer process in the host country. For example, culture may influence how policy makers deal with different choices about adopting a program, and actors may have a prejudice towards a country due to historical tensions, such as colonial oppression, military invasions and so on.

Despite its importance, the discussion of culture in policy transfer studies has been largely avoided for various reasons. Culture is an ambiguous term with a myriad of usages. With no fixed definition, it can mean different things to different people, changing its meaning according to situations[128]. Without a fixed boundary, it is often difficult to figure out where one society or culture begins and where another ends. According to one scholar, culture is a term that has become irretrievably tainted by the politics of identity, and he is particularly critical of culture as a replacement for race, or racialising behaviour, which is something to be avoided, as it may impose harmful and inaccurate assumptions on individuals and communities.[129] The assumption here about cultural proximity in connection with national culture is problematic, as any given culture is never completely homogenous, it also dismisses cultural diversity and falsely equates culture with 'race'. Hence a discussion of culture may get in the way of policy transfer.

Further, even more problematic is the oversimplification of culture, such as drawing the simplistic conclusion that because Japan and Thailand are both 'Asian' cultures, they are culturally compatible and

[127] Geert Hofstede et al., *Cultures and Organisation: Software of the Mind: Intercultural Cooperation and Its Importance for Survival,* (McGraw-Hill, 2010): 17.
[128] Susan Haack, *Deviant Logic, Fuzzy Logic: Beyond the Formalism*, (Chicago: University of Chicago Press, 1996)
[129] Michel-Rolph Trouillot, "Adieu, Culture: A New Duty Arises." In *Global Transformation*, 97-116. (New York: Palgrave Macmillan US, 2003)

therefore policy transfer should happen quite easily between them. Using this assumption in policy transfer implies that policies can be more or less copied directly and pasted trans-nationally, when they cannot.[130]

Within policy transfer studies, we see some scholars distance themselves from cultural context altogether in order to avoid generalisations of culture, as explained above. Rose's renowned work on lesson-drawing explicitly describes culture as unnecessarily messy and ambiguous.[131] He points out that the presence of cultural context used to describe policy transfer would mean that any case of transfer would automatically fail, because culture is unique to each country. His 10-step framework in lesson-drawing is deliberately linear, straightforward and avoids cultural and historical discussions and he asserts his reasons in the following passage:

> 'The success of a programme in a given country is ascribed to its distinctive values and beliefs of 'style' of policy, implying that any attempt to export it elsewhere would be doomed to failure because each national culture is deemed unique. Generalizations about culture impute the same values to virtually every citizen in the country.'[132]

The above passage acknowledges that people are divided on values, but Rose discourages the overvaluing of culture or 'culturalism', to the extent that change cannot take place for the reason that culture is inherent to a country. And while I agree that Rose's prescriptive approach towards lesson-drawing is systematic and straightforward, not acknowledging culture as a variable that affects policy transfer would likely make the theory incomplete. His description of culture is misleading, as the way in which Rose ignores cultural concerns for the sake of expedience creates an automatic assumption that different societies can easily fit into simplistic cultural categories. It also assumes that decisions about policy transfer are made based on those simplistic cultural categories. Instead of overvaluing culture, Rose's method is an

[130] Richard Rose, "What is Lesson-Drawing?" *Journal of Public Policy* 11, no. 1 (1991): 3-30, https://doi.org/10.1017/s0143814x00004918.
[131] Richard Rose, *Learning From Comparative Public Policy: A Practical Guide,* (London: Routledge. 2005).
[132] Ibid., 92.

oversimplification of culture that fails to account for cultural distinctiveness. His opposition to culture in a way contradicts the very nature of the policy transfer process that is driven by complicated, messy, real-world circumstances. And the complexities of this non-linear process often stem from culturally specific values and standards that actors are inevitably bound to. An awareness of these cultural contexts when engaging in policy transfer is vital, in order to make sense of decisions that are based on culture, and create a more accurate and nuanced analysis of the process.

Moreover, while Rose is a leading expert on the study of lesson-drawing, I dispute his above simplistic and exclusive assumption about culture that reduces it within the framework of 'national culture'. Assumptions about culture, such as those made by Rose, mean that something that may work for one country can never work in another. Policy transfer as a framework would not exist with such a notion. Culture is a much more nuanced, complex concept, and embodies various patterns of behaviours, cognitive standards, traditions, and values that can carry diverse meanings within a social system. It would therefore require a more sensitive, careful and nuanced method to consider it analytically, without resorting to reductive categorisations of culture as belonging to a single nation. Culture is dynamic and fluid, changing from one generation to the next, not static in tradition or locked in time.

For example, in the context of the ongoing COVID-19 pandemic, studies have demonstrated that there is a diversity of cultural practices, such as the varying attitudes towards handwashing and mask- wearing, and that these behaviours correlate directly with the speed and spread of the virus during the early stages of its diffusion.[133] This suggests that authorities' response to the virus is context-specific and will need to be refined to fit the changing perceptions. Policy transfer itself is an activity that requires active participants from different cultural settings, where the framework has room to enquire into adjustments of the policy. Thus, culture plays an undeniable role in the shaping of policy transfer.

[133] Ganna Pogrebna, and Alexander A. Kharlamov, "The Impact of Cross-Cultural Differences in Handwashing Patterns on the COVID-19 Outbreak Magnitude," *Science of Cities: Urban Development and Wellbeing*, (2020): https://10.13140/RG.2.2.23764.96649.

One could also extrapolate further that the absence of culture in perspectives such as those made by Rose is suggestive of power. The simplistic characterisation of culture and history is a choice made in favour of his own view of the world. In the Foucauldian sense, to have such a choice is made from a one's position of power and thus is a demonstration of how power is present everywhere, seen through the expression of language and communication, practiced and performed by anyone.[134] Power in this sense also relates to knowledge, where those in positions of power, like Rose, may feel they have the authority to determine what constructions of reality are true.[135] Policy transfer without cultural context to shape it is an example of this. The Foucauldian approach enables us to reflect on the condition of the way subjects are perceived in society, shedding light on connections between knowledge, power and the truth.[136]

Other scholars have long observed the lack of cultural research in the field, as Geva-May (2002) labelled it, 'the neglected variable in the craft of policy analysis'.[137] Theoretically, while scholars may regard culture as messy, in real world scenarios if culture is neglected, devastating consequences can occur. International examples of transfers of policies where cultures should have been considered are plentiful. For example, the 1998 South Sudan food crisis was a harrowing incident of an inadequate food relief program that failed, as authorities from the United Nations international relief agency were unaware of the sociocultural practices of the local kinship network, which resulted in the delay of food relief and the preventable death of 100,000 people.[138] Another example is the investment policy introduced to Kosovo in the 1999s, where the World Bank investments on the railway project were aimed at raising standards of living , but actually resulted in unemployment, welfare issues and other consequent societal problems in the region. When the project planners were asked, they simply stated that 'I am a railway engineer, not a social scientist.'[139]

[134] Michel Foucault, *The History of Sexuality: The Will to Knowledge,* (Harmondsworth: Penguin Books, 1998), 63.
[135] Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences*. (New York: Pantheon, 1970)
[136] Danielle Guizzo, "Reassessing Foucault: Power in the History of Political Economy," *International Journal of Political Economy* 50, no. 1 (2021): 61, https://doi.org/10.1080/08911916.2021.1894828.
[137] Iris Geva-May, "Cultural Theory: The Neglected Variable in the Craft of Policy Analysis," *Journal of Comparative Policy Analysis* 4, no. 3 (2002): 243-265, https://doi.org/10.1080/13876980208412682.
[138] Daniel Bertram, "Accounting for Culture in Policy Transfer: A Blueprint for Research and Practice," *Political Studies Review* 20, no. 1 (2020): 2, https://doi.org/10.1177/1478929920965352.
[139] Iris Geva-May, "Cultural Theory: The Neglected Variable in the Craft of Policy Analysis," 246.

Although there is currently no systematic, comprehensive framework to analyse culture as a variable within policy studies, cultural context needs to be embraced in order to construct new avenues of discourse, as opposed to limiting the discourse. I argue that culture, without its deterministic, bounded, homogenous justifications, can be used within policy transfer framework to constructively analyse and bridge the gap between theorising policy transfer and its practical applications in real-world scenarios. New avenues of analysis where culture is present will create constructive discussions on perspectives, ways of life and cultural biases within the study of policy transfer. Policy analysis that is attuned to cultural context implies an understanding of actual needs, speaking the cultural language of the interested parties, and allowing for a successful fit of policy to the people using within their respective cultures.

In an attempt to conceptualise culture, Gita Steiner-Khamsi has created stages known as reception and translation, to process context within the policy transfer framework. The reception stage explains that the act of framing foreign ideas in the local context demonstrates receptiveness that should take place during the early stages of policy adoption.[140] Reception describes the input, its underlying motivation and introduction to S-TOP's agenda. Other scholars, such as Legrand[141] emphasise in the same light that policy diffusion can occur with greater ease when there are similar institutional and cultural arrangements in place, such as significant cultural values that increase the likelihood of localisation. This may be founded on an already established and significant relationship between nations that will deepen receptiveness at this stage. This is certainly the case for Thailand-Japan relations, because these countries, as explained in Chapter 1, have a historically long and cordial relationship.

Steiner-Khamsi's notion of translation describes how cultural orientations can also be used to denote certain design features of a policy transfer, by the fact that actors favour the adoption among culturally proximate choices. For example, in the case of transferring policy in a specific context where countries

[140] Gita Steiner-Khamsi, "Cross-national Policy Borrowing: Understanding Reception and Translation," *Asia Pacific Journal of Education* 34, no. 2 (2014): 153-67, https://doi.org/10.1080/02188791.2013.875649.
[141] Tim Legrand, "Elite, Exclusive and Elusive: Transgovernmental Policy Networks and Iterative Policy Transfer in the Anglosphere," *Policy Studies* 37, no. 5 (2016): 440-55, https://doi.org/10.1080/01442872.2016.1188912.

experience the same emergency political narrative, such as in the case of the Syrian refugee crisis, Italy, Germany and France adjusted their policies according to local needs. This differs in comparison to the same policy adoption in Australia, the United Kingdom, Switzerland and Ireland that was not heavily framed by the migration flows from the Syrian civil war.[142] Therefore, within the broader context, there are several countries that are deemed 'close' because they are influenced by a shared contextual narrative that explains design choice. [143] The shared contextual narrative in the case of this research is about ageing society and the health challenges that this poses to Japan and Thailand. In accordance with the above discussion, Thailand and Japan may be considered as 'close' countries, and Thai actors may favour the adoption of Japanese ageing related policies and programs over other countries, because of shared challenges framed by the broader social and demographic context of ageing population. Such shared experiences often invoke a strong sense of comradery, support and trust, particularly as both Thailand and Japan also share long-term cordial relations (discussed further in Chapter 3, section 3.2), which will influence the design choice of S-TOP.

Among other studies of policy transfers some have emphasised the role of communication, a process that is deeply dependent on the role of the actors.[144] Diana Stone's work categorised eight different groups of agents, from private businesses, think- tanks to bureaucrats, government officials and international organisations. As well-established knowledge within literatures on marketing and communication, any involvement of an individual or organisational agency in policy making, whether conscious or unconscious, is guided by cultural parameters, and implies the forces of culture to which actors are subject.[145]

[142] Daniel Bertram et al., "Factoring in Societal Culture in Policy Transfer Design: The Proliferation of Private Sponsorship of Refugees," *Journal of International Migration and Integration* 21, no. 1 (2020): 253-71, https://doi.org/10.1007/s12134-019-00738-0.
[143] Ibid.
[144] Chisung Park et al., "The Importance of Feedback: Policy Transfer, Translation and the Role of Communication," *Policy Studies* 35, no. 4 (2014): 397-412, https://doi.org/10.1080/01442872.2013.875155.
[145] Diane Stone, "Transfer Agents and Global Networks in the 'transnationalization' of Policy," *Journal of European Public Policy* 11, no. 3 (2004): 545-66, https://doi.org/10/1080/1350176040001694291.

In summary, culture is a multidimensional concept that must be seen and studied from various angles at different levels, as part of the process and challenge of policy transfer study. The question is whether culture should be included in the analytics of the study. However, upon closer inspection, when policy transfer fails in the real world, it may be caused by the policy's incompatibility with the persistent cultural values of a community, that sometimes impede the process, and are complex and difficult to identify. For the purpose of this thesis, the notion of national culture was not employed. Interviewees did not refer to national culture in their discussions of policy transfer and their perspectives, as presented in section 5.3.5 Cultural Context in the Transfer of S-TOP, concentrated on specific local problems and practical insights of their daily operations.

2.3 Methodology

2.3.1 Analytical Framework

The case study of policy transfer in this project will be guided by a series of questions formulated by Dolowitz and Marsh,[146] the leading theorists of the policy transfer framework.

Who are the actors of policy transfer?

The process of seeking new knowledge and adopting foreign policies is linked to key transfer agents. The usual suspects are policy makers, civil servants, government officers and supra-national organisations such as the EU, UN and World Bank. Apart from these, we can identify the role of policy entrepreneurs, NGOs, epistemic communities and social enterprises as also having a prominent place.[147] In relation to the case study, the question helps identify who are involved in the resourcing, implementing and facilitating the transfer of S-TOP and what their roles in the process of transfer are.

[146] Dolowitz and Marsh, "Who Learns What from Whom: A Review of the Policy Transfer Literature," Political Studies 44, no. 2 (1996): 343-57, https://doi.org/10.1111/j.1467-9248.1996.tb003344.x.
[147] James, Perry, and John W. Kingdon, *Agendas, Alternatives, and Public Policies*, (Boston: Longman Press, 2011), 621.

What is transferred?

By determining what is being transferred, we may begin to classify what kind of transfer is being pursued, such as whether or not the transfer is a governmental or non-government transfer. It is important to clarify the subject of a transfer, as this will in turn provide further information about the reasons for such a transfer and where on the continuum this is taking place. The central concern of this question is to identify the substance of what is being transferred and the nature of it. In other words, is it a policy goal, program, ideas or attitudes that are transferred in the case study?

From where are lessons drawn?

This question determines where actors look to for lessons and why. Rose states that the scope for learning may vary and there is no limit to the distance across international borders.[148] However, several works have observed that policy transfer as a phenomenon is mainly restricted by geographical territories. Countries that operate within the same structural environment such as the EU may experience a sustained level of cooperation between states, a greater confidence, and share the same legal framework and overall a higher likelihood of positive adoption.[149] Region-to-region borrowing, such as the United States and Canada, is commonly identified by studies such as McCann (2011), who researched Canada's approach in selecting foreign 'hot' policy ideas from the United States.[150] Thai-Japan relations will be discussed in later sections of this study. Here, the study denotes where the program being transferred derives from and why actors are inspired to adopt the foreign program in the first place.

What is the purpose of the transfer?

[148] Richard Rose, "What is lesson drawing?" *Journal of Public Policy* 11, no. 1 (1991): 3, https://doi.org/10.1017/s0143814x00004918.
[149] Simon Bulmer, David Dolowitz, Peter Humphreys, and Stephen Padgett, "Policy Transfer in European Union Government: Regulating the Utilities." *Journal of Common Market Studies* 45, no. 3 (2007): 760-61.
[150] Eugene McCann, "Urban Policy Mobilities and Global Circuits of Knowledge: Toward a Research Agenda," *Annals of the Association of American Geographers* 101, no. 1 (2011): 107-30, https://doi.org/10.1080/00045608.2010.520219.

Related to question number two, knowing what is being transferred is not enough to ascertain how the transfer is being approached. To obtain the full picture, we need to understand the reasons behind the transfer. The most basic purpose of a transfer implies a conscious judgement to firstly change the original state, due to dissatisfaction with the current systems. Secondly, it implies 'a judgement about doing the same elsewhere.'[151] For S-TOP, there may be a number of underlying preconditions involved in solving a particular problem faced by actors within the transfer between Japan and Thailand. Identifying these issues will reveal the contextual factors of the transfer and will acknowledge the potentially varied social, cultural and economic factors involved.

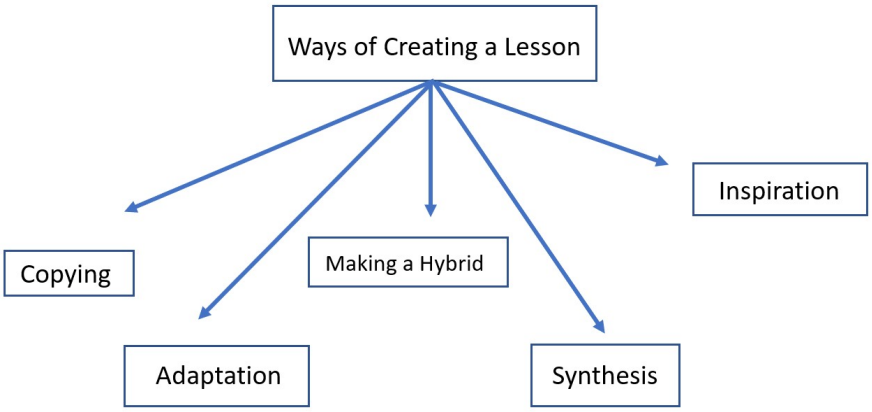
What is the degree of transfer?

The literature on lesson-drawing provides a convenient framework for assessing the degree of transfer. The diagram below explains the various degrees of lesson-drawing in a policy transfer.

Figure 2. Ways of Creating a Lesson[152]

[151] Richard Rose, "What is lesson drawing?" *Journal of Public Policy* 11, no. 1 (1991): 3, https://doi.org/10.1017/s0143814x00004918.

[152] Robert Nash, "The Use and Application of Rose's Theory of Lesson Drawing in Peripheral Areas of Scotland," *International Journal of Tourism Research* 5, no. 5 (2003): 133-45, https://doi.org/10.1002/jtr.422.



Source: Created by the author, based on Nash [153]

Copying: Copying or emulating involves accepting a programme from the exporting region in its entirety and the reason for doing so can be because it 'provides the best standard for designing legislation at home…'[154]

Adaptation: Adaptation refers to 'adjustments for different circumstances, of a programme already in effect in another jurisdiction.'[155] This is deemed by scholars as the most practical process, as it rejects copying a lesson and makes allowances for changes, such as different cultural and geographical attributes, as well as institutional arrangements.[156]

Hybridisation: 'Combine elements of programmes from two different places.'[157] Rose states that one can replace elements of one's own system with lessons from a different place, and so the combination consists of elements of programmes from two different regions.

Inspiration: Rose defines inspiration as: 'Programmes elsewhere used as intellectual stimulus for developing

[153] Ibid.
[154] Richard Rose, "What is lesson drawing?" Journal of Public Policy 11, no. 1 (1991): 21, https://doi.org/10.1017/s0143814x00004918.
[155] Ibid., 22.
[156] Nash, "The Use and Application of Rose's Theory of Lesson Drawing in Peripheral Areas of Scotland," 137.
[157] Rose, "What is lesson drawing?" 22.

a novel programme without an analogue elsewhere.'[158] According to Nash, inspiration involves 'developing a new and inspired programme that has not been done before.' However, it extracts lessons and examples from other regions to use as 'stimulus for developing new or novel lessons or programmes.'[159]

Synthesis: Rose defines synthesis as: 'Combining familiar elements from programmes in effect in three or more different places.'[160] Synthesis involves the same process as hybridisation but assembles several different programmes into one that is distinct.

This question serves as a convenient typology to categorise and identifying the type of transfer that is observed in the study. As Rose argues, 'policy transfer is not an all-or-nothing process'[161], so the process may or may not involve more than one type in the process.

What is the context in which the idea/policy was articulated and accepted?

As discussed above in section 2.2.1, recognising broader contextual variables, such as the societal, political, economic and cultural conditions of the importing country factors into the policy transfer process in understanding where dissatisfaction exists and how issues can be framed. Design choice of a policy transfer should align with a country's societal and cultural makeup, and would thus likely lead to a more successful transfer. Westney's work, for example, takes into account the cultural context of how the role of the samurai contributed to Japan's adoption of the French model of policing.[162] These interactions between policy transfer actors and the wider societal context may have a direct bearing on the way in which certain Japanese ideas, policies and programmes are chosen, while others are not.

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[158] Ibid.
[159] Nash, "The Use and Application of Rose's Theory of Lesson Drawing in Peripheral Areas of Scotland," 138.
[160] Rose, "What is lesson drawing?" 22.
[161] Dolowitz and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making," *Governance (Oxford)* 13, no. 1 (2000): 13, https://doi.org/10.1111/0952-1895.00121.
[162] Eleanor D. Westney, *Imitation and Innovation: The Transfer of Western Organizational Patterns to Meiji Japan,* (Cambridge, Mass.: Harvard University Press, 1987)

What are the anticipated long-term effects and consequences of implementing foreign policy transfers?

The question of efficiency and long-term success in policy transfer is an important one. Admittedly, there are cases of policy transfer that have not been successful, and there are transfers that have succeeded with short-term results, as well as those that have long-lasting positive results. This question deals with the predicted outcomes, reactions and end results for the importing country in adopting and implementing foreign policies. For my case study, notes may be taken on the anticipated effects of the transfer on those involved, and ultimately who has benefited from it and in what way.

2.4 Research Method

2.4.1 The Case Study

The study will involve making an analysis of the healthcare program known as the Seamless Health and Social Services Provision of Elderly Persons (S-TOP). S-TOP was adopted by the Thai government at Ratchaphiphat Hospital following a proposal and with the guidance of the Japan International Cooperation Agency (JICA). Fieldwork for the case study was undertaken at both the JICA Bangkok office of the Ministry of Public Health and at Ratchaphiphat Hospital, a public hospital located in Bang Kae district on the outskirts of Bangkok. Originally S-TOP was implemented in Japan, and was used in hospitals as part of the provision of intermediate care for the elderly. In the hope of introducing an intermediate care program to Thailand, the Ministry of Public Health in Thailand accepted the proposal to adopt S-TOP. Trials were conducted at eight pilot hospitals across Thailand, one of which was Ratchaphiphat Hospital, the location which forms the focus of my study. Although initially there were multiple sites available for my study, the transfer of S-TOP was by far the most well-established instance of policy transfer in the field of ageing population. Other instances of policy transfer in the same context that were not chosen were still in their initial stages as mere ideas, and thus would not have allowed for a substantial investigation.

Case-study based research allows an investigative, context-specific study to be conducted, in particular within the environment of policy transfer, which involves community-based problems such as aged care, healthcare and so forth. By looking at a specific case, the study is able to create more complete and nuanced observations by using various results, namely quantitative and qualitative data based on the perspectives of interviewees. As this study deals with issues surrounding an ageing society, the benefit of examining case studies from the health care sector is that it places the study directly within the industry most affected by population ageing, and thus reveals the real-world applications of policy transfer and its direct impact. Data for the case study analysis was collected in three stages, as described below.

2.4.1.1 Stage 1: Data collection

The timing of S-TOP starting in 2017 was such that it conveniently coincided with my own research, starting in the same year. And as S-TOP had already embarked on the preliminary stages of set-up, there was no need for me to backtrack or retrace steps, thus saving time and allowing the research to commence without delay. The selected case study also proved to be long-lasting, in comparison to other case studies available at the time, and had the potential to progress well beyond the years of my research. The Thai government at the time had just started producing measures and was talking about solving the ageing crisis, making the implementation of S-TOP even more relevant and timely within Thailand's social and political climate. I began my first round of investigation from November 2018 into January of 2019, when preliminary interviews were conducted at Ratchaphiphat Hospital and at the JICA head office, located inside the Ministry of Public Health in Bangkok. Access to participants was mostly limited to the hours of the appointment, when I interviewed doctors and nurses. However, upon my return to Melbourne, interviews continued via telephone and online in order to maintain relations. A second round of detailed interviews proceeded in late 2019 and early 2020.

The semi-structured interviews were set up in stages, according to how much information the recipient could detail at the time of S-TOP starting. The second round of interviews turned out to provide more substantial information, as S-TOP had progressed into its first year of receiving patients in care. General and specific questions were asked during the interviews, such as, what aspects of ageing in Japan have been relevant to the organisation? What stage is the transfer at? Who are/have been involved in the transfers? Such are part of a series of questions guided by the 'who, what, when, where, how, why' variables of the policy transfer framework, as mentioned in section 2.3.1. To protect the names of informants, their names are identified using pseudonym or position, such as head nurse.

Below is a table of all the key informants interviewed within the thesis:

Facility	**Profession**	**Pseudonym**
Japan International Cooperation Agency (JICA)	Chief coordinator of S-TOP at the Japan International Cooperation Agency	Mr K
Ratchaphiphat Hospital	Head nurse	Head nurse
Ratchaphiphat Hospital	Resident Nurse	Nurse Laura

2.4.1.2 Stage 2: Thematic analysis

Data gathered from the interviews reveals discursive themes, which were sorted and categorised and discussed in later sections of the thesis. The outcome of this process contributes to an understanding of the cultural context behind the policy transfer, as well as raising an awareness of what problems or obstacles have occurred during the process. Thematic analysis is also significant in revealing the underlying motives and reasons behind the involvement of both parties. One wonders, what social and cultural factors enables a Japanese program to be transfer into Thailand and what does this say about the Japan-Thai relations.

2.4.1.3 Stage 3: Revisiting and interviewing the key informants

A second visit to Ratchaphiphat Hospital was made in December of 2019. This was to investigate the progress of S-TOP as part of an update to the same body of work and a reanalysis of the data collected from 2018. Interviews were conducted in Thai, English and Japanese, and translated by the researcher. As the pandemic of Covid-19 effected international travel to Thailand, the researcher conducted interviews by telephone between the years 2020 and 2021.

2.4.2 Researcher's Position

My position as a dual Thai-Australian citizen and having acquired Japanese language proficiency has aided my study in various ways. Having been raised in Bangkok, and Thai being my first language, the setting of my study is in my native culture, within an environment of which I have considerable experience. These personal circumstances bring significant advantages to accessing the contacts and locations necessary for my study, and provide cultural insight that only a native person would be cognizant of. Apart from the linguistic advantage, having situational awareness, which comes from many years of cultural exposure and gaining cultural orientation, allowed myself to build trust among the interlocuters and be given an invitation to observe home visits at the patients' homes, normally restricted to doctors and family members. This opportunity allowed me to bypass the phases of initial orientation, as I was able to speak to

doctors and nurses directly while on route to the patient's home, making friends with student doctors, and gaining an insider's information into what goes on in preparation for and during home visits.

While Japan is not my native culture, my contact with Japan spans decades, having spent time visiting and living there over a number of years as a student and intern. In addition, the value of having majored and completed an Honours degree in Japanese studies at an Australian university provides a vantage point from which to analyse the topic of my study. The years spent in Japan provided me with valuable insight into the hidden nuances in social interactions and helped me gain an understanding of its people and culture. My interactions with JICA officers and my understanding of JICA's project required Japanese language and cultural skills that I already possessed. Being familiar with my field site brings several benefits, such as being able to establish personal relationships and having access to resources in languages other than English, which has allowed me to use academic works and to acquire an insight into cultural dynamics.

At the same time, one could also argue that closeness to the field site may also be a disadvantage, such that the researcher can become too familiar with the setting, and hence might not recognise important aspects or issues that require the fresh perspective of an outsider. I acknowledge that it is not necessarily the case that my "native" association with Thailand and Thai culture will improve my research. In fact, it may create difficulties in the analysis of the case study in ways that I may not immediately be aware of, and that various factors such as my education abroad, class privileges may have influenced my perception in this study.[163]

In Chapter 3, the case study of the field site, Ratchaphiphat Hospital will be introduced in detail. Chapter 3 begins by describing S-TOP and the site at which the program is being implemented. Drawing on relevant background information, as well as data from interviews, the research showcases these locations as a foundation to explain how the transfer of S-TOP initially came about, its objectives and the stakeholders

[163] Kirin Naraya, "How Native Is a "Native" Anthropologist?" in *Situated Lives,* ed. Lamphere, L., Ragone, H. and Zavella, P. (Routledge, 2014), 29.

involved in its implementation. Finally, contextual background in the relevant terms in Thai is given for a nuanced understanding of the program and how it is perceived by actors.

Chapter 3. Japan International Cooperation Agency's S-TOP Program as a Case Study

In Chapter 3, the focus turns to the case study of the Japan International Cooperation Agency's (JICA) official development aid program, known as Seamless Health and Social Services Provision of Elderly Persons program (S-TOP). Fieldwork for this study was undertaken at the Ratchaphiphat Hospital, a community hospital in which S-TOP had been adopted and was being implemented as part of the provision of care to ageing patients. In section 3.1, background information about Ratchaphiphat Hospital prior to its engagement with JICA will be given. By profiling the hospital, we may be able to determine factors that influenced doctors, nurses and hospital administrators to engage in S-TOP. Later in this chapter, section 3.2 will describe the origins of S-TOP through an understanding of how JICA, as a Japanese governmental institution, provides support for the transfer of S-TOP. Commonly used terms in S-TOP, such as intermediate care and rehabilitation will then be defined, as well as the practical issues of their usage in Thai society. In the final sections of the chapter, a mapping of the Thai healthcare network that S-TOP belongs within, as well as the workforces behind the delivery of care will be discussed.

3.1 The Field Site: Ratchaphiphat Hospital

Ratchaphiphat Hospital is a community hospital located two hours west of Bangkok, close to the border of Nakhon Pathom province. It nestles between five district communities: Bang Kae, Nong Kem, Taweewattana, Parsijareon and Talingchan. The hospital started construction in 1996 in celebration of the Royal Jubilee 50th wedding anniversary of the late King Bhumibol and Queen Sirikit. The seven acres of land where the hospital stands were donated by the Promjeen family and construction funds were the combined accumulation of local donations collected by Abbot Phra Thep Prasitmon from the local temple

as well as government funds.[164] The hospital first opened its doors in 1999. Today it has 150 beds, treating on average of 1000 patients per day. Since 2017, the hospital has witnessed a rise in patient numbers that has put a strain on the hospital's resources, due to both an increase in the elderly population in the area, and the recent Covid-19 pandemic that has increased patient numbers. In 2017 the hospital raised more than 300 million baht from mostly private donations for medical equipment and the construction of a second building dedicated to age-related care. All construction projects are expected to be completed in 2020.[165]

There may be various types and rankings of hospitals depending on their capacities and capabilities, such as community hospitals, private hospitals and specialised hospitals. Regional hospitals โรงพยาบาลศูนย์ (rong phyābān sŭn) located in provincial centres, have a capacity of up to 500 beds and provide comprehensive care given by specialised staff. As of 2022, there are 34 regional hospitals operating under the Ministry of Public Health in Thailand.[166] On the other hand, general hospitals โรงพยาบาลทั่วไป (rong phyābān thawpai) located in major districts or provincial capitals, have a capacity of 120 to 500 beds and provide secondary care. There are currently 69 general hospitals located throughout Thailand.[167] While most hospitals in Thailand are affiliated with the Ministry of Public Health[168], there are nine general hospitals that belong under the Medical Service Department, a government agency operating within the Bangkok Metropolitan Administration (BMA).[169] The Medical Service Department of BMA provides for the medical services, health promotions, disease prevention, management of emergency medical services and educational training and

[164] "Ratchaphiphat Hospital, Mortality with Medical Technologies," Ratchaphiphat Hospital Website, Accessed April, 10 2020. http://www.rpphosp.go.th/

[165] "ทุ่ม 300 ล้านขยายตึก รพ. ราชพิพัฒน์" [Investing 300 million to Expand Buildings at Ratchaphiphat Hospital] Thairat News, Accessed April, 10 2020. https://www.thairath.co.th/news/907197

[166] "โรงพยาบาลศูนย์" [Regional Hospital] Healthserv, https://healthserv.net

[167] "โครงสร้างการบริหารงานสาธารณสุขไทย" [Thai Public Health Administration Structure] Khon Kaen University. http://nongerun.go.th/UserFiles/File/kmi/h3.pdf

[168] "สำนักงานแพทย์ กรุงเทพมหานคร" [Medical Service Department] http://www.msdbangkok.go.th/history.html

[169] In addition, in Thailand there are also hospitals and nursing homes that operate under other agencies, such as the Thai Red Cross Society, the Ministry of Defence, Ministry of Education and so on.

development with all nine hospitals listed under the BMA.[170] All hospitals in Thailand are obliged to provide care under the universal health coverage scheme that is free of charge through three government programs (discussed later in this chapter). Community hospitals throughout Thailand are funded by the Ministry of Public Health (MOPH), the governmental body responsible for the oversight of public health in Thailand. Hospitals outside of Bangkok, in other provinces are supervised by the MOPH's Office of the Permanent Secretary of Health within each district. Ratchaphiphat Hospital, listed as a community hospital in Bangkok operates under the supervision of the Bangkok Medical Service Department (see figure 4). The hospital receives government funding as well as private donations from generous individuals in the local area.

According to hospital staff, the effects of urbanisation in the surrounding communities have led to an increase in seniors living alone who rely heavily on hospital resources for care. As the younger generation moves away from outskirt areas to live and work in central Bangkok, older family members are left behind, finding themselves reliant on their local community hospitals such as Ratchaphiphat Hospital. Nursing homes remain scarce and as a result Ratchaphiphat Hospital initiated programs to allow for the changing demography. In 2016, the administrative team initiated systematic reforms that made the hospital become one of the few in Bangkok to provide intermediate care, palliative care and rehabilitation, alongside other alternative treatments in modern medicine, as part of its holistic approach.[171]

Alongside increases in the number of senior patients, Thai hospitals have also experienced a rise in demand from lower income households and migrant workers. A major shift in eligibility to access healthcare occurred in 2001, with the introduction of Thailand's universal health care coverage, known as the 30 Baht Healthcare Scheme. Created by the Ministry of Public Health during the time of the ousted prime minister

[170] สำนักการแพทย์ กรุงเทพมหานคร Medical Service Department, (Source: http://www.msdbangkok.go.th/HOMEENG.html#:~:text=is%20responsible%20for%20the%20management,counseling%20of%20emergency%20medical%20operations).

[171] Care characterised by treatment of a whole person, taking into consideration mental, physical and social factors, rather than just treating symptoms of a diagnosed disease or illness. (Source: Valizadeh, Leila, Madineh Jasemi, Vahid Zamanzadeh, and Brian Keogh, 2017. "A Concept Analysis of Holistic Care by Hybrid Model," *Indian Journal of Palliative Care* 23 (1): 71-80. https://doi.org/10.4103/0973-1075.197960.)

Thaksin Shinawatra, the scheme cleared up many uncertainties about rights and coverage by means of its well-publicised campaigns and advertisements. The scheme also solved many eligibility problems for migrant workers, who in the past were unable to comply with complex bureaucratic regulations and would now be able to receive benefits within the scheme by using the 'The Golden Card' (also known as low-Income cards).[172] Throughout their working life most migrants remain unregistered, living as 'illegal aliens', with no rights to healthcare or legal support in their jobs.[173] For low-income individuals,[174] it has allowed those who had previously missed out on receiving 'The Golden Card', or are not covered by other government-sponsored forms of insurance to have healthcare coverage. However, while the popularity of this universal healthcare scheme has enabled low-income people and migrant workers to gain access to healthcare, hospitals such as Ratchaphiphat hospital, have needed to reform management systems and increase their capacity to keep up with demand.

Thailand's ageing population is not made up only of Thai nationals. The increasing rise in the number of migrant workers in Thailand also puts pressure on the government to provide proper access to care, further exacerbating issues of scarcity and demand for the healthcare providers. According to the 2022 census published by the Foreign Workers Administration Office, the number of registered migrant workers in Thailand was 2,408,716.[175] Alongside the Thai elderly in need of care, there is also a population of working migrants, namely families and individuals from neighbouring countries such as Burma, Laos, and Cambodia. This is a migrant workforce, consisting of both men and women, who come to Thailand to seek employment and a better life for their families. The demographic profile of Thailand's ageing population indicates that there will be a sustained demand for more migrant workers, and that the Thai population will

[172] Anchana NaRanong, Viroj NaRanong, "Universal Health Care Coverage: Impacts of the 30-Baht Health-Care Scheme on the Poor in Thailand," *TDRI Quarterly Review* (September 2006): http://tdri.or.th/wp-content/uploads/2012/09/t5s2006001.pdf

[173] Derina Johnson, and Robbie Gilligan, "Youth Agency in Everyday Precarity: The Experiences of Young Migrants and Refugees Growing up on the Thailand-Myanmar Border." *Journal of Youth Studies* 24, no. 2 (2021): 142 – 61.

[174] Low-income groups: single person earning less than 9000 baht per month (approx. $300 AUD) Source: Ministry of Labor, www.mol.go.th

[175] "สถิติจำนวนแรงงานต่างด้าว ที่ได้รับอนุญาตทำงานคงเหลือ ทั่วราชอาณาจักร ประจำเดือน สิงหาคม 2565," [Statistics on the number of foreign workers authorised work balance all throughout the Kingdom of Thailand for the month of August, 2022] (Source: Foreign Workers Administration Office, https://www.doe.go.th/prd/assets/upload/files/alien_th/116f9495b6745ffced7265d0802c67f0.pdf)

become increasingly dependent on migrants to fill labour shortages.[176] Their meaningful contributions to the labour market are mainly in labour-intensive sectors, such as agriculture (rubber, sugarcane and maize plantations),[177] food production for export, construction,[178] tourism and services, such as in the domestic setting as helpers and uncertified care givers (see further discussions in section 4.3.3, Sharing Experiences through the Action Plan). The government census reports the number of migrant workers as increasing steadily by an average of approximately 100,000 persons entering Thailand per month, due to ongoing social, economic and political instabilities in neighbouring countries since the 1980s, such as the civil unrest in Myanmar.[179] The issues of supporting the needs of millions of migrant workers and their families in Thailand continue to be an ongoing matter of national discussion. Despite the benefits of the 30-Baht Healthcare Scheme and other schemes for migrants, namely the Compulsory Migrant Health Insurance Scheme (CMHI),[180] access to proper care is often limited due to a lack of documentation.[181] And while some are able to go to hospital, they often face discrimination against their nationality and class.[182]

Interviews with staff gave me the impression that Ratchaphiphat Hospital was innovative. Doctors and nurses took pride in explaining their holistic approach to aged care and said that much of the success of the hospital was due to Dr Phuritat, a researcher within the medical field, a family doctor and a key figure in

[176] Labour Mobility and Social Inclusion. IOM UN Migration Thailand. (Source: https://thailand.iom.int/labour-mobility-and-social-inclusion)
[177] "Working and employment conditions in the agriculture sector in Thailand: A survey of migrants working on Thai sugarcane, rubber, oil palm and maize farms" International Labour Organization (Source: https://www.ilo.org/asia/publications/WCMS_844317/lang--en/index.htm)
[178] Rebecca Napier-Moore, and Kate Sheill, "High Rise, Low Pay: Experiences of Migrant Women in the Thai Construction Sector," *International Labour Organization* (2016).
[179] Valentine Ostaszewski, "Migration Matters: Thailand – the Land of Migrants and Refugees," Asia Pacific Foundation of Canada, 2016, https://www.asiapacific.ca/blog/migration-matters-thailand-land-migrants-and-refugees.
[180] Rebecca Napier-Moore, and Kate Sheill, "High Rise, Low Pay: Experiences of Migrant Women in the Thai Construction Sector," *International Labour Organization* (2016), 12.
[181] There are four types of documentation used to identify migrant workers: Memorandum of Understanding (MOU) scheme, a temporary visa for migrants to enter and work in Thailand with a work permit of up to two years; the National Verification pathway, which allows migrants to enter Thailand without paperwork and be issued with a temporary passport; the Migrant Worker Card, which provides temporary amnesty to migrants with no documentation within a limited period of time; and migrants who are able to access the national health scheme and the Stateless Card, no longer in operation, while current cardholders must apply for permission to travel for work in the zone they are registered in. For further details see Rebecca Napier-Moore, and Kate Sheill, "High Rise, Low Pay: Experiences of Migrant Women in the Thai Construction Sector," *International Labour Organization* (2016), 16.
[182] United Nations Human Rights Office of the High Commissioner. "In Dialogue with Thailand, Experts of the Committee on the Elimination of Racial Discrimination Ask about the Situation of Indigenous Peoples, Migrants, Asylum Seekers and Stateless Persons," 2021. https://www.ohchr.org/en/press-releases/2021/12/dialogue-thailand-experts-committee-elimination-racial-discrimination-ask.

directing the hospital's aged care programs. Dr Phuritat explained that to equip themselves quickly for the rise in the ageing population, the hospital administrators saw the need to create services in geriatric care, to provide rehabilitation and to establish their own centre to train staff.[183] Accomplishing this in 2017 marked the beginning of the hospital's objective in becoming recognised as a one-stop service in aged care. Further, the hospital became even more unconventional, in that mainstream medicine was combined with a wide range of alternative medicines. The hospital's long-term care plans for palliative patients included mainstream treatments, herbal medicine, Thai traditional medicine, acupuncture, psychological care, occupational therapy, body movement therapy and physiotherapy. All of these were part of the Head doctor's plans for holistic care.[184] These services produced a highly mixed, skilled team of medical practitioners, all specialising in various fields. The hospital has been well-recognised for its work and has received several awards, including the 2018 United Nations Public Service Award for Bangkok's Geriatric and Palliative model. Together their work would lead them towards implementing their own intermediate care program and later, with the guidance of JICA, to adopt and transfer the S-TOP program into their regime of care.

My interviews with staff at the hospital in 2018 and 2019 compelled me to think that staff were reform-minded and quite used to changes happening at the hospital. While the hospital dealt with changes in creating new aged care programs, staff were also working with changes to their structural surroundings, as construction work on new hospital buildings continued until 2020. Despite their being forward-thinkers, innovative and committed to care, several issues, such as the lack of resources, space and staff numbers, do not enable the team to create long-lasting fundamental change. While multidisciplinary approaches do tend to have a positive impact on the quality of care, the lack of staff in fields such as occupational health means that staff often end up doing various other tasks to cover for each other. This leads to confusion,

[183] Thairat News, "ศูนย์การเรียนรู้ "Geriatric Academy" ต่อยอดโรงพยาบาล ราชพิพัฒน์: รักษากาย ใจผู้สูงอายุ" [Geriatric Academy Learning Center Continues at Ratchaphiphat Hospital: Elderly Body and Mind Treatment] Accessed April, 10 2020. https://www.thairath.co.th/news/local/1189823

[184] Phuritat Sangtongpanichakull, "Innovation of Geriatric, Palliative Care and IMC model in Aging Society," *Ratchaphiphat Hospital, Medical Service Department.* https://www.thailivingwill.in.th/sites/default/files/ptt_

overworked staff and an ineffective use of resources. These challenges are examined in more depth in the context of S-TOP in chapters 4 and 5.

Ratchaphiphat Hospital exists as a singular entity. The team of medical staff that I interviewed in 2019 and 2020 included the head nurse and the head doctor, both of whom have a history of implementing unorthodox, new approaches to aged care schemes to assist elderly patients in the local area. Later in Chapter 4, in sections 4.1, 4.2 and 4.3, the study discusses Ratchaphiphat Hospital, its multidisciplinary team of practitioners, and the role that doctors and nurses have in implementing S-TOP.

3.2 The S-TOP Program: Seamless Health and Social Services Provision for Elderly Persons (S-TOP)

The S-TOP program in Thailand is a technical assistance project developed in 2017 by JICA to assist local hospitals in implementing intermediate care systems for elderly patients. The development of S-TOP illustrates the important interplay between key service providers, foreign interests and local partners in facilitating a health care program to tackle issues arising from Thailand's ageing population. To investigate the transfer of the S-TOP program, we must first understand the origins of S-TOP.

Since 1954, Japan has been providing official development assistance (ODA). The beginning of Japan's ODA activities came about with the signing of the Colombo Plan in 1954, starting with a modest level of reparation payments to Southeast Asian countries. It was Japan's a decision to engage in promoting peace and stability through monetary aid for non-military operations, such as the Colombo Plan, government-sponsored foreign student scholarship programs, and post-war recovery payments through UNESCO.[185] Among the various types of ODA that Japan now coordinates, JICA was created in 1974 to affect the direction of education aid projects to developing countries. These bilateral aid projects branched out into

[185] Takao Kamibeppu, *History of Japanese Policies in Education Aid to Developing Countries, 1950s-1990s: The Role of the Subgovernmental Processes*, East Asia (New York, N.Y. 2016), 39.

four schemes: grant aid, technical cooperation, loans, and contributions to multilateral organisations.[186] They were undertaken by various departments without a specific coordinating unit.[187] Aid grants assist in projects for education, research, the building of schools, grassroot projects and cultural activities. Over the past 68 years, Japan has contributed to the international development of communities in various areas beyond education aid, and has looked in the direction of economic and social growth, such as rural development, infrastructure building and improved living conditions in rural areas by promoting community health centres and so on.[188] JICA has created country-specific projects, spanning 150 countries, including Thailand.[189]

JICA's activities in Thailand come under several scheme types, namely Project-Type Technical Cooperation, Individual Expert Team Dispatch, and Research Cooperation, all known collectively as Technical Cooperation Projects.[190] Since 1995, JICA's programs in Thailand have prioritised three key areas: 1. Sustainable development of the economy and coping with a maturing society, 2. Coping with common issues in ASEAN countries, and 3. Promotion of cooperation with countries outside the ASEAN region.[191] The aims of S-TOP fits well into JICA's activities and objectives, as identified above. S-TOP's aims are to 'ensure the nationwide expansion of community-based models developed for the seamless provision of medical, rehabilitative, social and life-support services for elderly persons.'[192] The running of S-TOP in Thailand since 2017 came at a time of peak political and social interest in the topic of Thailand's ageing population. Public discussions, debates among Thai scholars and newspaper articles impressed the public with a sense of urgency, using words describing Thailand's future as worrying[193], 'an ill-prepared society'[194]

[186] Ibid., 22.
[187] Ibid., 18.
[188] Ibid., 77.
[189] "History," Japan International Cooperation Agency, https://www.jica.go.jp/english/about/history/index.html
[190] "Activities in Thailand," JICA. https://www.jica.go.jp/thailand/english/activities/coop03.html
[191] "Activities in Thailand," JICA. https://www.jica.go.jp/thailand/english/activities/index.html
[192] "The 1st National Seminar on the Development of Intermediate Care Service Model Project on Seamless Health and Social Provision for Elderly Persons (S-TOP)," Japan International Cooperation Agency, Accessed April 8, 2020. https://www.jica.go.jp/thailand/english/office/topics/180720.html
[193] TNN, "สถานการณ์ผู้สูงวัยในไทยน่าเป็นห่วง" [The situation of the elderly in Thailand is worrisome]. Accessed April 15, 2020, https://www.tnnthailand.com/content/17840
[194] "Ageing in an Ill-prepared Society," Bangkok Post, Accessed April 8, 2020, https://www.bangkokpost.com/opinion/opinion/1684440/ageing-in-an-ill-prepared-society

with 'creaky foundations'[195] for a society that is rapidly ageing and starting to witness issues of labour shortages. At the same time books with affirmative messages about health promotion among the elderly[196], life-long learning[197], television programs, documentaries, products targeting the elderly, along with mega real estate construction projects,[198] the majority of which refer to Japan in some way or another, became highly commercialised and popular among the middle-aged and retirees alike. Japanese-style loft homes[199], property developments,[200] as well as traditional-style houses[201] with their minimalism and consideration for the elderly have come into high demand in Thailand for upper class and middle-class Thais,[202] with Japanese developers also flocking to the Thai property market.

11 May 2017 marked the official signing of the S-TOP program, jointly implemented by four parties, namely the Thai Ministry of Public Health, Ministry of Social Development and Human Security, National Health Security Office and JICA. The S-TOP program is the third within the series of elderly care related projects created by JICA, after the 'Community Based Integrated Health Care and Social Welfare Services Model for Older Persons in the Kingdom of Thailand', also known as C-TOP (2007-2011), and the 'Long-term care Service Development for the Frail Elderly and Other Vulnerable People', L-TOP (2013-2017).

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[195] Pichaya Svasti, "Our Ageing Society is on Creaky Foundations," *TDRI*, Accessed April 8, 2020, https://tdri.or.th/en/2015/06/our-ageing-society-is-on-creaky-foundations/

[196] Kinokuniya Thailand, "Healthy Aging เกิดแก่ (ไม่) เจ็บตายสูงวัยอย่างมีคุณภาพ" [Health Aging, Birth (not) Hurt, Die, Age with Quality]. Accessed April 8, 2020, thailand.kinokuniya.com/bw/9786167982427

[197] SE-ED Bookshop, "ชาญชรา ก้าวสู่สังคมสูงวัยด้วยความรู้และปัญญา วรเวศม์ สุวรรณรดา" [Charn Sen: Stepping into an Aging Society with Knowledge and Wisdom, Worawet Suwannada]. Accessed April 8, 2020. https://m.se-ed.com/Product/Detail/9786163290663

[198] "Japanese Real Estate firms are flocking to the Thai property market," RWT International Law, Accessed April 9, 2022. http://www.rwtlaw.co.th/japanese-real-estate-firms-are-flocking-to-the-thai-property-market/#:~:text=Japanese%20developers%20have%20been%20flocking,Mitsubishi%20Estate%20group%2C%20Tokyu%20Corp.

[199] "Mono – Japanese Loft Homes in Koh Keaw," Real Phuket Estate, Accessed April 9, 2022, https://realphuket.net/estate/mono-japanese-loft-homes-in-koh-keaw/

[200] "Luxury reimaged: Raimon Land joins hands with Japanese property developers to redefine luxury in heart of Bangkok," The Japan Times, Access April 9, 2022, https://www.japantimes.co.jp/country-report/2021/09/08/thailand-report-2021/luxury-reimagined-raimon-land-joins-hands-japanese-property-developers-redefine-luxury-heart-bangkok/

[201] "Homebuilders bring a touch of traditional Japan to Bangkok" Nikkei Asia, Accessed April 9, 2022. https://asia.nikkei.com/Business/Markets/Property/Homebuilders-bring-a-touch-of-traditional-Japan-to-Bangkok

[202] Naya Residence, "โครงการบ้านที่ออกแบบเพื่อดูแลคนสูงวัยครบด้านให้คนสูงวันอยากมาใช้ชีวิตอยู่อย่างยืนยาว และไม่เป็นตราบาปสำหรับลูก" [Naya Residence, A House Project Designed to Take care of the Elderly in All Aspects for the Tall People Who Want to Live Long and Not a Stigma for You] Accessed April 9, 2022, https://readthecloud.co/naya-residence/

Both C-TOP and L-TOP had a different focus from S-TOP. C-TOP focused on building community-based systems in four pilot sites at sub-district levels of Thailand: Chiang Rai (North), Khon Kaen (North-East), Nonthaburi (Central) and Surat Thani (South), each of which mark the four regions of Thailand. For each pilot site C-TOP developed a model that specifically targeted a prevalent lifestyle-related disease within that particular region. Chiang Rai focused on hypertension, caused by cholesterol, unbalanced diet and a lack of exercise, the C-TOP pilot site in Khon Kaen focused on diseases of the eyes and mouth among the elderly, such as cataracts, Nonthaburi's C-TOP focused on creating a rehabilitation centre for the elderly to use three times a week, and Surat Thani's C-TOP focused on building a mobile one-stop health and welfare service, whereby welfare officers would visit villages and communities to provide screening and health consultations every month.[203]

L-TOP on the other hand was more extensive, with six pilot programs in Chiang Rai, Khon Kaen, Nonthaburi, Surat Thani, Nakhon Ratchasima and Bangkok. L-TOP's focus was on the establishment of long-term care for the quality of life of elderly persons. Three main outputs were created in L-TOP, 1) the creation of a long-term care model service by ministries and organisations adopting the program, 2) developing training programs to transfer care skills to care workers and coordinators who participated as part of the Japan-to-Thailand human resource development, and 3) making policy recommendations based on pilot projects in the experience for a future policy response shared by researchers in seminars.[204] L-TOP and C-TOP may have paved the way for the implementation of S-TOP, in that JICA's networks with the key agencies have been established, its work and history of performance are now accepted and known within Thailand, thus making for a smoother transition into the newer project, S-TOP. Perhaps even more significant for S-TOP is the timing, in that it coincided with 'ageing' becoming an item on the national agenda with the highest

[203] "Press release: First National Conference for Presenting Community Based Integrated Health Care and Social Welfare Services Model for Older Persons – A Trial for the Rapid Aging Population in Thailand, run jointly between Thailand and Japan," Japan International Cooperation Agency, 2010, Accessed April 18, 2020. https://www.jica.go.jp/thailand/english/office/topics/c8h0vm0000biwn1g-att/press100816_01.pdf

[204] "Project on Long-term Care Service Development for the Frail Elderly and Other Vulnerable People (L-TOP)," Japan International Cooperation Agency, Accessed April 16th 2020. https://www.jica.go.jp/project/english/thailand/015/materials/c8h0vm00008wrv0x-att/L-TOP_en.pdf

priority in 2019.

3.2.1 Understanding Intermediate Care and Rehabilitative Care

This section defines the key terms most commonly used among S-TOP users: 'intermediate care' and 'rehabilitation'. Sections 3.2.1.1 investigates the meaning of both 'intermediate care' and 'rehabilitation' as well as how the terms are used as part of the linguistic experience of Thai doctors and nurses within the setting of Thai hospitals. Words used in a certain language, and within a certain cultural framework, possess a specific cultural meaning, and by bridging the linguistic barriers, we may be able to see through the same lens that doctors and nurses view the world through. In other words, we may bring ourselves to step into the shoes of doctors and nurses and understand how they view S-TOP at Ratchaphiphat Hospital. Finally, in section 3.2.1.2, the analysis turns towards the Thai health system in which S-TOP is being implemented.

3.2.1.1 Intermediate Care and Rehabilitation in Thailand

Beginning in 2017 and closing in August of 2022, eight public hospitals in Thailand were selected by both JICA and the Ministry of Public Health to implement S-TOP as a method of creating an 'intermediate care' system. To have 'intermediate care' means to provide care to patients that mainly revolves around rehabilitation, including a wide variety of care that is interwoven into the treatment program depending on the needs of the patient. Therefore, intermediate care is typically considered as a treatment scheme that varies from patient to patient. Intermediate care may be needed during the acute stage. Intermediate care may be conducted for stable but recovering patients at home. Intermediate care may also be included in the care plan of unstable patients recovering at hospital. Intermediate care may continue into end-of-life care. Therefore, it requires an extensive network of services that coordinates the needs of patients from the first instance of diagnosis. Such a model, requiring a developed network of local health and social care from interdisciplinary joint services had previously been non-existent in Thailand's health care system. More as a governmental policy response, the Thai government places great emphasis on intermediate

care's potential to become a long-term national strategy for alleviating system pressures, such as over-crowded hospitals, limited hospital resources, understaffing of nurses and doctors, preventative measures for risk of injury among the elderly, preventing the unnecessary readmission of aged patients, all of which to date are still ongoing problems throughout the country.[205]

When defining intermediate care, other scholars agree that its definition is ambiguous, conveying little meaning other than being about care that is 'in between'. Although intermediate care still does not have a specific, scientific definition that is distinctive, its main objective is the prevention of unnecessary hospitalisation of elderly individuals through restoring independence.[206] Intermediate care offers short-term rehabilitative support, using multidisciplinary approaches, to assist individuals to live more independently.[207] The focus of intermediate care is to reduce hospital admission and allow earlier discharge. It does this by: 1) assisting individuals to become independent as soon as possible after the hospital stay, 2) supporting individuals to live at home despite physical disabilities or difficulties due to illness, and 3) preventing the unnecessary institutionalisation to residential homes when this may not be the best outcome.[208] On the other hand, rehabilitation is defined generally as the process of helping somebody to have a normal, useful life again after they have been very ill, that is, treatment aimed at restoring the patient to their former state, following an illness, accident, or after imprisonment.[209] Before the modern concept of intermediate care, rehabilitative care is discussed from the viewpoint of physical therapy, and is used in various health systems such as the National Health Service in the United Kingdom.[210]

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[205] "The Thai-Japan project to offer elderly better 'intermediate care'," The Nation Thailand, Accessed April, 9 2020, https://www.nationthailand.com/breakingnews/30315828

[206] Rene J. F. Melis et al., "What is intermediate care? An International Consensus on What Constitutes Intermediate Care is Needed," *BMJ (Online)* 329, no. 7462 (2004): 360-361.

[207] Brenda Roe, Roger Beech et al., *Intermediate and Continuing Care Policy and Practice,* (Oxford; Malden, MA: Blackwell Pub., 2005), 3.

[208] "Factsheet 76: Intermediate care and Reablement," Age UK, Accessed May 22, 2022, https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs76_intermediate_care_and_reablement_fcs.pdf

[209] *The Concise Oxford Dictionary*, tenth edition, (Oxford University Press. 1999)

[210] Sally Jacobs, and Kirstein Rummery, "Nursing Homes in England and Their Capacity to Provide Rehabilitation and Intermediate Care Service," *Social Policy and Administration* 36, no. 7 (2002): 735-752.

Doctors and nurses from Ratchaphiphat Hospital were interviewed about intermediate care and rehabilitative care within S-TOP. They had a tendency to use the term 'intermediate care' interchangeably with 'rehabilitation' in Thai, which caused some confusion during the transcribing and translation of their interviews. For the purpose of investigating S-TOP, it is important to be able to distinguish why participants use these terms interchangeably, in order to understand how S-TOP works, and what skill is being spoken about. More importantly, as an outsider in the medical field, it is crucial for myself to grasp how the terms are understood by Thai staff in the context of treating their patients.

On closer inspection, one suspected reason for interchanging these terms may be linguistic or semantic. In Thai, there is no single word meaning 'intermediate care'. The Thai for 'intermediate care' is การบริการฟื้นฟูผู้ป่วยระยะกลาง (kārn brikārn fṭ̂nfū p̄hû p̀wy raya klāng), which refers to a type of service, การบริการ. On the other hand, 'rehabilitation', เวชศาสตร์ฟื้นฟู (wechs̄āstŕ fṭ̂nfū) is considered as a field of medicine. Both terms contain the word ฟื้นฟู] (fṭ̂nfū), meaning restoration, recovery and rehabilitation. Whenever 'intermediate care' in Thai felt clumsy in a conversation, interviewees simply referred to it as ฟื้นฟู (recovery or rehabilitation) for convenience. This caused confusion for myself as to whether they meant 'intermediate care' or 'rehabilitation'. To make matters worse, interviewees could also simply be referring to a patient's recovery in a general sense, describing a patient's physical condition, and not 'intermediate care' or 'rehabilitation' as a process in S-TOP. Contextual understanding here is important during interviews with staff at Ratchaphiphat Hospital. To distinguish the uses of these terms I might also reiterate and ask further, in order to clarify the confusion in my own understanding, especially when interviewees are explaining the benefits of intermediate care, or describing when rehabilitation should take place at a particular stage of S-TOP.

To distinguish 'intermediate care' from 'rehabilitation,' doctors and nurses may sometimes include words such as 'stage' ระยะ (raya) or 'system' ระบบ (rabob), making 'intermediate care' a stage of care or system of care: 'intermediate care system', ระบบฟื้นฟู (rabob fṭ̂nfū) or 'intermediate care system' ระยะฟื้นฟู (raya fṭ̂nfū).

The term 'Intermediate care system' alludes to the involvement of many interrelated elements, with different functions for the purpose of this particular type of care, performed at a particular stage of rehabilitation. Sometimes, to make communication clearer, interviewees would also use the English words 'intermediate care', while 'rehabilitation' is simply expressed with the abbreviated English word 'rehab'.

Linguistically, when we dissect the word 'rehabilitation' in Thai, the first part of the word เวชศาสตร์ฟื้นฟู (wechṣāstŕ fṭ̂nfū) is derived from two Sanskrit words, เวช (wech), meaning physician, medicine or doctor, and ศาสตร์ (śāstra), the suffix for science, field, branch or knowledge, - ology. And this is followed by ฟื้นฟู (fṭ̂nfū) meaning recovery, rehabilitation. This may give us some indication of the way in which, rehabilitation is understood in Thailand as an area of study that physical therapy and 'intermediate care' falls within.[211]

Further, while the idea of intermediate care is new to Thailand,[212] rehabilitation as a branch of medicine is not. Historically, the study of rehabilitative medicine in Thailand can be dated back as far as the 1930s, when the first medical school was established.[213] Semantically, there is an intersect in the meaning of both terms, as both focus on the physical improvement of patients, even though technically intermediate care is interdisciplinary, and is inclusive of a wide variety of medical fields and not only rehabilitative medicine.

3.2.1.2 JICA's S-TOP in Thailand

[211] 'The department of rehabilitation medicine is an overview of the treatment of rehabilitation of a patient's body. It encompasses the broad scope of duties that also includes physical therapy. It includes diagnosis, symptom assessment, treatment and rehabilitating the patient's condition. And as a result, the department of rehabilitation medicine has many teams of personnel, working together.' (Translated by researcher. Source: 'What is rehabilitation medicine and how is it different from physical therapy in a hospital?' [เวชศาสตร์ฟื้นฟู คืออะไร มีความแตกต่างจากกายภาพบำบัดในโรงพยาบาลอย่างไร ?], Accessed October, 18 2022 www.rakmor.com)

[212] Intermediate care is a recent form of care that first emerged in the mid-1990s in the British health and social care system. There is no known date for when it was first introduced into Thailand.

[213] The first college for rehabilitation, specialising in psychiatry established in the year 1935 by Major General Pathum Satjajuda. (Source: The Royal College of Psychiatrists of Thailand, Accessed April, 29 2020, http://rehabmed.or.th/main/)

Mr K, the Chief Advisor of JICA S-TOP project, is one of the key informants in this study. His comments and ideas feature prominently in this study, as he heads the transfer of S-TOP with Ratchaphiphat Hospital. His career in health and welfare in Japan spans decades. From 1985 to 1996, his work within the Ministry of Health, Labour and Welfare (MHLW) related to food safety, retirement pension systems, the national health insurance scheme and national land development planning. From 1996 he was appointed to a position as a secretary to the Embassy of Japan in the United Kingdom. Prior to his work with JICA, he became the director for various divisions within the MHLW of Japan, including working with the Ministry of Education, Pension Bureau and the National Rehabilitation Center for Persons with Disability, from which he was appointed as the Chief Advisor of the current JICA project S-TOP in Thailand from November of 2017. As a high-level official in charge of social welfare and health policies, more particularly in the field of social welfare and human resource development, his experience provides much value within the field of health and welfare of the elderly which S-TOP is targeting. Throughout 2018 and 2019, I had the opportunity to meet, interview and share information with him on the approaches he took to the implementation of S-TOP in Thailand, and acquired useful data for this study. It should be noted that while JICA's activities in Thailand may be associated with broader geopolitical influence, JICA's personnel and the trajectory of their aid activities remain relatively unaffected by political instabilities within Thailand. Their activities are consistent regardless of the local political situations, and in the light of this interviews with JICA officials are focused specifically on the policy transfer with the Thai hospital, and no mention of governance or attitudes towards politics is made.

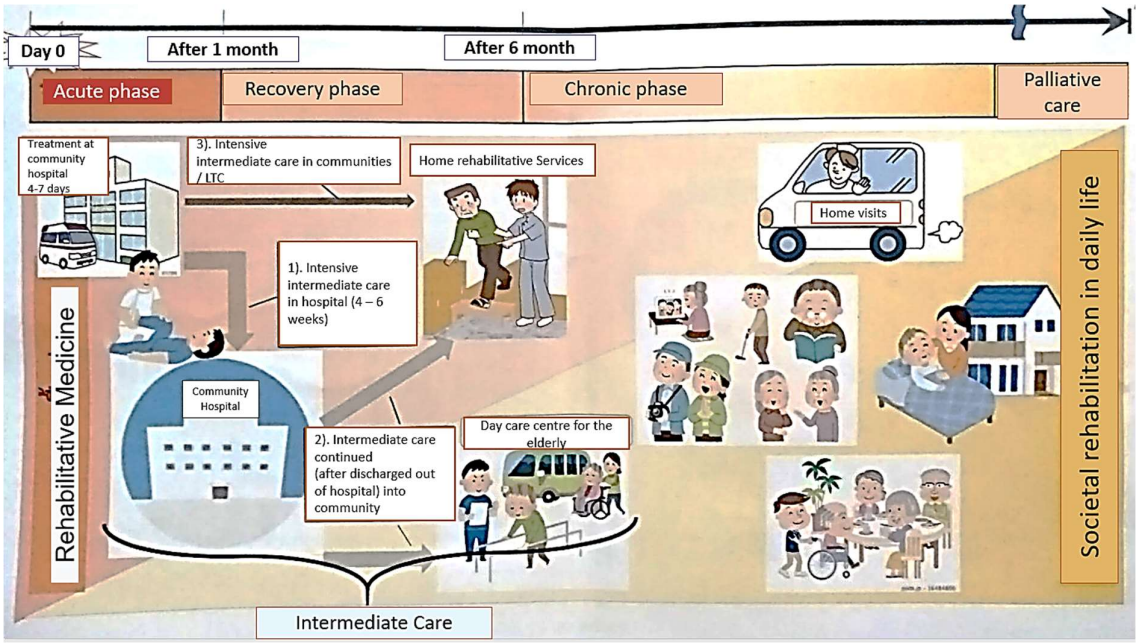
Mr K explained that S-TOP serves to benefit patients in Thailand who suffer from three main categories, namely: 1), stroke 2), spinal cord injury, and 3) traumatic brain injury. According to Mr K, these are the three main ailments suffered among the elderly Thai population. However, Mr K stated that S-TOP is not exclusive and also applies to patients in the pre-aged groups suffering from the ailments stated above and who also rely on intermediate care. 'The first category, stroke, is related to ageing, but the other two are relating to accidents,' Mr K explained. 'Road accidents are a very big problem in Thailand and I do not intend to exclude younger people from the S-TOP program. While older persons are at the centre of our

concern, we do not intend to exclude others who can benefit from this.' The 'S' in S-TOP, that stands for the word 'seamless', comes from the way in which resources are used effectively for the purpose of creating an uninterrupted chain of patient care. During the phases seen in figure 3 (below), the transfer of care becomes the responsibility of various entities. S-TOP's aim here is to shift the burden of care from the hospital to families, carers, community volunteers, social services, neighbours in the community and to the patient themselves.

Figure 3 illustrates the stages of care in S-TOP. The diagram was provided by Ratchaphiphat Hospital staff and demonstrates the flow and sequence of events, that is, when care should be provided at various stages of patient care. The diagram was modified from the original diagram widely used in Japan. For the purpose of using S-TOP in Thailand, JICA proposes that there should be two streams of intermediate care that flow seamlessly from one to the other. The first stream of intermediate care begins at the acute phase, when the patient receives initial treatment at the hospital or at a separate, more localised rehabilitation centre. The first stream of intermediate care as described in the diagram is intensive and may last up to six weeks. Prior to discharging the patient, nurses and doctors from Ratchaphiphat Hospital are to conduct a housing and environmental assessment to determine what modifications are necessary to meet the needs of the patient's physical disabilities. This period of adjustment might also require doctors to train family members in order to support patients' needs and assist in their rehabilitation. Once the patient is discharged, rehabilitative treatment continues at home by visiting doctors and nurses, family members or volunteers. Regular visits to the hospital are expected to continue. Insufficient intermediate care follow-up has often resulted in the patients becoming bedridden after being discharged from the hospital too soon.[214]

Figure 3. S-TOP Diagram for Ratchaphiphat Hospital

[214] "Care for the Elderly with Peace of Mind: Japan's Care Service Experience Contributes to Health and Longevity in Thailand," Japan International Cooperation Agency, Accessed June 16, 2022, https://www.jica.go.jp/english/news/field/2019/20191108_01.html



Source: Ratchaphiphat Hospital. Translated into English by the researcher.

The second stream of intermediate care occurs to gradually prevent lapses and manage patient care at home. As much as possible, there is a gradual shift from hospital to home-rehabilitation or community-based care. In many cases where the patient is unable to rely on family and requires extra on-going support, they may be sent to day care centres during the day, located in the community where they live. Welfare facilities for the elderly or day care centres in Thailand are not the norm, and community-based care in most neighbourhoods consists of neighbours volunteering to look after one another, with little to no funding from the municipalities. Some of the issues with planning these strategies are caused by internal organisational factors, such as conflict of interest, lack of leadership in municipality decision-making, lack of a structured national policy and funding.[215] In contrast, in Japan day care services for the elderly have become commonplace in communities, temples and local government offices. Nurses and doctors of S-TOP continue to conduct home-visits to facilitate the on-going intensive and specialised rehabilitation and to monitor the needs of the patient when necessary.

[215] Chaimongkhon Supromin and Sirirat Choonhakhlai, "The Provision of Public Services in Municipalities in Thailand to Improve the Quality of Life of Elderly People," *Kasetsart Journal of Social Sciences* 40, no. 3 (2017): https://doi.org/10.1016/j.kjss.2017.12.011.

With this strategy a flow of services can be established, starting at the hospital, then to prepping family members, training carers, community volunteers and thus facilitating the smooth return of patients from hospital to home life or community-based support. By overlapping two streams of rehabilitation, first intensive rehabilitation followed by consistent support using various resources in intermediate care, patients may have a greater chance of physically returning to normal daily life at least to some extent. Thus, it aims at preventing a recurring fall in the elderly, preventing rehospitalisation, and the unnecessary institutionalisation of an elderly patient. Mr K informed me at the very beginning of my meetings with him early in 2018 that the crucial first few weeks of a patient's recovery are a 'golden opportunity' that may either see someone return home as a functioning member of society, or become bedridden. This is where the catchphrase for S-TOP comes from, 'S-TOP bed confinement'.[216] It seems that S-TOP provides room for rehabilitation to become part of the services that are provided by the hospital, as well as being a flexible service that can be provided by other resources. This is something that most Thai doctors and hospitals have not yet given much consideration to.

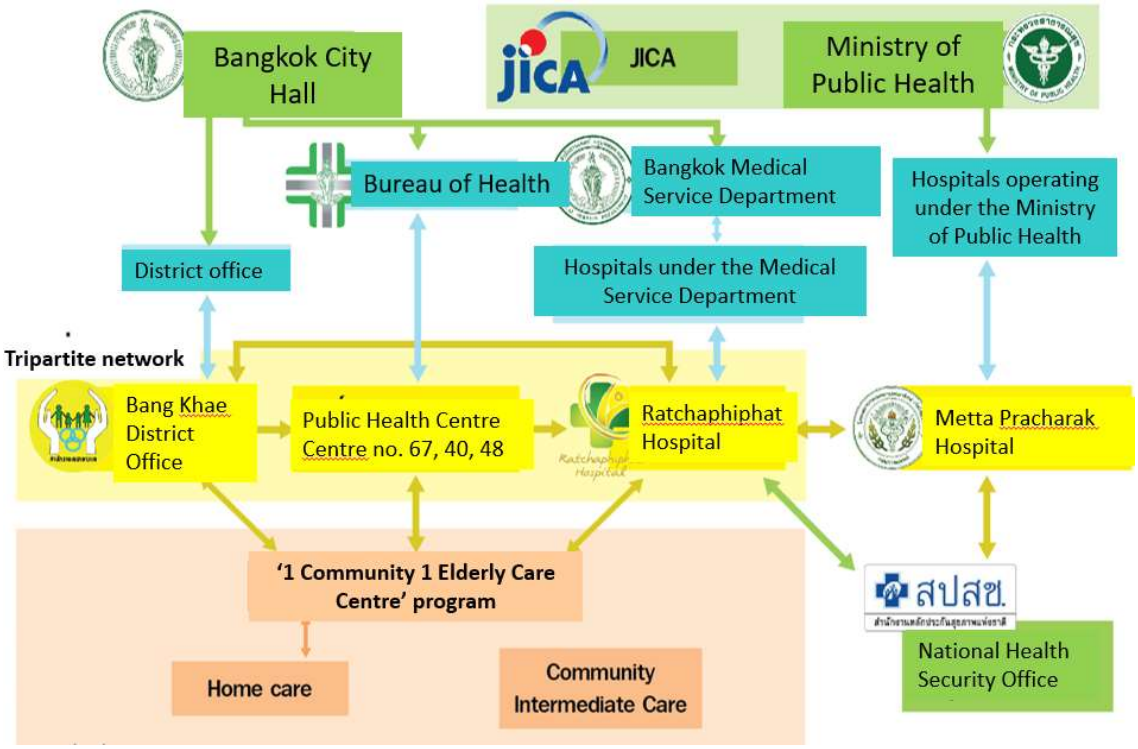
Mr K explained that a crucial element of S-TOP is the transfer of knowledge from staff to carers. This is done for the eventual independence of patients from hospital care and to relieve systems pressure from the hospital. That is, S-TOP's philosophy here is focused on patient and family ownership and less on reliance on doctors and community hospitals. Further, S-TOP is located within the context of an ageing population that relies on scarce labour, and has created logistical systems to combine existing services for a more structured and reliable form of care in communities with a high population of the elderly. S-TOP pulls in resources from the municipality, volunteer organisations, community hospitals, neighbours, families and other additional forms of assistance. At Ratchaphiphat Hospital where S-TOP is being implemented, staff described how their work also relies on other government programs, such as the initiative headed by the

[216] "Care for the Elderly with Peace of Mind: Japan's Care Service Experience Contributes to Health and Longevity in Thailand," Japan International Cooperation Agency, Accessed June 16, 2022, https://www.jica.go.jp/english/news/field/2019/20191108_01.html

Medical Service Department called Bangkok Cares for the Elderly with Strong Hearts Program, กทม ใส่ใจผู้สูงวัยหัวใจแกร่ง (kothomo saijai phû sŭng wai hwajai kræng).[217] Support in this initiative assists the elderly in very low-income households, mostly single people or couples living below the poverty line. This program has been incorporated into S-TOP as part of a larger network of care for the increasing cohort of the elderly living in poverty in and around Bangkok.

[217] "สำนักการแพทย์ กรุงเทพมหานคร" [Medical Office Bangkok] Msdbangkok.go.th, Accessed June 17 2022, http://www.msdbangkok.go.th/news%20101061.html

Figure 4. The Network of Seamless Care Services



Source: Translated into English by the researcher from an original diagram in Thai, provided by Ratchaphiphat Hospital

Figure 4, provided by Ratchaphiphat Hospital, informs us of the various government agencies involved in the delivery of care within the operation of S-TOP. These services link together to form the network that facilitates the seamless flow of care as embodied by S-TOP's philosophy, implemented by JICA alongside the Ministry of Public Health. According to the diagram, primary (blue), secondary (yellow) and tertiary (pink) level services are linked together, led by Bangkok City Hall, JICA and the Ministry of Public Health. Divided into three levels, the web of arrows represents the referral pathways that one may take as a patient, demonstrating the relationship of governmental bodies working together to transfer patients from the primary source of care, down to the district level, and eventually to community-based care or home care.

Firstly, at the primary level of care there are a number of regional and general hospitals affiliated with the Ministry of Public Health, which work alongside JICA to implement S-TOP. Under S-TOP, a patient being admitted to a general or regional hospital will receive intensive intermediate care (as illustrated in figure 3), alongside the treatment for the acute illness that they were admitted for.

From there, at the secondary level of care, the patient will be transferred to a community hospital to receive further rehabilitation and intensive intermediate care in the district that they live in, such as at Ratchaphiphat Hospital, or at other local public health centres located at the district level of the Bangkok Metropolitan Administration. Community Hospitals, sometimes also referred to as secondary hospitals, provide limited treatment and will refer patients in need of more advanced or specialised care to general or regional hospitals. They have a capacity of 10-120 beds, depending on the size of the hospital, and there are currently 723 community hospitals throughout Thailand. Some hospitals have the capacity of providing both primary and secondary care.[218]

Lastly, at the tertiary level of care, once a patient returns home, day care centres for the elderly, such as the '1 Community, 1 Elderly Care Centre' program, municipal volunteers and home care, are services (labelled in pink) that can support the family and patients through at-home rehabilitation. Tertiary services coordinate directly with the district and require funding from the district level bodies. The '1 Community, 1 Elderly Care Centre' program is a tertiary level service, a government initiative with 12 pilot programs throughout Bangkok in 2020, funded by the Bangkok Health Security Fund. It was created for the purpose of rehabilitating patients with mobility issues who require help during the day. Each site is equipped with the necessary medical equipment, with nurses and doctors from community hospitals, as well as municipal volunteers using the facility to rehabilitate and mentally support patients who may regain physical mobility for their own independence. The diagram above is essentially a blueprint in which one can visually

[218] "โครงสร้างการบริหารงานสาธารณสุขไทย" [Thai Public Health Administration Structure] Khon Kaen University. http://nongerun.go.th/UserFiles/File/kmi/h3.pdf

recognise the different actors involved in S-TOP. It is a representation of S-TOP within a wider context of the Bangkok Metropolis.

As mentioned above, healthcare in Thailand is overseen by the Ministry of Public Health alongside other non-ministerial government agencies. S-TOP's services, as used by Thais at community hospitals, such as at Ratchaphiphat Hospital, operate under Thailand's universal healthcare system, which can be divided into three health insurance programs: the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS), and Universal Coverage Scheme (UCS, also known as the 30-Baht Scheme).[219] Information on the three programs is relevant to the study of S-TOP, in that each patient's experience of S-TOP will likely be affected by the conditions attached to the health insurance program they belong to. Further discussion of the effects of the health insurance programs on patients' experience of S-TOP will continue in Chapter 5. The National Health Security Office provide funds for these schemes through the universal healthcare system.

CSMBS is a comprehensive health insurance program that covers care for current and retired civil servants and their dependants (spouse, parents and up to three children).[220] The scheme is one of a number of fringe benefits to curb cost and help compensate for their low salary rates. This means that users under this program receive care for free at public hospitals, financed by taxpayers. On the other hand, SSS provides care for all Thais who are not civil servants or working for a state enterprise. SSS is a mandatory scheme under the labour law for employees in Thailand and is used to cover non-work-related expenses, such as maternity leave and funeral grants.[221] Funds are taken from the social security contributions made by both the employers and employees that are deducted from wages per month.[222] Finally, patients who are not

[219] Seung Chun Paek, Natthani Meemon, and Thomas T. H. Wan, "Thailand's Universal Coverage Scheme and Its Impact on Health-Seeking Behavior," *SpringerPlus* 5, no.1 (2016): https://doi.org/10.1186/240064-016-3665-4.
[220] Nada Wasi, Jirawat Panpiemras, Wanwiphang Manachotphong, "The Impact of a Billing System on Healthcare Utilization: Evidence from the Thai Civil Servant Medical Benefit Scheme," *Oxford Bulletin of Economics and Statistics* 83, no.1 (2021): 228.
[221] Viroj Tangcharoensathien, Anuwat Supachutikul, and Jongkol Lertiendumrong, "The Social Security Scheme in Thailand: What Lessons Can Be Drawn?" *Social Science & Medicine* 48, no. 7 (1999): 913-23. https://doi.org/10.1016/s0277-9536(98)00392-x.
[222] "กองทุนประกันสังคม" [Social Security Scheme] Social Security Office. http://capr.tsu.ac.th

eligible or have declined both CSMBS or SSS, may be eligible for the UCS, a government scheme implemented in 2002 that provides universal health coverage for all Thai citizens, targeted in particular at low-income people. UCS is the main health insurance program for 75 percent of Thais.[223] Users are given a gold card as part of their application to join UCS, and so patients are also sometimes known as gold card holders. While UCS comes with many benefits (free treatment for traffic accidents, surgeries for all illnesses, annual health checks, consultations for all types of illnesses and so on), it also has number of downsides that affect the experience of users, some of which are: users are limited to government hospitals, users must be aware of eligibility requirements to access certain treatments, and UCS does not cover treatment beyond the basic necessities.[224]

3.2.2 The S-TOP Workforce

Although it may initially look like S-TOP's main workforce consists of only doctors and nurses, other types of labour, in the form of hired care and volunteers also make up for the workload of care in the program. In this section, the different types of workforces involved in the delivery of S-TOP will be introduced. S-TOP's workforce comprises of two domains: formal workforce (doctors and nurses employed on an ongoing basis by Ratchaphiphat Hospital, and external workers hired temporarily by the hospital specifically for the implementation of S-TOP), and informal workforce (consisting of volunteers and family carers). Among the pressing issues of concern for staff at Ratchaphiphat Hospital is the insurmountable work load on the team's limited resources. What quality of care can the team provide for the elderly? What does the future of S-TOP look like with limited staff? These concerns prompt the S-TOP team to continually advertise for more staff. Ratchaphiphat Hospital is already severely under pressure to cater to the rise in elderly population in the surrounding districts and adopters see human resources as a critical limitation of S-TOP,

[223] Seung Chun Paek, Natthani Meemon, and Thomas T. H. Wan, "Thailand's Universal Coverage Scheme and Its Impact on Health-Seeking Behavior," *SpringerPlus* 5, no.1 (2016): 1. https://doi.org/10.1186/240064-016-3665-4.
[224] Thitima Chucherd, and Ranchana Pongsapan, "Universal Health Insurance Program Project Sustainability Assessment," *Bank of Thailand* https://www.bot.or.th/Thai/MonetaryPolicy/ArticleAndResearch/DocumentEconomicSeminar/07UC_thitima25May2007.pdf

in its current capacity and for its expansion in the future. To immediately remedy this issue, the S-TOP team has mobilised a mixed workforce of formal and informal staff. It appears that combining workforces is also financially beneficial in containing costs for the running of the hospital. The S-TOP program's formal workforce consists of 16 medical professionals. Since S-TOP's inception, doctors and nurses understood the limitations on human resources and have used available staff on rotation to implement the program with hopes of hiring external workforce to fill in the gaps when necessary.

Hired by Ratchaphiphat Hospital, private nurses provide formal care as temporary workforce on occasions such as public holidays and when there is high demand for care in the elderly wards. They receive training by the S-TOP team about intermediate care, and thus provide professional care in the formal setting of the Ratchaphiphat Hospital. Paid care givers on the other hand, are hired externally to diffuse care into communities. Different health organisations and services are linked through a network of policies set by the Ministry of Public Health for services that occur outside hospital. Paid care givers are services provided outside hospital resources, and their funding and claims are set by Ministry. Essentially, they work in-between volunteers and doctors visiting patients' houses whenever there is shortage of care from informal care, volunteers and formal visitations from doctors. Their role is to provide formal care within the informal setting of the patient's home.

S-TOP is also made up of informal intermediaries (i.e., family carers, neighbours, community volunteers, also sometimes referred to as municipal or neighbourhood volunteers). They facilitate the continuation of care and help patients maintain ADL levels at home, even when family and formal resources are no longer available to assist. While patients transition back home from hospital and eventually into the community, much of the initial work in visiting these patients at home is conducted by medical practitioners from Ratchaphiphat Hospital.[225] However, after a time, once the patient shows strong signs of recovery and

[225] Home-visits consist of a myriad of check-ups by doctors, nurses and physiotherapists, as well as consultations relating to rehabilitative training.

mobility, it is expected that reliance shifts from the hospital to family, community and/or volunteers to provide care or check-ups on patients.

In the next chapter, the stages of S-TOP's implementation are outlined. From stage 1, which looks at the initial impetus for adopting the program, up to stage 3, the action plan that is used to implement S-TOP. The study delves into JICA and Ratchaphiphat Hospital's working relationship, processes and challenges encountered in the transfer. Central to the policy transfer research is to investigate the way in which ideas are taken from the starting-point, and taken through various stages into the host setting. The step-by-step methods revealed in the case study will assist in a better understanding of policy transfer, as seen through the eyes of two different parties and the various actors within them.

Chapter 4. Stages of the S-TOP Policy Transfer

In this chapter, the transfer of S-TOP will be described in three stages. Stage 1, the initial adoption of the S-TOP program, a preliminary stage where actors from Japan and Thailand engage with each other to reach an agreement on the adoption of S-TOP. Stage 2, the Japan Training, an in-country experience organised by JICA for Thai staff to learn about S-TOP in Japan. Lastly, stage 3, the action plan, the documentation processes of monitoring the adoption of S-TOP. I employ supportive evidence from my fieldwork and interviews to observe and discuss how practitioners enact and interpret S-TOP throughout the three stages.

4.1 Stage 1: The Initial Adoption of the S-TOP Program

This section is an inquiry into the initial activities of adopting the S-TOP program at Ratchaphiphat Hospital. It contextualises the experiences of actors involved in the planning and structuring of S-TOP. For JICA this is the stage at which the scope of S-TOP is conveyed and is negotiated in formal and informal settings. For Ratchaphiphat Hospital, it serves as an introduction to understanding S-TOP, establishing a working relationship with JICA and learning about Japanese-style management. Tracing the timeline of the events in this stage identifies who key actors in the process are, how these actors come together, and what motivations and ideologies they present.

In September 2017, members from several governmental organisations such as the Ministry of Public Health, Ministry of Social Development and Human Security, National Health Security Office participated in the signing of an official declaration together with JICA officials to implement the S-TOP program in Thailand. It is important to note that there are two levels of adoption to be observed here in the case of S-TOP. The first is the Thai government's adoption of a Japanese policy approach to aged care, provided by JICA. The second is Ratchaphiphat Hospital's adoption of S-TOP, a specific program provided by JICA. The two levels are not the same, but are overlapping in this situation. At the very least, the two levels involve

different actors and thus the benefits of adopting S-TOP serve different actors for different purposes. For the Thai government, the adoption of S-TOP may have been presented by JICA as an opportunity that would benefit Thailand's national interests, while at the local level, Ratchaphiphat Hospital would benefit from S-TOP in the treatment and care of the elderly in the local communities. My case study is focused on the transfer of S-TOP to Ratchaphiphat Hospital. Therefore, the decisions that led to the initial agreement by the governments involved are beyond the scope of my research.

The overall goal for implementing the program was to transfer and utilise a model of care nationwide, starting with eight pilot hospitals located in various regions of Thailand, including Ratchaphiphat Hospital in Bangkok.[226] For convenience of location in visiting and interviewing participants in this case study, this study's scope focuses on one location among the eight pilot sites, that is Ratchaphiphat Hospital in Bangkok. Hospital administrators from each of the pilot sites signed an agreement in acceptance of S-TOP. The agreement made by ministry officials, hospital administrators and JICA stipulated that the hospital and JICA work together to transfer S-TOP as a community-based model for delivering seamless provision of rehabilitative, social and medical support services to elderly persons.[227] In return for accepting S-TOP and the attached terms and conditions of the agreement, the hospital would receive technical support, training of human resources, as well as all-expenses-covered educational trips to Japan for all Thai medical staff implementing S-TOP for the full term of cooperation (from 8th of November, 2017 until 31th of October, 2022).[228] In return for receiving JICA's assistance staff must meet certain expectations of cooperating and engaging with JICA experts. Regular participation of staff at meetings with both JICA experts in Thailand are expected. Thai staff are also obliged to disclose details of the ongoings of the hospital, such as situations and incidents relating to S-TOP services, the experiences of doctors and nurses using S-TOP, experiences of families and patients in S-TOP, financial costs and revenue within the scope of S-TOP care and so on. Thai staff are also expected to actively promote S-TOP at national forums, and seminars whenever the chance

[226] "Outline of the Project," Japan International Cooperation Agency, 2017, https://www.jica.go.jp/project/english/thailand/026/outline/index.html
[227] Ibid.
[228] Ibid.

arises in order to expand S-TOP towards a nationwide adoption, which is JICA's goal as stated in their project purpose.[229]

The Head nurse is a key informant in my study of S-TOP and assists the Head doctor (introduced in Chapter 3) in leading the S-TOP team at Ratchaphiohat Hospital. She had been an enthusiastic supporter of my study since my initial visit to Ratchaphiphat Hospital in 2019. With a career in nursing spanning 27 years, The Head nurse's profession as a registered nurse started in 1995. In 2011, she began her role as an advanced practice registered nurse at Ratchaphiphat Hospital. Her responsibilities include supervising and making recommendations on the performances of other medical co-workers in various wards. In 2017, she produced a research paper investigating the development of palliative care system for the elderly at Ratchaphiphat Hospital. Her observations revealed that the hospital's palliative care program focused on physical therapy and treatment that facilitated the prolonging of the patient's life, which sometimes does not match with the intention of the patient and relatives. A proper screening process during the admission of the patient will enable relatives to better communicate their needs and participate in the decision-making process for treatment options for their loved ones. Apart from the administrative duties at Ratchaphiphat Hospital, her role in S-TOP is various including supervising patient's rehabilitative care, supporting the needs of patient and families, liaising between the hospital and JICA, and assisting Dr Phuritat in research. Further, the Head nurse is responsible for conducting training for junior doctors and nurses, as well as receiving visiting guests from universities, hospitals and government officials. She is a key figure in representing the hospital and in its affiliations with JICA. Her research, experience and extensive knowledge in age-related care proves her dedication and suitability in implementing S-TOP.

Head nurse explained to me that officials from the Ministry of Public Health facilitated the connection between JICA and the hospital in 2017:

> 'In the beginning, it was the Ministry of Public Health that visited our palliative care facilities. What they saw here surprised them, and that our approach to care was refreshing and new. Then I think

[229] Ibid.

they sent this information to JICA. Dr Lertluck, our director at the time, saw that the hospital didn't have a proper intermediate care program, and we wanted JICA's help.'

It seems that JICA's connections to the hospital was initiated through a formal recommendation from the Ministry of Public Health in 2017. This led to subsequent visitations to the hospital by JICA officials and later an official invitation was sent to the hospital for their participation in S-TOP. The decision to accept S-TOP was made by the then director, Dr Lertluck Leelaruangsaang, who was described by staff members as an open-minded individual, with a positive outlook on the potential benefits of transferring S-TOP.

In 2018, 20 medical practitioners formed the S-TOP team at Ratchaphiphat Hospital. Medical practitioners for S-TOP were multidisciplinary and included family doctors, nurses, physiotherapists, psychiatrists, occupational therapists and palliative carers. This team was led by Dr Phuritat, an academic researcher and family doctor who is a key figure in directing S-TOP alongside JICA. He was assisted by Head nurse, whom I first had the opportunity of interviewing in late 2019. On the day I first interviewed the head nurse, she had briefly stepped out of a lecture given to visiting medical students from Chulalongkorn University, learning about rehabilitation and their adoption of S-TOP. These lectures and guests to Ratchaphiphat Hospital are frequent and throughout my visit it became clear that Ratchaphiphat Hospital was unique in that it did things its own way, attracting attention from other medical institutions throughout Bangkok.

Much of the initial planning for S-TOP was done during Dr Lertluck's time as director of the hospital from 2018 to May 2019. Head nurse placed particular emphasis on the role of Dr Phuritat as a key actor, a team leader, who understood JICA's visions for S-TOP. 'The very first doctor who really understood JICA's S-TOP model inside-out was Dr Phuritat,' she said. 'He is a family doctor who also dabbles in the field of ageing. It was actually his idea to adjust the S-TOP model, so that we could use the original team of staff from the ageing ward as a starting point of S-TOP.'

Throughout 2018, both Ratchaphiphat Hospital and JICA participated in various national-level seminars and conferences that gave Ratchaphiphat Hospital an opportunity to meet with other participating pilot hospitals and government bodies, such as the Department of Health (DOH) (a department operating within the Ministry of Public Health (MOPH)), the National Health Security Office, Ministry of Social Development and Human Security, Department of Medical Services, Bureau of Elderly Health, and directors from the Institute of Geriatric Medicine and JICA. 'The network of the Seamless Care Services' and 'The 1st National Seminar on the Development of Intermediate Care Service Model Seamless Health and Social Provision for Elderly Persons (S-TOP)' [230] were among the several events held by the different governmental bodies together with JICA to discuss S-TOP in 2018. This initial phase gives us an idea of the level of positive cooperation by the Thai government bodies and JICA to provide momentum for these events to take place and facilitate S-TOP. Moreover, initial discussions at events such as the ones mentioned are typical of Thai-style bureaucratic seminars and forums, held as a platform to showcase the benefits of the project that all parties have a hand in. It reflects well on the work being done and gives credit to all involved. In the case of S-TOP, JICA uses these events as a platform to showcase their efforts with the local authorities. For JICA, creating strong connections with different Thai governmental bodies is important not only for future projects such as S-TOP, but it also reflects positively on their position in Thailand as a foreign organisation. Ratchaphiphat Hospital also, as a local recipient of S-TOP, benefits from showcasing their affiliations with a large foreign enterprise such as JICA. It is important to note that selected representatives, hospital administrators and directors are looking to develop their intermediate care service systems, but are not directly involved in the practical process of implementing the S-TOP program within hospitals on a day-to-day basis. Those decisions are made by doctors and nurses who are assigned to S-TOP.

Less formal lectures and meetings with JICA experts were held regularly throughout the five years of S-TOP.[231] Photos on their Facebook page publicised the hospital's affiliations with JICA, and allowed locals to

[230] "The 1st National Seminar on the Development of Intermediate Care Service Model Project on Seamless Health and Social Provision for Elderly Persons (S-TOP)," Japan National Cooperation Agency, Accessed April, 19 2020. https://www.jica.go.jp/thailand/english/office/topics/180720.html

[231] Ratchaphipat Hospital Facebook Page. https://www.facebook.com/Rachapiphat

witness the beginning of the development of S-TOP program. Mr K (introduced in Chapter 3) explained that regular informal meetings are essential to ensure that understanding of the initial set-up of S-TOP goes smoothly and that every opinion and comment is heard:

> **'**Rehabilitation in Thailand is now in its initial stages of development. At the moment the situation is similar to the 1980s in Japan. We can easily understand the current situation in Thailand, so we are confident to provide such knowledge to Thailand, but sometimes we have unsuccessful experiences to share with Thailand as well. This is what the concept of the S-TOP project is about.'

4.1.1 Learning from Saraburi Hospital

At a different hospital, Saraburi Hospital, located three hours northeast of Bangkok in Saraburi province, JICA helped implement Thailand's earliest model for intermediate care. In an attempt to understand what intermediate care is about, Ratchaphiphat S-TOP staff were invited to learn from Saraburi's model. As Head nurse explained: 'The Ministry of Health informed us that Saraburi Hospital was the main prototype for intermediate care. We took 30 doctors to Saraburi Hospital with budget provided for by the Ministry of Public Health, as the Ministry of Public Health explained that this was a project in which they collaborated with JICA.' Lectures at Saraburi Hospital consisted of learning about how the hospital adapted S-TOP to fit the capacity of its existing hospital system, and staff demonstrated the practices involved in intermediate care. Head nurse described the trip as their first point of contact with S-TOP in a Thai hospital setting. The trip was significant in that it provided an example for how Ratchaphiphat staff could adapt S-TOP at their own hospital. 'That tour to Saraburi Hospital,' the head nurse recalled, 'gave us a much clearer picture of what JICA wanted to achieve, how we should set up our wards, how to create the team meetings, and why S-TOP is important for provincial hospitals and community hospitals to have.'

Saraburi Hospital is a franchise comprising multiple hospitals including provincial and community ones which all operate under the Saraburi name. And as a franchise, it is able to leverage its resources with the community hospitals operating under the same name. According to Head nurse, this meant that Saraburi

Hospitals' facilities, infrastructure and resources for intermediate care can perform at a higher level of efficiency, particularly in coordinating and transferring patients. 'Of course, the main difference from Saraburi is that Ratchaphiphat Hospital isn't a franchise. We exist on our own.' Ratchaphiphat Hospital looks towards Saraburi Hospital as an important example of seamlessness that it wants to replicate, while also recognising the limitations in its own capacity and size. In contrast to Saraburi Hospital, Ratchaphiphat Hospital is an independent hospital without other associated branches. **'**Ratchaphiphat is a standalone hospital, and we don't have other associated hospitals operating under our name for us to use in the same way,' the head nurse explained. 'We must discuss carefully how to equip our hospital with an intermediate care system using the limited space and funding that we have.' Despite various differences between the two hospitals, Ratchaphiphat staff benefited greatly from visiting and observing Saraburi Hospital, drawing lessons from a domestic example of S-TOP at the earliest stages of the transfer process.

4.1.2 Integrating the S-TOP Program into the hospital's existing systems

Prior to the hospital's affiliation with JICA, Ratchaphiphat Hospital had foreseen many issues in service provision for the elderly. A description of Ratchaphiphat Hospital in Chapter 3 section 3.1 gives a picture of a hospital with various existing programs and models for different types of aged care. Head nurse explained that, in the pre-JICA days, they invested time and money in developing their very own aged care facility, with specialised services for the elderly. However, due to the lack of information, know-how, infrastructure and staff, their attempts at creating their own intermediate care program were not very effective: **'**When we first started talking about the structure of S-TOP, especially allocating space for it - which unit would cater for such areas and so on, we carefully re-evaluated our system as a whole, to see what would work best for our patients' needs.' With the assistance of JICA, Thai staff were given flexibility to design S-TOP as they saw fit, provided the hospital meets its obligations to JICA regarding reporting and documentation.

Head nurse stated that many decisions made to structure S-TOP services were considered within the boundaries of the hospital's capacities and limitations:

> ‘We used the same staff we had from the ageing ward. Ageing wards exist at almost every hospital, because in Thailand, the Bangkok Medical Office pays attention to this specific demographic group of the population. They know that in every hospital there’s a ward for the elderly. So, we decided to use the same team of staff to implement S-TOP. We hired a few extra staff always to make it all work.’

One message that emerged from my interviews thus far was that S-TOP was an ambitious program for a small community hospital of this capacity. Ratchaphiphat Hospital not only suffered from limited staff, but it had limited financial resources and space.

From my visits to Ratchaphiphat Hospital, a notable trait that may have facilitated the transfer of S-TOP to the hospital was its multidisciplinary team of doctors and nurses. Ratchaphiphat Hospital’s staff members selected for S-TOP specialise in varied fields. Head nurse recounted that in the elderly ward, existing staff were already multidisciplinary, which is in line with the intermediate care that JICA envisioned in S-TOP. In 2019, I had the opportunity of meeting the S-TOP team which included doctors and nurses covering various positions including rehabilitative medicine, orthopaedics, psychiatry, oncology, paediatrics, geriatrics, as well as doctors from alternative medicine, who treated patients in palliative care wards. Head nurse explained that:

> ‘Dr Phuritat said the work for S-TOP is similar to everything we have encountered before. The main difference is that we needed a lot more teamwork and coordination. It is not about having one outstanding surgeon. For this to really work, S-TOP needs each doctor and nurse to be well-rounded, knowledgeable in other fields of treatment, and everyone to be able to collectively integrate their ideas into a packaged diagnosis. In that way S-TOP would operate like clockwork and we (medical staff) weave in and out of it.’

While the accounts from the head nurse reveal important insights about the transfer of S-TOP from the perspective of someone in a higher administrative position, there are also many other doctors and nurses who may have varying opinions and valuable stories of S-TOP.

According to Head nurse, systematic adoption of S-TOP took almost a year, from 2018 to 2019. First, trials were conducted and the hospital began receiving patients for S-TOP officially in June of 2019. The main tool for measuring patients' success in S-TOP is the Activities of Daily Living scale. The Barthel Activities of Daily Living Indicator, simply known as ADL, is an indicator in rehabilitative care that measures a patient's ability in managing one's basic physical needs across the six skills, (bathing, dressing, toileting, transferring, continence and feeding), with a maximum score of six points for fully independent.[232] Firstly, doctors should rate the patient as either fully independent (no supervision, direction, or personal assistance needed) or dependent (needing supervision, direction, personal assistance, or total care).[233] Scoring is then summarised as 0 to 4 for total dependence, 5 to 8 indicating severe dependence, 9 to 11 as intermediate dependence, and 12 to 20 for individuals with intermediate to high independence.[234] Dependent individuals are those that receive a score of less than 12. A patient's ability to perform ADL will determine what type of care and senior living arrangements are suitable for the patient at the present time. Over time, the ADL assessment can also serve as a documentation of a patient's functional deterioration or improvement.[235]

Head nurse described the hospital's initial set up:

> 'We don't have space for a large ward for S-TOP, so we are starting with three small units. The first is the male surgical ward with four beds. The second is in the palliative care unit with four beds.

[232] Michelle E. Mlinac, and Michelle C. Fend, "Assessment of Activities of Daily Living, Self-Care, and Independence," *Archives of Clinical Neuropsychology* 31, no. 6 (2016): 509. https://doi.org/10.1093/arclin/acw049.
[233] Ibid.
[234] "แบบประเมินกิจวัตรประจำวัน ดัชนีบารเธลดีแอล" [Daily Routine Assessment form using the Barthel ADL Index], http://www.pknhospital.com/2019/data/starRPST/homecare/cpso_star62_05.pdf
[235] "คู่มือ การคัดกรองและประเมินสุขภาพผู้สูงอายุ พ.ศ.2564" [Manual of Elderly Health Screening and Assessment 2021] "คณะกรรมการพัฒนาเครื่องมือคัดกรองและประเมินสุขภาพผู้สูงอายุ กระทรวงสาธารณสุข, Committee for Development of Screening and Health Assessment Tools for the Elderly Ministry of Public Health. (Source: http://www.tako.moph.go.th/takmoph2016/file_download/file_20210129131952.pdf)

> The third is for post treatment with four beds. And we have to let JICA know that we currently have 12 beds that serve the purpose of the program.' This marks the start of the S-TOP program.

The conventional understanding that I had prior to my arrival at the hospital was that intermediate care was a separate discipline with specialised treatment that warranted a separate ward. The statement above by Head nurse paints an entirely different picture in which intermediate care operated within the space-limiting capacity. However, this also makes sense, as intermediate care can be considered to occur in tandem with acute treatment. Regardless of what the diagnosis of acute illness may be, whether stroke, pneumonia, or a traffic accident, intermediate care is required and even encouraged by guidance provided during JICA's training, (illustrated later in section 4.2, the Japan Training to Kaikokai Rehabilitation Hospital).

While Thai staff observed and learned that intermediate care should ideally be integrated during treatment at the acute phase, the issue of space makes it difficult for staff to do so. Nurse Laura is another informant in the study of S-TOP who was interviewed in late 2020. A registered nurse at Ratchaphiphat Hospital, she is responsible for rehabilitating patients and providing acute treatment of patients. She works under the guidance of the head nurse within the S-TOP team. Nurse Laura suggested that another possible features that may improve patients' experience was a requirement of rooms that segregates S-TOP patients from other inpatient care, as well as among S-TOP patients themselves. 'We'll need clearer allocations of rooms; each ward serving a specific purpose, for which patients at what stage of intermediate care. For dementia patients who require rehabilitation, there are many stages of dementia and we can't simply treat them all in the same room.' She explained further: 'For mild dementia, there's more of a chance for them to regain muscle function, but it might be a matter of 80% patient's work and 20% family support.' Statements like this provide a glimpse into the need for individualised care. The importance of in-home care is also emphasised here, where home visitations and the training of carers and volunteers must be facilitated as part of S-TOP, as will be discussed later in section 4.2. When dealing with family carers Head nurse explained: **'**Our goal from the hospital's point of view is that we provide rehabilitative training for patients,

and we hope that their ADL improves. In the end, we talk to the family and explain that there is a very strong likelihood that the patient will continue to improve, and we then create a plan with them.'

To illustrate what would normally occur at Ratchaphiphat Hospital without the S-TOP program, Head nurse provided an example of a typical scenario of an elderly patient's hospitalisation experience. A man in his 60s is presented into hospital with pneumonia. He is admitted for two weeks and is treated according to his condition. He recovers fully from pneumonia after two weeks and is ready to return home. However, a new set of problems occur when it appears that over the course of those two weeks the patient has lost muscle tone in his limbs. As a result, he remains at home, bedridden and immobile. His predicament rests in the hands of his children, when they have to choose whether to care for him full time at home, or to send him to a nursing home for extra care. Although treatment of the initial illness had been successful, the patient leaves the hospital in a lower functioning state. 'It's like the hospital doesn't care,' the head nurse said. 'When the patient's ADL drops while they're in the hospital it's a problem, but then they get sent home because they're cured from whatever illness they had.'

Without the rehabilitation and intermediate care services, patients are sent home, where they may sustain injuries from a fall as a result of lack of mobility and inappropriate home care and are of this readmitted into hospital or into institutional care. The cycle of rehospitalisation occurs frequently at Ratchaphiphat Hospital: 'Initially when we didn't have S-TOP, patients might get better after getting treated, but they will return home disabled. Their relatives might also readmit them into hospital asking for rehabilitation, or they may choose to put the patient straight into a nursing home.'

In the first year of the program (from 2017 until 2018), both JICA and Ratchaphiphat Hospital had one year to negotiate externally and internally on what S-TOP at Ratchaphiphat Hospital would look like for staff members and for their patients. These initial decisions, though not permanent, were significant foundations that would impact on the quality of life of the patients, households and communities that rely on the hospital.

4.2 Stage 2: The Japan Training

In this section, based on interviews with the JICA program coordinator, Mr K, and nurses from Ratchaphiphat Hospital, the study will address JICA's in-country training, known as the Japan Training. The Japan Training forms part of the transfer process, as Thai staff learn about S-TOP from a historical context through visiting sites and observing Japan's methods in intermediate care from industry experts. The Japan Training gives the Thai participants a glimpse into Japan's ways of doing things, as well as an awareness of what is achievable in Thailand. The trip also provides adopters with a better picture of JICA's aims for S-TOP once implemented in Thailand and the direction that they can aim to take.

Training programs have been widely used in JICA's projects and are a major component of Japan's international cooperation. Since 1954, trainees from around the world have participated in training programs to acquire specific knowledge from Japanese organisations in order to upgrade their skills in various fields, such as education delivery,[236] environmental conservation and other major issues in developing countries.[237] These JICA training programs are tailored to the specific needs of the country that is sending its trainees.[238] They are facilitated by various levels of cooperation, from government, local governments, public corporations, private companies, universities, NGOs and so on. For the Thai participants of S-TOP, the Japan Training is an opportunity for doctors, nurses, and even hospital directors to learn about S-TOP directly from the Japanese experience in Japan. Each trip is a carefully coordinated educational tour, organised by JICA with various partner hospitals and local governments in Japan. Activities include lectures, tours of medical facilities, cultural activities and discussions with Japanese doctors and other experts.

[236] Atsushi Matachi, and Kosako Masato, "JICA's Support to Education in Africa in the Last Two Decades: Focusing on Mathematics and Science Education," *CICE Hiroshima University, Journal of International Cooperation in Education* 19, no. 2 (2017): 35-53

[237] "Gender and Development," Japan International Cooperation Agency, Accessed February 13, 2020. https://www.jica.go.jp/english/our_work/thematic_issues/gender/background/training.html

[238] "JICA Training Program," *JICA*, https://www.jica.go.jp/bangladesh/english/activities/04_2.html#a03

The Japan Training is organised into two separate trips. On the first trip, Thai medical staff from the eight pilot sites, including Ratchaphiphat Hospital, take turns travelling in groups for a period of two weeks. In a separate trip, hospital administrators, government officials and policy makers also visit a selection of medical facilities and engage in talks. Mr K explained that due to time constraints and the busy schedule of the higher-ranking officials, the second trip is only a one-week trip. For the purpose of this research, the first Japan Training trip (to Nagoya), where only the Thai medical staff engage in the Japan Training, is of more relevance to the transfer of S-TOP, and details of that trip will be presented in this section.

My interview with Mr K at the beginning of 2020 revealed more about the Japan Training than previous interviews at the beginning of 2019. This is because JICA had already conducted several trips to Japan in 2019 (both first and second trips for a number of years), and were at the time of the interview, was preparing for another Japan Training for administrators and directors only (not including staff from S-TOP) to go to Hokkaido in February 2020, just a few months after my interview. Mr K stated that the number of participants fluctuates in each trip. However, on average no more than 25 participants are involved per trip. With S-TOP staff, Ratchaphiphat Hospital's Head nurse designates who among their staff will take part in the Japan Training trip in a given year.

For Ratchaphiphat Hospital, the number of participants attending a trip can fluctuate between one to three persons per trip. By 2022, when S-TOP officially comes to an end, every member of the S-TOP team at Ratchaphiphat Hospital will have experienced the Japan Training. Some higher-level staff of S-TOP such as Dr Phuritat and Head nurse will have participated in several trips to Japan with JICA officials and their own team on both the 2-week Japan Training and the one-week study trip.

The Japan Training itinerary, presented below is for medical staff, visiting Nagoya. The trip involves visiting leading institutions, hospitals, universities, nursing homes and local governments, with a focus on observing Japan's intermediate care, different health care systems and community care. Activities include on-site

visits, attending lectures by health professionals and university professors, group discussion sessions, and networking sessions. Stakeholders and practitioners from eight pilot sites and JICA staff are encouraged to network during the trip to strengthen ties between hospitals. The relationship building exercises during group work and presentation sessions may help provide a sense of community among S-TOP adopters, and these connections will be useful when spreading S-TOP at the national level. Locations and other details of the itinerary are shown below.

Figure 5. Itinerary from Japan Training conducted in January and February 2020.

Date		Program	Venue
25 Jan (Sat)		Leave Bangkok	
26. Jan (Sun)		Arrive in Nagoya	
27. Jan (Mon)	AM	-8:30-10:40 Orientation (JICA Chubu) -10:00-12:00 Medical health check (JICA Chubu)	JICA Chubu
	PM	-13:00-14:00 Lecture 1 Program orientation (S-TOP) -14:20-16:00 Self-introduction and Q&A	
28. Jan (Tue)	AM PM	Fujita Health University -Lecture 2 Integrated community support center in Toyoake Housing complex -Lecture 3 Introduction of rehabilitation in Fujita Health University and Japan's rehabilitation -Observation 1 Fujita Health University -Q&A session	Nagoya city
		Review led by organisers of S-TOP	
29. Jan (Wed)	AM PM	-Kainan hospital (acute hospital) Lecture 4 General introduction of the hospital Lecture 5 Rehabilitation on acute phase and cooperation to Recovery phase Lecture 6 Cooperation system for seamless service Observation2 Rehabilitation in acute phase Lecture7 Integrated community support center at Kainan hospital and LTC rehabilitation service	Yatomi city

		Observation 3 Integrated community support centre at Kainan hospital and LTC rehabilitation service		
		Review of the day led by organisers of S-TOP		
30. Jan (Thu)	AM	Kaikokai rehabilitation hospital (IMC hospital) Lecture 8 Rehabilitation hospital and its cooperation with acute hospital Lecture 9 Role of Nurse in Rehabilitation Lecture 10 Cooperation for discharge support	Yatomi city	
	PM	Observation 4 Rehabilitation room, wards and so on. Yatomi city municipality Lecture 11 Practices in health promotion and disease prevention in Yatomi city Courtesy call to the mayor of Yatomi city		
31.Jan (Fri)	AM	Kamiiida Daiichi hospital (acute and sub-acute hospital) Lecture 12 Rehabilitation in Acute phase and Cooperation between Acute hospital and Rehabilitation hospital in the urban area Lecture 13 Integrated community care ward	Nagoya city	
	PM	Observation 5 Rehabilitation, integrated community care ward.		
		Observation 6 Nagoya social welfare equipment plaza	Nagoya city	
		Review of the week, group discussion (S-TOP)	JICA Chubu	
1. Feb (Sat)		Day off	Nagoya city	
2. Feb (Sun)	AM	Moving to Saku city from Nagoya city	Saku city	A hotel in Saku

3.Feb (Mon)		Saku city municipality office	Saku city	
4.Feb (Tue)		Long Term Care service	Saku city	
5.Feb (Wed)		Home visit medical services on seamless care Practice of rehabilitation at Saku general hospital	Saku city	
6.Feb (Thu)		Kakeyu rehabilitation hospital	Ueda city	
7.Feb (Fri)		Action plan presentation General evaluation of the course Closing ceremony	Saku city	
8.Feb (Sat)		Leave Saku city to Narita International Airport Leave Narita International Airport for Bangkok		

Among the many sites listed in the itinerary, Mr K spoke of Saku Central Hospital (*Saku Sōgō Byōin*) most extensively. He explained that the visit to Saku Central Hospital in Saku city, Nagano Prefecture, marked an important point in the trip, due to the context of the hospital's post-World War Two history, its relationship with the grassroots community, and its rags-to-riches story. 'Saku provides a very famous, pioneering model of Japanese public health. I believe they're inspired by our model and can share that with the Thai situation.'

To explain the significance of this hospital further and show why JICA selected it for the training of S-TOP, we turn briefly to the history of Saku Central Hospital. Established at the height of the Asia-Pacific War, Saku Central Hospital first started operating in 1943 in the rural mountain village of Usuda in the region of Saku, Nagoya Prefecture.[239] Before this time, the effects of the Great Depression and the war had devastated many Japanese agricultural communities and had resulted in the neglect of personal health

[239] Hikari Sandhu et al., "Community Theatre for Health Promotion in Japan," in *Arts and Health Promotion: Tools and Bridges for Practice, Research, and Social Transformation.* (Cham: Springer, 2021), 109.

among farmers, who focused more on the recovery of their finances than on health. Saku Central Hospital became the first hospital with proper medical equipment in the area, initially with military motivations for producing healthy soldiers. Ultimately, the hospital improved the health of local farmers within the community[240] and, as Mr K explained, the hospital boasts of having one of the best public health care programs in all of Japan.

In 1945, Dr Toshikazu Wakatsuki, a physician, was posted at Saku Central Hospital and it was he who devised a new system of care, when seeing how farmers were demotivated to receive treatments due to the financial cost. Under the administration of Dr Wakatsuki, more approachable strategies were introduced, such as improving health literacy among villages and providing mobile medical check-ups or home visits. The hospital produced its own medical journal and other publications, regularly performed medical drama plays about health that became very popular[241], and conducted informal discussion groups for young farmers on political and social views.[242] These interactions were educational and formed a two-way communication, from which medical staff could pass on medical knowledge to the villagers, and in turn the villagers felt they were heard. Wakatsuki's strategies created trust, as villagers bonded with doctors, promoted a better understanding of care, and 'humanised' the image of doctors and hospitals in the eyes of the local villagers, and thus fostered a sense of community.

The case of Saku is also mentioned in a study of rural cooperativism undertaken by historian Tessa Morris-Suzuki. On a number of occasions, Morris-Suzuki writes, the local residents of Saku formed a united front in defending the hospital against various forms of resistance, such as the political purge of suspected communist activities through the 1950s and 60s, or the threat of government takeover of the hospital, as well as natural disasters.[243] The trials and tribulations of Saku Central Hospital are a testimony to the hospital's slogan: 'Together with the Farmers'. Mr K noted: 'Although Saku was and still is one of the

[240] Ibid., 108.
[241] Ibid., 110.
[242] Ibid., 69.
[243] Tessa, Morris-Suzuki and Eun Jeong Soh, *New Worlds from Below: Informal Life Politics and Grassroots Action in Twenty-First Century Northeast Asia.* (Action, A.C.T.: Anu Press. 2017)

poorest areas in Japan, the Saku model is the foundation of Japan's current public healthcare system.' The rural initiative that became the Saku model at Saku Central Hospital was unique and unorthodox, and it continues to be refined to the present day, with the hospital becoming a place for education, treatment and community. These strategies have inspired a range of similar initiatives in other parts of Japan, as explored by Honda and his research on infant mortality in Iwate Prefecture.[244]

Outside Japan, the Saku model has been used by JICA in the Japan Training, as an example of the similar philosophies shared by Ratchaphiphat Hospital staff in their own pursuit of alternative care. Ratchaphiphat's initiatives in creating palliative care services, as described in section 4.1, and its visions of intermediate care prior to its engagement with JICA, reflect the same principles of commitment to the care of its local ageing demographic. The challenges of a changing social and demographic environment in the lower income communities surrounding the hospital drove doctors and nurses to look for more sustainable aged care services, within the limitations of a small-scale, labour-shortage hospital. Like Saku Central Hospital, Ratchaphiphat Hospital at present still gains much support from its local community, through various monetary and land donations (frequently posted on the hospital's Facebook page[245] and website[246]). In the early days of the hospital, extra funds for building construction and the provision of medical equipment were coordinated by the abbot of the local temple and Buddhist lay supporters. Today Ratchaphiphat relies on its strong ties with community volunteers, as the demands for elderly care facilities have increased during the pandemic.[247] The community efforts no doubt reflect the hospital's long-standing relationship with the locals, and are a reason for its continued aspirations to provide the best care.

Mr K explained that their visits to Saku municipality in Nagano Prefecture, and to Yatomi city in Aichi Prefecture (discussed below), were an opportunity for the Thai staff to recognise the key role that

[244] Toru Honda, "Health Equity: Japan's Post-war strides towards Universal Health Coverage: Grassroots Perspectives," 2014, http://blog.livedoor.jp/share_jp/archives/52678274.html
[245] Ratchaphipat Hospital, https://www.facebook.com/Rachapiphat
[246] Ratchaphipat Hospital Website, http://www.rpphosp.go.th/
[247] "โรงพยาบาลราชพิพัฒน์ช่วยคนไทยร่วมบริจาค ซื้ออุปกรณ์การแพทย์ และสร้างห้องปฏิบัติการตรวจเชื้อโควิด" [Ratchaphiphat Hospital Invites Thai people to donate money for the purchase of medical equipment for its COVID laboratory] MGR Online, 2021, https://mgronline.com/entertainment/detail/9640000044573

municipalities play in coordinating community health services. Mr K explains: 'In Japan, the municipality, which is probably similar to the "muang" or "tambon" in Thailand, has a uniform system of medical services and is responsible for the service provision and cooperation with the hospitals. This model was developed 20 years ago in Japan, and later in the year 2000 we developed Long-Term Care Insurance. So, the municipalities are designated in managing care services within the long-term care insurance scheme.' The adoption of the Saku model by other hospitals in various prefectures shows that the hospital's work is inextricably connected to the work of the municipality. The municipality enables the widespread dissemination of care, within which hospital initiatives can be mobilised using government and non-governmental bodies, as well as an informal workforce such as the recruitment of volunteers. Without these services, care would become inaccessible to those who are bedridden or those who live in remote areas of the countryside or in country towns.

In the context of Thailand's ageing society, Mr K identified Thailand's community and neighbourhood volunteers as being valuable to S-TOP: 'I believe that the volunteering community in Thailand is still a very good and strong system, and we can feel the power of these volunteers. They are a great asset for Thailand. It's difficult to find that in Japan anymore.'

According to a survey conducted by the Cabinet Office's National Census, almost 30 percent of people in Japan have stated that community ties have declined over the past decade.[248] Community-based societies and inclusive neighbourhoods in rural and urbanised areas are an important source of volunteerism that is born out of long-lasting mutual relationships between residents. When close-knit communities diminish due to population decline and ageing, relationships between residents weaken and more residents tend to experience social isolation and loneliness.[249] The decline in local populations also brings about a lack of locally sourced volunteers who provide support for elderly residents, putting them at risk of reduced well-

[248] "National Survey of Lifestyle Preferences," The Government of Japan, https:www5.cao.go.jp/seikatsu/senkoudo/senkoudo.html. Accessed 9 July 2022.
[249] Akihito Nakajo, "Development of Community Welfare Activities with Resident Participation and Their Important in Hilly and Mountainous Area," in *Community-Based Integrated Care and the Inclusive Society: Recent Social Security Reform in Japan,* (Singapore: Springer, 2021), 355.

being, with the likelihood of solitary death for those living alone.[250] Volunteers within the community, whether neighbours or from governmental organisations such as the municipality, are crucially needed as a secure source of care. These individuals are someone who lives within the community nearby elderly residents and can take on responsibilities for aid. Consequently, more individuals with the capacity to care can form teams to routinely check up on residents on a regular basis, and in this way life challenges of the elderly can be addressed. With regard to S-TOP, creating seamless care for an ageing population relates to securing informal sources of support that exist in the form of volunteers. As observed by Mr K, the formation of communities and social relations in Thailand can be utilised for this purpose. Further discussion on the role of community volunteers in the transfer of S-TOP will continue in Chapter 5.

Finally, I asked Mr K's opinions on the Thai municipalities and how they could be strengthened. He said:

> 'I believe that Thailand should give more power to their municipalities and they need to scale up by merging municipalities together, combining them. In Japan we have also tried to merge these municipalities. For example, 30 years ago there were 3,200 municipalities. Now the number is only 1,800 municipalities, a 60 percent decrease. This is so that we can give more power to the municipality, and at the same time the Japanese government wants to decentralise power to the municipalities. Some municipalities are capable of receiving power and money from the central government to manage their human resources. Some are not capable of managing services and resources well. So, the capability of the municipality concept is connected to human resources as well as top management. It is important to grow such capability of the municipality.'[251]

[250] Etsuko, Tadaka et al., "Development of a Community's Self-Efficacy Scale for Preventing Social Isolation among Community-Dwelling Older People (Mimamori Scale)," *BMC Public Health* 16, no. 1 (2016): https://doi.org/10.1186/s12889-016-3857-4.

[251] In 2006, Japan completed its efforts to merge smaller municipalities through the Great Heisei Consolidation that had been in effect since 1999. Municipalities with fewer than 200 residents were either merged or dissolved, creating larger municipalities, where more administrative power could be transferred to the local level. (Source: Kiyotaka Yokomichi, "The Development of Municipal Mergers in Japan," *The National Graduate Institute for Policy Studies (GRIPS)*, 2).

Relating to the importance of the municipality, among the many common buzzwords related to ageing, such as active ageing, a newer Thai buzzword, 'ageing in place' ผู้สูงวัยในถิ่น (phû sŭng wai nai tìn) has been trending since late 2020.[252] Born first out of a recognition that living at home and the benefit of community welfare services improved quality of life, the on-going pandemic created more awareness around 'ageing in place', and that one's home and the services of the community were the best option for senior living. In Thailand, news about the elderly being infected by Covid-19 in institutional housing such as nursing homes and hospitals with long-term care intensified people's understanding of 'ageing in place' and its ideology of 'community-based' living. Beyond the losses of life in institutional care, the inevitable shortages of nursing homes and the deepening national budget deficit all assisted in highlighting the benefits of 'ageing in place' and the need for stronger municipality support in senior living.[253] For this reason, building an efficient and capable municipality is an important theme throughout the Japan Training that Mr K envisions Thai staff can learn from and implement as part of the transfer of S-TOP. With effective management of resources Ratchaphiphat Hospital staff may become less burdened by the responsibilities of supporting the patient's recovery at home.

Among other sites visited during the Japan Training, Ratchaphiphat staff also learnt about Japanese technological innovations and their uses in aged care. As a contrast to the post-war community initiatives, robot technology developed for aged care at Fujita Health University was part of the effort to confront the issue of labour shortage. Located in Aichi Prefecture, the Fujita Health University collaborated with Toyota to build Toyoake, an elderly-centred housing complex run by nursing robots and doctors. Nursing robots are installed in each house to perform simple daily tasks such as fetching objects, conducting exercise classes, opening curtains, and monitoring the general well-being of elderly residents. While Toyota designed and developed these interactive robots, Fujita Health University provided human interactions by medical students, who were encouraged to live at the facility in order to provide human contact with the

[252] Wanporn Worapornpong et al., "Aging in Place," *Journal of Suvarnabhumi Institute of Technology* 6 no. 2, 2020.
[253] "สำรวจเทรนด์โลก "Ageing in Place" สูงวัยในที่เดิม ความท้าทายที่ไทยต้องเผชิญในยุคสังคมสูงอายุอย่างสมบูรณ์," [Exploring the global trend of "Ageing in Place" Challenges that Thailand faces in a complete aging society], *Foundation of Thai Gerontology Research and Development Institute (TGRI),* December 27, 2021, https://thaitgri.org/?p=39983

elderly residents.[254] Combining human care with technology in this way ensured that small tasks could be delegated to robots and thus allow care givers to engage in the more complex tasks of care giving. In Thailand's hospitality and health care sectors, research has already begun to explore the potential of artificial intelligence technology. Notably, Mr K mentioned that although these robotic endeavours are not financially viable even for Japan, he suggested that maybe a mixture of different solutions would be ideal: AI technology together with volunteers and the community support. 'We are trying to incorporate robot technology to help with flexibility for the persons working in health care and flexibility for the patient. But to develop this it is very expensive, even in the Japanese context.' Mr K seemed to be suggesting that to deal with various challenge in ageing, Thailand requires a combination of strategies, as seen at Saku Central Hospital with its community-led support and the robot technology at Fuji Health University.

As a final example of the Japan Training expedition, Thai staff visited an acute hospital, the Kaikokai Rehabilitation Hospital, located in Yatomi city, Aichi Prefecture. This hospital offers medical, social and psychological support for patients after treatment at the acute stage. As community hospitals often require coordination with acute hospitals, Ratchaphiphat Hospital S-TOP team are likely to have benefited from witnessing the administrative running of the hospital, as well as seeing the treatment methods of an acute hospital that also specialises in rehabilitation. For one nurse in particular, the trip to Kaikokai Rehabilitation Hospital provided valuable insights into how intermediate care should be integrated into acute care: 'The Japanese staff members at the hospital really emphasised the benefits of introducing intermediate care immediately after the acute phase, even before the patient is discharged from the acute ward. This is to prevent patients from becoming bedridden. The patient can maintain muscle, even while they are recovering from another disease. They taught us that a plan needs to have already been put in place, from the beginning of the hospitalisation cycle.'

[254] "Aichi university, Toyota in joint project for robot-aided seniors complex," The Japan Times, accessed March 3rd 2020. https://www.japantimes.co.jp/news/2016/06/27/national/aichi-university-toyota-in-joint-project-for-robot-aided-seniors-complex/#.XpYA5_gzbIU

Informants from Ratchaphiphat Hospital reflected positively on their experiences of the Japan Training. One nurse pointed out that:

> 'Prior to 2018, I had no knowledge of what intermediate care was all about. After the hospital introduced the S-TOP program, we have had an effect on people's lives, changing them from becoming potentially bed-ridden to having full or semi-mobility.'

During interviews, other staff members shared several points of comparison between the methods of intermediate care observed in Japan and S-TOP at Ratchaphiphat Hospital. One nurse stated:

> 'The way doctors and nurses do home visits in Japan is very detailed. In Japan they examine the distance of the patient's home to the workplace, they look at the condition of the roads, how long it takes for the patient to commute to the shops, and figure out the best solution for that patient's mobility status. At Ratchaphiphat we only examine the condition of the home.'

Other differences in home-visits were also noted:

> 'The Japanese do home visits individually, not as a team like ours. They explained that each professional has their own way of doing things, so taking turns allows them to have more time with the patient, instead all going together, when opinions might clash. It is also too overwhelming for the patient, and I think this is something that Ratchaphiphat Hospital will need to consider changing in the future.'

Many new pieces of information, drills, ideas and strategies noted from the Japan Training were adopted and implemented with the guidance of JICA when staff returned to Thailand. Head nurse explained: 'We learned that there has to be an intermediate care program before discharging the patients. We learned that ADL (activities of daily living) needs to be at a certain level according to the criteria and standards that JICA showed us. The three hours of rehabilitation per day is also the standard that they taught us. They have several indicators for us to follow and they taught us about how to conduct team meetings, which we now do every Friday before assessing patients.' Prior to adopting the S-TOP program, Thai staff conducted

rehabilitation sessions one hour per day for each patient. These sessions also varied depending on the availability of staff. JICA finds this insufficient, and benchmarks were put in place in order to achieve a higher turnover of patients in intermediate care.

I enquired further as to what other aspects from the Japan Training the staff would like to see implemented into Ratchaphiphat's S-TOP program. Nurse Laura noted: 'I'd like to see doctors and nurses provide documentation for the patients and their families after home visits, like a summary of that meeting. In Japan these are written in simple language. Any time the family need to refer to anything, they just look at the folder. But here we usually speak to the families without giving them anything in writing, so they might forget what we told them. Especially if we speak to them as a group, they're likely to forget.'

JICA's itinerary varied greatly from community hospitals to private acute hospitals and other facilities in between. Each site gave practitioners an insider's view into Japan's wide-ranging practices that would otherwise be inaccessible to mere tourists. The trip was also valuable in that Thai staff have the opportunity to see a bit of everything, identify with certain practical points, and to select elements to implement in their hospital. The Japan Training provided practical, historical and ideological perspectives, allowing Thai staff to broaden their views on care and inquire into the future of Thailand's health care systems. Beyond the practical techniques required to transfer S-TOP, exposing the participants to how the Japanese approached aged care, what the role of the hospital is in aged care, and the differing cultural nuances that contrasts with the Thai approach, might also assist them in understanding the basic rationales behind S-TOP.

Outcomes from government-led tours and training such as this are often seen as leading to a deepening of relations through collaboration in a range of areas. The Japan Training offers opportunities to share and exchange, with Thai staff networking and building connections with Japanese staff, as well as links between government officials and private industries. Building partnerships in this event may prove useful later on. At the outset, the processes and outcomes of the Japan Training might have been intended for creating good

will. However, some other motivations might not have been as clearly articulated. For JICA the trip itself may also have been a business opportunity to market Japan and its technologies, using its status as the world's leading expert in ageing as the framework through which age-related products and services could be showcased at institutions during the trip.

4.3 Stage 3: The Action Plan

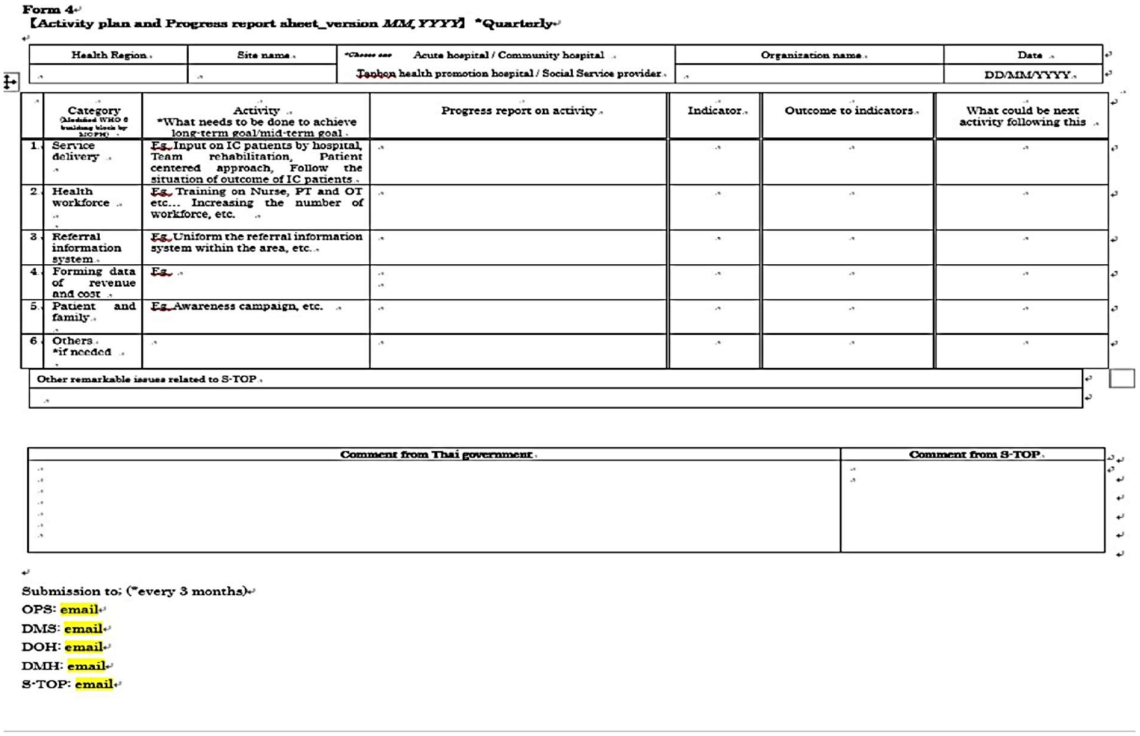
Returning from Japan, participants are required to complete a document called an 'action plan'. Mr K described it as a guided plan, written by participants to establish concrete aims and outputs for S-TOP in six different categories known as 'building blocks': service delivery, health workforce, referring information systems, forming data on revenue and cost, patient and family and other areas. JICA's six building blocks have been modified from the World Health Organisation (WHO)'s six building blocks, which consists of service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance. The six WHO building blocks were created to strengthen health systems, using a simple framework to track data from health intervention projects in developing countries, where accurate data on health service delivery is limited.[255] While the building blocks have been developed and organised around service delivery, they mostly remain silent on aspects that take account of the demand side, such as work-life balance, intergenerational relationships, household structures, household financial resources and so on.[256] This gap allows JICA, together with Ministry of Public Health, to modify the framework by keeping certain building blocks that suited the context of the type of communities where S-TOP will be applied.

[255] "Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies," World Health Organization, 2010. Accessed March 15, 2020, https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

[256] Social mobility is a concept that takes into account the movement of individuals, families and members of the community, moving through the social hierarchy. It involves horizontal, vertical, upward, downward mobility, inter-generational mobility and intra-generational mobility. Ageing population is often closely interconnected with social factors, such as inter-generational distancing, socioeconomic mobility in families with elderly persons, social barriers and inequality in opportunities for aged persons.

4.3.1 Formulating an Action Plan

Figure 6. Sample Template of an Action Plan



Form 4

【Activity plan and Progress report sheet_version *MM, YYYY*】 *Quarterly

Health Region	Site name	*Choose one* Acute hospital / Community hospital / Taohon health promotion hospital / Social Service provider	Organization name	Date
				DD/MM/YYYY

	Category (Calculated WHO 6 building block by MOPH)	Activity *What needs to be done to achieve long-term goal/mid-term goal	Progress report on activity	Indicator	Outcome to indicators	What could be next activity following this
1	Service delivery	Eg. Input on IC patients by hospital, Team rehabilitation, Patient centered approach, Follow the situation of outcome of IC patients				
2	Health workforce	Eg. Training on Nurse, PT and OT etc… Increasing the number of workforce, etc.				
3	Referral information system	Eg. Uniform the referral information system within the area, etc.				
4	Forming data of revenue and cost	Eg.				
5	Patient and family	Eg. Awareness campaign, etc.				
6	Others *if needed					

Other remarkable issues related to S-TOP

Comment from Thai government	Comment from S-TOP

Submission to: (*every 3 months)
OPS: email
DMS: email
DOH: email
DMH: email
S-TOP: email

Source: Provided by Mr K, JICA.

The action plan has a range of purposes. It is intended to improve the quality of care, decrease costly and preventable mistakes that may happen in S-TOP, and to provide close feedback to guide the trajectory of S-TOP. JICA's supervisory role is put into action here on paper, as revealed by Head nurse. For JICA, the action plan is a communicative tool to monitor progress at each hospital pilot site. For Ratchaphiphat Hospital, it is also a line of communication for doctors and nurses to propose ideas and receive feedback on certain outcomes. The action plan becomes a tool to bridge the linguistic and cultural gaps between Thai staff and JICA experts. The feedback from JICA is significant to Ratchaphiphat Hospital staff. One nurse noted that JICA's feedback improves their benchmarks for the next trimester: 'We are always adjusting and taking in the recommendations from JICA. Any questions we have are always taken seriously and the feedback is constructive.'

The action plan helps reinforce concrete objectives and creates practical steps for participants, from abstract ideas to tangible goals. Mr K noted: 'For each pilot site, we set up a date for them to finalise their action plans. Each hospital will set up targets to improve the quality of care and create quantitative targets. For example, their goal could be that every stroke patient will have consultation with a rehab team, or that 70 percent of such patients will receive rehabilitation service. That kind of concrete target.'

When visiting Ratchaphiphat Hospital in 2019 to conduct interviews, I was shown a completed presentation file, and attached to it an action plan report filled in from the previous month. Similar in structure to figure 6, various recommendations from JICA were written in English in red beside each of the categories as follows.

1. Service delivery building block

This section evaluates the quality of services, such as timelines of care, mode of communication with discharged patients and families, home-visits and hospital check-ups. Examples of quantitative data recorded in this section include bed occupancy rates for patients' hospitalisation within the 45-day period, and the rate of home-visits made by doctors. Recommendations by JICA were to add more visiting teams for home-visits, more screening for potential intermediate care patients, with particular focus on those who fall under the category of extreme poverty living in the communities surrounding the hospital, and increasing tripartite home-visits with volunteer groups in the neighbourhood.

2. Health workforce

The diversity of tasks in intermediate care demands coordination from the S-TOP team, which can only be achieved through a competent workforce and in adequate numbers. Doctors described this section as the progress of training. All medical personnel are obliged to enrol in training courses to reinforce or relearn certain skills in their medical profession within a specific timeframe. Apart from this, the training of family

carers as well as community volunteers is one of the essential parts of the functioning of S-TOP, as is discussed in Chapter 5.

3. Referral information system

This section of the action plan evaluates how information is shared between health centres, such as between Ratchaphiphat Hospital and other hospitals. This is done to measure the efficacy rate of patient transfers between hospitals and as a way of reviewing information shared to third party participants such as community volunteers during home-visits.

4. Forming data of revenue and cost

All financial aspects of S-TOP are documented. The table presents costs and profits of S-TOP, calculated based on the billing of patients who have used the program. It takes into consideration the diagnosis and whether the patient needing S-TOP had age-related illnesses such as stroke. A number of issues related to overstaying of patients was under review at this time during my investigation. As detailed earlier in section 4.2, a little more investigation revealed that the hospital had problems related to patients overstaying, due to family abandonment.

5.The patient and family

With JICA's focus on the 'patient-centred' service, the S-TOP team assess the support network that Ratchaphiphat Hospital provides to the patients and their families. Due to a lack of resources, Ratchaphiphat Hospital recently established a project called the 'One Community, One Nursing Home' home care project, which aims to equip and train members of the community to become care givers. This is done in order to meet the rising demand in conducting home visits, as the hospital depends on community involvement in volunteering for home visits, in particular to check on patients who live alone and rely heavily on volunteer support. The project's objectives extend beyond the scope of supporting patients registered with the S-TOP program. Training is conducted in low-income neighbourhoods where there are no nursing homes, in order to facilitate community-based long-term care and to support the elderly

population in these areas**.** 'One Community, One Nursing Home' is an initiative that was directly influenced by the ideas presented at Saku Central Hospital during the Japan Training. Making medicine accessible and delivering regular check-ups to doctorless villages as in the alpine areas of Nagano Prefecture is what Ratchaphiphat Hospital aims to achieve, in order to reach as many elderly individuals within and beyond the districts that it serves, seeing that many are unable to commute to the hospital for routine check-ups.

6. The sixth building block

The last building block is dedicated to any other aspect of S-TOP that does not fit into the above-mentioned categories. These may include successful results, challenges, problems and analysis that the team want to bring up with JICA.

The action plan is ongoing work for the participants throughout the five-year period with JICA. As Head nurse explains, frequent face-to-face schedules give the team an opportunity to discuss details of the action plan in person with Mr K and other JICA experts. 'JICA wants to follow up every trimester. The S-TOP team will report on the action plan, how many patients are currently hospitalised, how many have gone home, how many have been re-hospitalised, what our profits and losses are, and so on. We send this information directly to JICA and then we make an appointment to have a team presentation, offering this information again to JICA in person.'

4.3.2 Action Plan in Practice

I sensed in my discussions with Mr K, when our conversations were often mixed Japanese and English, that manoeuvring through this multilingual terrain of Japanese, English and Thai presented opportunities for miscommunication to occur. What steps are taken to minimise linguistic complications? One nurse pointed out that the action plan, written in Thai, is translated from Thai into English by translators, for JICA experts to read. Likewise, Mr K's feedback, whether in English or Japanese, would also be translated back into Thai for staff to understand. In this way, the parties create the narrative of S-TOP together in this blueprint.

Nurse Laura explained that interpreters are always present at meetings, after which any comments mentioned would be written down and a summary document would be sent to them, as a reminder of what went on during the meeting. 'During all the meetings documents are translated, and there is always an interpreter there to feed them information from what we are saying.' I would suggest that the role that interpreters and translators play is a significant factor in process of conveying and interpreting ideas and expectations needed for the transfer of S-TOP.

Reflecting on this, while the work of S-TOP is hands-on, it is also heavily tied to bureaucracy. On top of the many administrative tasks that Thai medical staff have to undertake, the action plan and preparing for JICA presentations both represent an extra administrative burden for the small team at the hospital. Over time this administrative burden could result in a loss of quality in the running of S-TOP. Moreover, the extensive back and forth of paperwork is a time-consuming process. With a slow turnaround time, this makes for a clumsy procedure and is not conducive to the swift systematic change that is needed in the fast paced, high-intensity work environment of a hospital, where decisions need to made with immediate effect. In fact, it may also be somewhat counterproductive to the seamlessness that S-TOP needs. While this is the case, translation and having a record of correspondence also seem necessary in order to effectively overcome linguistic and cultural differences. And although not stated, JICA officials would most likely also have documentation, noting their version of events in Japanese to present to JICA headquarters in Tokyo as a reflection of their progress in the ODA mission.

Nurse Laura described the feedback process in more detail. 'When our presentation is finished, they give us feedback immediately about what they like, what they agree with, what we should do more, and then all of this is summarised in a report to be sent to us later. It's submitted by the JICA experts who are Thai doctors working with JICA, as well as the Japanese experts.' Finally, in a separate meeting at Ratchaphiphat hospital, the S-TOP staff decide which recommendation from JICA is achievable and which is not. From Nurse Laura's description of the process, it seems that JICA allows room for medical professionals to negotiate their own terms, and to adjust S-TOP goals according to what they see fit.

In addition, one may also recognise that JICA's meticulous and structured approach reminded me of a Japanese organisation's workflow known as "nemawashi" [根回し]. Nemawashi (literally 'digging around the root') is an informal but systematic process in which consensus is built first, and approval is gathered from all acting parties before any change can be carried out.[257] This method ensures that 'the decision-making process is not from the top down, but is arrived at from the bottom up.'[258] In the context of implementing S-TOP, this concept has important implications, since the approval process requires input from staff of a multi-disciplinary team. Through the use of documentation and presentations for Thai staff to prepare, one could argue that the processes provide an opportunity for all members of the S-TOP team to propose ideas before the meeting with JICA commences. Although the process is time-consuming, for the management of complex, intra-organisational dialogue, this method best represents the way in which cross-cultural and collaborative discussions can take place with care. Laying a solid groundwork also provides a systematic structure that perhaps is lacking in the workflow of Thai staff at Ratchaphiphat Hospital.

4.3.3 Sharing Experiences through the Action Plan

An action plan written in the first trimester of 2020 revealed that the S-TOP team encountered several issues relating to dementia patients in intermediate care and an overall increase in patients suffering from mental health conditions. In the context of an ageing society, diagnoses of neurological diseases such as senile dementia and Alzheimer's are predicted to also increase in tandem with the ageing population. Under the comment section of 'service delivery' in the action plan, a unit of measurement, known as Thai Mental State Examination (TMSE)[259] had been marked in red. Head nurse explained that they had reported to JICA the need for an alternative system, due to inaccuracies when using TMSE. This produced unreliable

[257] Javier Villalba-Diez et al., "Nemawashi: Attaining Value Stream Alignment within Complex Organisational Networks," *Procedia CIRP* 37 (2015): 134-39. https://doi.org/10.1016/j.procir.2015.08.021.
[258] "The Japanese Decision-Making Process," In *Japan As It Is,* ed. Tanaka Y. (Gakken. Tokyo, 1990)
[259] TMSE is a measurement used to test the cognitive impairment in the elderly and used to screen the prevalence of dementia in the Thai population. Used widely in a research and clinical setting, in Thailand the suggested cut-off point to determine cognitive impairment is 23 out of 30.

scores and inconclusive evidence to evaluate whether or not a patient with a low ADL value is suffering from dementia. There is a probability that patients who fail the ADL test may likely be suffering from underlying brain impairment and present symptoms similar to the early onset of dementia.

Several medical articles state that the TMSE system was indeed problematic, namely that social variables such as age, education and economic factors influence the TMSE score.[260] For instance, a literate man and an illiterate man, both in their 50s, contribute very different TMSE results. Hence this is the reason why various factors should be considered before employing a single system for identifying impairment in a patient. The S-TOP team require a more complex set of tools to measure the cognitive impairment of their patients in intermediate care.

In a different section of the action plan, doctors noted that dementia patients represented the majority of those re-hospitalised at Ratchaphiphat Hospital within 28 days. Head nurse explained: 'Elderly patients with depression and/or dementia represent quite a large number of cases for us. Personally, I find that among the elderly, if they have depression or suffer from dementia, it's very difficult to improve their ADL levels. Their ADL might go up for a while, but it will usually decrease again.' This means that both groups of patients would eventually be re-hospitalised due to an inability to retain memory of the exercise, or are unwilling to do the exercises that would allow them physically to be able to live at home.

In order to gauge the full extent of this issue, we need to look at the hospitalisation cycle of a patient. At Ratchaphiphat Hospital, patients receive rehabilitation during or after acute treatment for a period of from two weeks to 45 days, depending on their physical condition. A patient's physical condition can range from moderate to severe disability, depending on the initial cause of trauma, such as stroke, brain injury or spinal cord injury. In the majority of cases elderly patients suffer most from a stroke and need rehabilitative training. Within this particular group, a large proportion of patients show signs of dementia. Symptoms

[260] Weerasak Muangpaisan et al., "The Distribution of Thai Mental State Examination Scores among Non-Demented Elderly in Suburban Bangkok Metropolitan and Associated Factors," *Journal of the Medical Association of Thailand* 98, no. 9 (2015): 922.

usually show in patients with slow recovery and inconsistent physical improvements, even after they have completed their rehabilitative training. There is a suspicion at this stage that the patient has not remembered the exercises taught to them. Further complicating matters, as some patients with dementia also suffer from some degree of depression, it becomes very difficult for staff members to clearly distinguish symptoms. Are the patients showing signs of a mood disorder, or do they have some kind of degenerative brain disease? While patients with dementia may show some improvement with a rise in ADL after rehabilitation, this is usually temporary, as they cannot retain memory of what actions they were taught. Without being able to demonstrate that they can perform certain activities on their own, and with ADL values dropping over time, the patient is eventually sent home for home care.

Here, nurses experience another set of challenges, as explained by Head nurse: 'When it is time to discharge the patients, they experience a lot of anxiety when it comes to their relationships with family members.' She explained that friction occurs between staff and family when specific dates and a timeline for discharging patients are being discussed and negotiated. 'Sometimes we bring a psychiatrist to prepare the patient mentally first. But even if we do this, the patient's stress has to do with the mental health of family members, and that is not something we can fix. In the end, the patients will eventually go home, but within a month or two they come back, because their ADL has dropped.'

Digging a little deeper, I asked her why the prospect of a family reunion and getting to go home causes so much stress and anxiety. She explained that the patients' psychological conditions are often triggered or heightened by the lack of clarity in the situation and the prospect of being abandoned by family. 'We usually start by talking to the relatives beforehand about our goals for the patient. We explain to the families that the patient should be able to walk again soon, and we set a distance for the patient to achieve this. But once the patient achieves these targets, their relatives start worrying about what will happen when the patient returns home. Who is going to look after them? How will anyone look after them as well as the doctors and nurses did? Then they ask for an extension.' Many relatives have made requests to extend hospitalisation for up to two weeks and more. However, due to the lack of space and limited beds,

extended hospitalisation is reserved for special cases and most requests are declined. Nevertheless, the family's requests are persistent and cases like these have been increasing at the hospital.

There could be many possible combinations of reasons as to why loved ones show reluctance in this way. A sense of being overwhelmed by the daunting task of care, or perhaps the lack of training and skill to become a carer could be the reason. Also, important to consider are various inherent cultural beliefs in Thailand. The notion that doctors are practically gods เห็นหมอเป็นเทวดา, (hěn mŏr bpen thewadā: 'see doctors as devas') and reverence for their abilities to heal are still common among villagers. Doctors are considered by some as a demigod, semi-divine and remarkable in their abilities. Hence leaving your loved ones in the care of a divine being would bring about the best outcome. Head nurse interpreted this as showing filial piety. Choosing to leave relatives in the care of doctors, when nursing homes and other options of care are not available, would be a sign of filial piety.

Apart from this, she stated that in some cases reasons relating to work are also a factor. Younger family members may have secured a job during the time that their relatives were in hospital. This raises a dilemma of work and care, division of labour in the household and availability. When prompted to explain further, Head nurse stated that the relatives themselves do not speak very openly about their work and financial situation. Within the socio-cultural context, observations on Thailand's class, wealth and status symbol may be needed to create a better of care within the household. Historically, in Thailand members of the family would take care of their elders. Filial piety is deeply embedded in longstanding cultural values and Buddhist virtues of showing gratitude and appreciation towards parents, and thus refers to a child supporting parents. The duties of care for ageing parents thus often rests on children.[261] In the early agricultural days where Thai families farmed and lived in large, intergenerational households in order to save on labour in farming, the duties of care and household chores can be designated or divided among

[261] Luechai, Sringernyuang, and Tida, Sottiyotin, "'Ya Luk Ka tan Yoo': An Ethnography of Filial Piety Culture, Medication Usage, and Health Perceptions of the Elderly in Rural Southern Thailand." *International Journal of Environmental Research and Public Health* 19, no. 19 (2022): 12134.

household members. These days changing lifestyles for better education and economic opportunities result in internal migration and urbanisation, (together with other factors such as low fertility) has created smaller nuclear families. This often means that the duty of care for ageing family members fall on government volunteers. For families with more disposable income, care can also be outsourced by employing in-house helpers.[262] The outsourcing of helpers to care for members of the household may sometimes be a reflection of the wealth and class of the family concerned. These class divisions in Thailand's socioeconomic system are also often to be observed in popular Thai TV soap operas (lakorn), where helpers are depicted as being of a lower class than the family they serve. In connection with this representation, such families are often of a wealthier and more privileged class than average, lower-income households. The meanings constructed in these class distinctions and roles of people inside homes allow us to reconsider that the notion that having helpers is merely a necessity for providing care, due to a lack of help around the house. Being able to afford helpers in the first place may be an expression of power and wealth, because money creates opportunities for families to outsource duties of care. Thus, within the context of Thai class categories, social hierarchies and money allowing wealthy families to afford round-the-clock care for their ageing parents.[263]

Due to the family's behaviours, and discharge dates constantly changing, the patient, who once looked forward to going home, becomes unmotivated and demoralised. 'Even if the relative asks for just a couple of days of extension, the ADL of the patient drops immediately, because they just want to go home. They have worked hard in their rehabilitation, and then the family cut off their hopes, so the patient refuses to cooperate further with anything. They feel as if their families have tricked them.'

[262] The role of the domestic workers employed in the family may be ambiguous and loosely structured. They may also be considered as domestic helpers, carers and servants, with various duties that can include cleaning, cooking, and caring for the needs of all members of the family, including the elderly members. The majority of domestic workers are females and migrant domestic workers make up a large proportion of this demographic, coming from surrounding neighbouring countries, such as Burma, Cambodia and Lao. (Source: Jackie Pollock, and Soe, Lin Aung, "Critical Times: Gendered Implications of the Economic Crisis for Migrant Workers from Burma/Myanmar in Thailand." *Gender and Development* 18, no. (2010): 213-27.

[263] Kanokwan Jitrogjanaruk, Monthon Sorakraikitikul, "คุณภาพชีวิตในการทำงาน: แรงงานต่างด้าวที่ทำงานรับใช้ในบ้าน" [Quality of Work Life: Migrant Domestic Workers] *Social Research Journal* 39, no. 2 (2016): 139176.

The above explanations and insights have so far revealed several issues in the experience of implementing the S-TOP program. The undiagnosed mental conditions of S-TOP patients and family dynamics are some of the unforeseen challenges for staff to achieve the S-TOP program goals. JICA officials and hospital staff must now realise that S-TOP and its objective of creating a seamless health care program for the elderly to regain self-reliance through intermediate care is reliant on many moving parts, some of which are out of their control. Often, without the cooperation of the family, staff see patients re-hospitalised due to a preventable fall or the lack of proper care at home. This costs more time, money and effort for the hospital. As will be discussed later in Chapter 5, the issue of a lack of human resources at the hospital is ongoing. Whilst the hospital boasts of its holistic approach, there is clearly a lack of resources in family counselling and mental health assessment that would be needed from the beginning of the patient's admission. All of these dimensions are brought together to paint a picture of the complexity of the S-TOP program and the aspects that are noted by staff in the action plan as needing improvement.

As mentioned earlier in section 4.1, part of the contractual agreement with JICA sees Ratchaphiphat staff's obligatory involvement in the promotion of S-TOP to other hospitals. Head nurse explains: 'While we are running S-TOP, we are also involved in selling it to other hospitals in Bangkok. We have presented talks about our intermediate care at many conferences.' Head nurse, alongside Dr Phuritat and hospital administrators, have spoken at various events, providing tours of their hospital in the hope of eliminating scepticism and demonstrating that S-TOP really works. Ratchaphiphat's team have also been outspoken about their S-TOP results thus far. Despite the seemingly positive response, it seems that many hospitals are still sceptical and view S-TOP as burdensome on their already overwhelmed health system. 'I think so far other stand-alone hospitals have agreed with the benefits of the S-TOP program, but they think that S-TOP is difficult to achieve,' She stated. 'They think S-TOP requires a lot of people, even though we have clearly explained and shown them that our team is very small.' I probed further, asking why other hospitals have not shown the same level of enthusiasm as Ratchaphiphat Hospital in adopting S-TOP. Head nurse's response relates to attitudes towards systemic change:

> ‘I see it as an attitude problem among the doctors and hospital administrators They have not really understood the point [of intermediate care] or looked deeply enough to realise how important it is, or understood that most hospitals do not aim to provide such services. They aim to specialise in an area that brings in money, like surgery. But of course, if they look into rehabilitation and intermediate care, they’ll see that rehabilitation exists as part of care, regardless of what kinds of diseases you’re specialising in.’

While Ratchaphiphat Hospital receives special benefits from JICA such as the Japan Training, staff remain in doubt that other adopters in the future would be able to experience the trip, or receive inducements from JICA. Head nurse explained:

> ‘We didn’t think it was going to be this difficult. But there are hopeful signs from interested hospitals. If JICA gives a five-year allowance for us to go to Japan, in the later years we might allow other hospitals who copy our S-TOP to go on these Japan Training trips. Like cutting a piece of the cake to share with them. Because Ratchaphiphat Hospital is small, after a while everyone here would have already done the Japan Training anyway.’

Sharing the incentives may help win over support. ‘I think S-TOP is a great program, but we need to change the attitude of the directors, because every hospital has a different aim.’

Two years since the head nurse’s statements above, Nurse Laura revealed to me in a separate interview that in 2021, Ratchaphiphat Hospital was finally able to secure the support of a number of community hospitals in Bangkok to engage in adopting S-TOP. Nurse Laura disclosed:

> ‘Sirindhorn Hospital medical research department and Wetchakarunrasm Hospital, both of which are located in the Eastern part of Bangkok have picked up the S-TOP program. Bang Khun Thian Geriatric Hospital as well. Bang Khun Thian Geriatric Hospital and Ratchaphiphat Hospital are located in the Western side of Bangkok. These hospitals including Ratchaphiphat Hospital all belong to the Medical Service Department of Bangkok. Each hospital is trying to use S-TOP to improve their pre-existing rehabilitation programs. In the future, there’s probably going to be an attempt to

create a network to connect S-TOP programs from other hospitals together to share data, and transfer patients.'

In Chapter 4, I have discussed the transfer of S-TOP as a program that consists of both hands-on application as well as backroom bureaucratic procedures. Clearly many issues faced in S-TOP were actually unexpected. It is important to acknowledge that S-TOP pivots and changes within the fast-paced and complex environment of hospital care. JICA's role has been in providing the much-needed structure to anchor these changes in the administrative sphere. One could say that although both groups of actors are distinctively different in their skill sets, as well as deriving from different cultural and linguistic backgrounds, when combined, their attributes have strengthened S-TOP. While JICA is the driver of formal aspects of transfer, practitioners make creative adjustments on the front line in their day-to-day interactions with patients and we see their relationships being affirmed through these practices.

Chapter 5. Discussion

Drawing on interview evidence from previous chapters, Chapter 5 provides a discussion of various characteristics identified in the transfer process, and evaluates how the transfer of S-TOP fits within the policy transfer continuum. This chapter considers the themes and patterns arising from the findings in previous chapters and attempts to answer the research questions set out in Chapter 1:

1) What specific initiatives have been (are being/will be) pursued in policy transfer related to Thailand's ageing society?

2) What factors impede/enable this policy transfer?

3) What insights does this case study offer into Thailand – Japan relations?

4) How can policy transfer be viewed within the broader context of ageing population in Thailand?

5) How will the case study extend our understanding of policy transfer in general?

Further, the chapter also discusses the importance of the formal and informal workforce in allowing a seamless operation of S-TOP to occur. Firstly, this evaluation draws attention to the dynamics of other actors, beyond the key actors. Secondly, using interviews from 2021, the study reflects on the changes in S-TOP during the global Covid-19 pandemic and how these have affected the capacity of the hospital and patients of S-TOP. Thirdly, the cultural contexts within the transfer that shape the S-TOP program for local users in Thailand.

5.1 'Seamless' Care and Human Resources

S-TOP's engagement with local volunteer groups suggests that S-TOP has successfully integrated itself with existing networks. Having networks with local services, such as the community volunteer networks from

neighbourhoods and from the municipality, as discussed in Chapter 3 section 3.2.2, demonstrates that various types of human resources are needed in S-TOP at a wider community level. We can consider both volunteers and the municipality workforce as intermediaries, facilitating care where gaps exist in formal care, commuting in and out of communities and relieving support issues, while decreasing wait times for patients at home. It becomes clearer from interviews that S-TOP would crumble without the support of volunteers to deliver intermediate care in a way that JICA and Ratchaphiphat Hospital intended. One should also note that the intermediaries are not key actors in the transfer of S-TOP. They are necessary facilitators for intermediate care. They help relieve pressures from the increase of patient numbers on Ratchaphiphat Hospital staff, and are a link in the chain of care for patients at home. Despite the importance of intermediaries, little is known about who does what in the facilitation of S-TOP.

Two key objectives of S-TOP lie in 'seamless' performance, as its name suggests, and the sustainable operation of S-TOP. To achieve these objectives, S-TOP adopters are heavily reliant on both skilled and unskilled human resources that will assist in the running of S-TOP. Without them, JICA and Ratchaphiphat Hospital could not effectively care for patients, retain employees, improve S-TOP and enhance patients' experience of intermediate care.

5.1.1 Formal Workforce

As presented in Chapter 3 section 3.2.1, Ratchaphiphat Hospital recruit 'formal' workforce hired externally, such as paid care givers and privately hired nurses (i.e., those who are not employed by the hospital on an ongoing basis). They are the source for extra support in the running of S-TOP. Without hiring more staff, fewer medical personnel would be assigned more tasks and would become overworked with heavier workloads amidst the rising rate of hospital admissions. Alternatively, if more staff are hired, so that the same quality of care can be maintained, the overall expenses of the hospital would increase due to increased labour costs. The decision to hire formal staff for the running of S-TOP is ultimately up to the discretion of the Head doctor and the Head nurse.

The S-TOP team rehabilitate patients within the same area as regular wards, working along-side other medical personnel who are treating the patients' acute illnesses. Introducing a new set of staff may create confusion in the roles and responsibilities of patient care. As explained by Head nurse in Chapter 4 section 4.1.2, doctors and nurses who belong to S-TOP and external medical staff have different capabilities that speak to or motivate specialised services in a type of care that is multidisciplinary. She explained that privately hired nurses perform tasks similar to the S-TOP team's nurses, but they may need on-the-job training with regard to intermediate care. Therefore, one should not assume that all members of the formal workforce are familiar with intermediate care: there are disparities of knowledge and experience between internal and external staff, and between ongoing staff (part of the S-TOP team) and other medical professionals (who may never have heard of S-TOP before).

5.1.2 Informal Workforce

S-TOP, with its aim to deliver 'seamless' care, would simply not work without the support of the informal workforce. Resource-poor hospitals like Ratchaphiphat Hospital are challenged to source large-scale human resources to create systems of care that extend into communities and families. Adopters find themselves reliant on community volunteers to dispatch care back into the communities where patients live. Here, the study acknowledges the important work in forming networks of volunteers that serve as an intermediary, allowing continuity of care in homes, and a smooth transition to occur from hospital care into home care. Often some elderly patients would transition back home alone without family, and in such cases the reliance on hospital resources and volunteerism seems stronger than for patients with family carers. Although nurses and doctors did not reflect on or draw this correlation themselves, I observed that mutual reliance between the medical team and people within communities, especially volunteers, is akin to that of the Saku Model at Saku Central Hospital. Discussed in Chapter 4 section 4.2, Saku Central Hospital receives little governmental funding and like Ratchaphiphat Hospital, it draws strength in numbers from the support

of community-led volunteers. JICA seems perceptive of Ratchaphiphat Hospital's relationship with the communities that it serves and is in favour of replicating this for S-TOP.

The significant contribution of community volunteers in establishing S-TOP should not be overlooked. Overall, if home-visits are discontinued, there is a danger that the patients' exercise and training would decrease, resulting in the patient descending into a state of immobility. This puts them at risk of injury from a fall and the possibility of rehospitalisation or going into institutionalised care. Here the goal of S-TOP is to prevent outcomes such as these and the solution proposed relies on the expectation that the patient continues to engage with rehabilitation that is assisted by formal or informal intermediaries. In particular, if family members are not available, then these tasks fall on community volunteers from neighbours, municipality and civic groups. S-TOP's goal of preventing return to institutionalised care is premised on the assumption that someone will continue to assist the patient throughout rehabilitation. In an environment like the one described in Ratchaphiphat Hospital's case; it is inevitable that responsibility for part of that assistance will be taken on by volunteers. In other words, volunteers are in fact essential to the achievement of the program's goals.

There are also limitations associated with volunteerism that need to be considered. Sustainability in sourcing volunteers is not an issue addressed in the action plan shared with myself in 2020. However, Nurse Laura (from Ratchaphiphat Hospital) and Mr K (JICA expert) both mentioned during interviews that retention of volunteers is one of the key issues that the S-TOP team is aware of. The average age of volunteers participating in S-TOP is between ages 50 and 55 years and with many volunteers reaching the age of retirement, there is a concern that older-aged volunteers' participation is not sustainable in the long-term. Older volunteers tend not to stick around for very long, especially when tasked with physically laborious work, such as lifting patients or carrying heavy oxygen tanks and so on. Moreover, volunteers may leave unexpectedly at any time, making this an unpredictable and unstable source of care for patients in S-TOP, and a potentially dangerous issue for patients who depend heavily on being closely monitored.

This problem calls for further research into the effective deployment of different age groups of volunteers in Thailand. How to gather them, and how to retain them, are key issues that Mr K also wants answers to. Further, in order to keep numbers of volunteers from falling, training new volunteers would become another aspect of the work that goes into implementing the S-TOP program that adopters as well as municipal workforce will need to consider. Nonetheless, the good news is that Thailand's ageing population means that there should be a larger pool of retirees showing an interest in volunteering roles. In other words, iIf overall the population of the elderly cohort increases, adopters may be able to recruit more volunteers from a plentiful supply of potential participants in this pool, even if they are short-term. Effective recruitment strategies targeting retirees and training them are logistical matters that both JICA and Ratchaphiphat Hospital staff should consider as part of implementing S-TOP.

The recruitment process is an important aspect for S-TOP, as the number of volunteers should be maintained to match the rising demand for care in an ageing population. The prospects of broadening S-TOP should be kept proportionate to the human resources that are capable of handling care on a larger community scale. Additionally, Nurse Laura explains that as the DOH handles services beyond the hospital, most of the training of volunteers is conducted by the DOH. This means that hospital staff have no real leverage over the performance and quality of volunteers, prompting scepticism of as to whether there are proper protocol and management systems in place to regulate volunteers working with the vulnerable in their homes. What kind of training is involved in dealing with physical rehabilitation as well as emotional and psychological care? If adopters of S-TOP utilise volunteerism, then it is paramount that they ensure that the uptake of human resources is monitored and properly managed, in order to support the rights of safety for staff and patients alike.

During the first interview with Mr K in 2018, he considered Thailand's volunteerism to be comparatively stronger than Japan's volunteerism, described in Chapter 3 section 3.3.1.2. He felt encouraged by this and recommended that Thailand should leverage this type of human resource as an asset while it is still available. His statement seems encouraging, but despite its positive tone, it contradicts directly with his

concern that volunteerism was an outdated system that is not sustainable or reliable. And while he notes the importance of volunteerism in S-TOP, during interviews it became apparent that JICA actually had very little to do with volunteers, despite their reliance on their services. JICA's presence in Thailand concentrated on efforts with Ratchaphiphat Hospital as the recipient of S-TOP, and left the training of volunteers to municipalities and the DOH. As described in Chapter 4, section 4.2, Mr K generously revealed to me information about the transfer of S-TOP, including details of meetings with Ratchaphiphat Hospital, Japan Training itineraries and so on. However, when questioned about volunteerism, particularly to what extent volunteers are involved in S-TOP, Mr K simply stated that they served as an asset in the general sense of confronting Thailand's ageing population issues. It seems likely that the recruitment, training and work of volunteers in S-TOP are external to JICA's operations and beyond the control or concern of JICA experts. It is also worth noting here that not many of my interviewees, including Head nurse herself, mentioned the details of volunteerism in S-TOP.

My interview with Nurse Laura in 2021 revealed that the volunteers' work in S-TOP was extensive, and the hospital was heavily reliant on it. Nurse Laura's understanding of the role of volunteers in S-TOP was remarkably insightful, extensive and discerning of the issues linking human resources and community health. Perhaps this is because my interview with her was conducted at a later stage of the adoption, and a proper picture of S-TOP could be formed.

In the face of all this, it seems slightly unrealistic for JICA to discuss the importance of volunteerism and robotics as part of the overall solution to the lack of human resources, and yet mention issues within that, which show little understanding of the people who volunteer their time in S-TOP. This may be a demonstration of JICA's inaccessibility to small communities and neighbourhoods, and a lack of contacts with Thai locals. Or it may simply be that JICA assumes that the responsibilities for supplying volunteers rest on the shoulders of DOH, a department operating within the MOPH, civic groups and the municipalities. This seems to be a clear breakdown, or a 'gap' in the policy transfer process. There is an assumption that an important element (volunteerism) is present in S-TOP, but nobody has taken responsibility for it. Overall,

one could speculate that volunteers are valuable for their services in caring for a population of the aged, as they may motivated by an internal desire to care for patients. Either way, the cost-effectiveness of their services may bring about a demand for volunteers to work in organisations and in turn may create pressures to make volunteer roles more formal, with governmental regulation, support, and a scalable approach in training more of them in the future.

Family members have long been considered a crucial part of care for the elderly. The importance of family-based care has been heightened further when confronted with the labour shortage in an ageing population. Family carers constitute the last link in the chain of care as the patient transitions from hospital to home. While the network of hospital staff and volunteers can to a certain extent substitute for the lack of family carers, the presence of family carers is almost always preferable to patients and medical staff, as they play a major role in the emotional and physical recovery of the patients at home. Thus, it is important to identify and tackle problems stated above in this stage of the chain of care. According to the population projections of the 2018 census[264], the areas surrounding Ratchaphiphat Hospital in Bang Kae (35,615), Taweewattana (15,610), Parsijareon (25,041), Nong Kem (14,836), and Talingchan (22,882) have among the highest proportions of the elderly in Bangkok. Those catering for the elderly cohort in these areas are usually family members. Family carers remain the backbone of the long-term care system in many areas of Bangkok, especially in rural and semi-rural areas, located on the periphery of the city. In some instances, even if family members could care for returned elderly patients, their capabilities to do so are limited. Vast differences in education, literacy and care competencies among family members cause unevenness in the care provided for patients across lower-income households. Low health literacy has consistently been associated with poor health status, a lack of knowledge of medical conditions and a lack of engagement from health care providers.[265] And while family carers, such as an eighteen-year-old caring for her

[264] รายงานข้อมูลผู้สูงอายุของกรุงเทพมหานครจากฐานประชากรในระบบทะเบียนราษฎร ณ เดือนธันวาคม 2561 และเปรียบเทียบกับข้อมูล ณ เดือนธันวาคม 2560 [Report on the population of the elderly in Bangkok registered in the civil registration system as of December 2018, with comparative data to December 2017] *Public Health and Environment Strategy Division, NESDB*. Accessed on: 10th July 2021.

[265] Upali W. Jayasinghe et al., "The Impact of Health Literacy and Life Style Risk Factors on Health-Related Quality of Life of Australian Patients," *Health and Quality of Life Outcomes* 14, no. 1 (2016): 68. https://doi:10.1186/s12955-016-0471-1.

grandfather, might encounter trouble reading prescription bottles, the JICA and the S-TOP team do their best to train them, with help from municipality volunteers to encourage and optimise all potential carers on the ground.

The efforts to educate the public are again reminiscent of the Japan Training in Nagano, discussed in Chapter 4 section 4.2, where the Saku Model demonstrates that empowering communities with knowledge about health and hygiene is important. Family carers are intermediaries that are crucial for filling in the gaps for the elderly where care is needed inside the homes. On the other hand, while family carers are much needed in an ageing society, Thai families are becoming smaller, and the burden on individual family caregivers to provide care long term can cause job losses, abuse of older persons and caregiver burnout. These issues of patients' reliance on family members have been observed on a daily basis at Ratchaphiphat Hospital. As discussed in Chapter 4 section 4.2, in certain cases, family carers do not pick up patients from the hospital, show reluctance to care for the elderly at home, and negotiate for longer hospitalisation of their relatives. These social issues, as witnessed by Head nurse, continue in a family-based care situation. Finding suitable human resources for a seamless program is not straightforward, as the technicalities and logistics of home care are more complex to coordinate. Thus, adopters of S-TOP do not rely entirely on either hospital staff, or on family-based informal care, but rather an integration of community-based skill-mix approach, optimising a formal and informal workforce jointly (i.e., volunteers, family carers, externally hired staff and medical professionals) to form the human resources of the S-TOP program.

As different types of support networks have different aims and missions, advice relating to intermediate care and the support that is given to adopters may differ from other types of human resources support, such as informal care. For example, privately hired staff may not share the same motivations and ideologies as regular staff in implementing the best quality of care. The potential for this raises the question of neutrality, namely that healthcare providers hold no personal values that are against the official values of S-TOP and its aims. On the other hand, informal volunteers, who are sometimes also related to the patient, may have the mission of protecting their family members and are better suited to provide advice to visiting

doctors about the patients' mental state during home visits. While both kinds of workforce possess positive and negative aspects, such as the ones discussed earlier, namely that hired nurses rely on revenue generated by their services, and volunteers are short-lived and unreliable, a division of labour among them ensures that adequate resources are available throughout the adopting process. In such contexts, varying and combining different types of staff can be beneficial to best utilise their capabilities together.

The process of implementing the S-TOP program is beset with barriers, gaps and problems, as discussed in the sections above. It demonstrates that policy transfer from Japan to Thailand is a difficult process, considering the many hurdles that exist to adapting to different social, economic, political and administrative cultures.[266]

5.2 The S-TOP Program and the Effects of Covid-19

The Covid-19 pandemic has given people around the world an opportunity to see what gaps, deficiencies and problems exist in their health systems. It has drastically reshaped industries and exposed major systemic problems that already existed prior to the pandemic. Within the context of S-TOP, some of these systemic failures include: breakdown of healthcare systems, ill-equipped staff, and a lack of infrastructure for online communication. The pandemic has provided a new opportunity for me to observe the operation of S-TOP under particularly extreme conditions, where systemic issues that were previously hidden came to the surface. As the virus entered Thailand in early 2020, home visits ceased and communities were closed to outsiders. These conditions continue at the time of writing in 2022. Because S-TOP's main patient groups are the vulnerable elderly who rely on the hands-on care, the training of volunteers and carers, as well as other activities normally observed in standard rehabilitative practices, had to be discarded, and rehabilitation via video call, called Tele-hab, was established in their place. Ratchaphiphat Hospital and JICA

[266] Martin Minogue, "Public Management and Regulatory Governance: Problems of Policy Transfer to Developing Countries," In *Leading Issues in Competition, Regulation and Development*, 2004-05-26. The CRC Series on Competition, Regulation and Development, edited by Cook, P. (Cheltenham: Edward Elgar, 2004).

experts have had to adapt S-TOP considerably during this time. In-person physical exercises create a great risk of infection through contact. At the same time, patients recovering at home, particularly those with no family, rely heavily on doctors' visits to assist with rehabilitative training and check-ups on their progress that would normally occur once or twice a week. Nurse Laura stated:

> 'The Tele-hab program was designed so that patients could speak to doctors and physiotherapists on the phone via the LINE application. They will participate in activities and show us their rehabilitation exercises for 15 to 20 minutes per call.'

On top of the day-to-day challenges of treating patients at the hospital, rehabilitation via telephone communication comes with its own set of challenges. S-TOP patients have become completely isolated within their homes, as Nurse Laura explained:

> 'Neighbourhood volunteers, who also sometimes happen to be a distant relative of the patient and live in the same neighbourhood, help us by visiting the patients. There are a couple of people like this in the program who continue to contact elderly patients and may go around from house to house in the community.'

Connectivity issues, unstable internet, elderly accessibility to and the affordability of smart phone devices, as well as teaching patients how to use the application on their own, remain key issues that staff must resolve daily. However, Nurse Laura recounted that evidence from patients using the Tele-rehab program demonstrated steady ADL levels, suggesting that despite lockdowns and curfews, mobility could be maintained with no doctor-patient contact. She explained, 'physiotherapists, who have been working with patients using Tele-rehab, have seen ADL levels maintained. We check up on the patients on LINE once a week and noticed that after one month, ADL levels have not dropped.' It remains to be seen what long-term effects the Covid-19 curfews have had on the recovery of patients overall in S-TOP. Accurately measuring ADL levels of patients through a mobile application may look rather problematical for JICA and the S-TOP team. It also remains unclear what better alternative arrangements can be provided in place of video calls in future, as the pandemic is on-going.

I observed that logistical issues in the implementation of S-TOP are remedied through improvised, makeshift methods, using resources available at-hand, such as the LINE mobile application, commonly used by Thais as a tool for communication. It is unclear whether these methods have also been recommended at other pilot hospitals. However, during my time with interviewees and visiting the hospital I observed that working environment and methods of operation are at times ad hoc and flexible. For instance, the use of space mentioned earlier in Chapter 4, where certain corners of a ward are temporarily adjusted as spaces for intermediate care, is an example of the makeshift nature that can be observed. These methods have been criticised by members of staff as mentioned in Chapter 4 section 4.1.2, as being rather haphazard and confusing for doctors and inadequate, particularly for dementia patients. However, understandably, with a limited budget, having to be creative and agile to tackle adverse situations is a fact of life that the hospital has become accustomed to.

Tension, stress and a feeling of being overwhelmed were palpable during interview calls from 2020 to 2021, when staff explained to me that hospital resources had tightened, and further pandemic restrictions under governmental rules resulted in drastic changes to the management within the hospital to prevent the spread of infection amongst elderly patients. I also observed that the policy transfer of S-TOP underwent lesson learning in 'real time' through the pandemic, as plans for S-TOP quickly changed and staff took on more responsibilities in a global fight against the spread of the virus. Under these conditions of uncertainty and urgency, the learning that occurred can be considered as another form of lesson learning for the S-TOP team and JICA. Under the strain of Covid-19, we see that S-TOP has survived through its adaptability. However, looking back, it also appears that JICA and Ratchaphiphat Hospital paid insufficient attention in the initial adoption stage to assessing whether the transfer of S-TOP could survive crises in the local setting, such as political instabilities, disease intervention and what access to essential resources or organisations would be available for S-TOP's capacity during such crises. In short, from the learnings of the pandemic, when transferring S-TOP, hospital staff and JICA should be better informed about approaches to crisis prevention, which may enable appropriate channels of communication to be created for S-TOP to recover,

pivot and take swift action.

5.3 Reflections on S-TOP through Policy Transfer Framework

Taking a step back, this section discusses how the S-TOP program fits within the policy transfer framework and considers the various degrees of transfer that appear in the implementation of S-TOP from different perspectives. As explained in Chapter 2 section 2.2, policy transfer continuum is a useful tool to help conceptualise types of transfer that range from lesson-drawing to direct imposition of a program.

5.3.1 Incentives and Coercion

At first, the S-TOP program seems rather straightforward, and when placing it on the policy transfer continuum, it appears to fall closest to, if not on, the voluntary end of the continuum. However, upon closer inspection, some form of pressure and coercion is bound to be present for policy change to occur. Holzinger and Knill argue that with regard to policy transfer, it is unclear 'where voluntariness ends and where coercion begins'.[267] Subtle mechanisms of influence between the transfer agent (JICA) and the target recipient (Ratchaphiphat Hospital) can manifest themselves even before policy transfer has started. In the case of S-TOP, the Ministry of Public Health has facilitated connections between local organisations and JICA for several JICA programs since 2007, with L-TOP, C-TOP (predecessor programs to S-TOP) and S-TOP to be implemented. The liaisons of the Ministry for various JICA programs demonstrate that there has been a long-standing relationship between JICA and the Ministry of Public Health, which has led to the adoption of S-TOP. The involvement of Ratchaphiphat Hospital in the adoption of S-TOP was brought about by the influence of larger, governmental organisations, and their role in the implementation of S-TOP was crucial.

[267] Katharina Holzinger and Christoph Knill, "Causes and Conditions of Cross-National Policy Convergence," *Journal of European Public Policy* 12, no. 5 (2005): 775-796, https://doi.org/10.1080/13501760500161357.

This suggests that the initial adoption of S-TOP could be seen as an imposition on Ratchaphiphat Hospital through the influence of the Ministry. Head nurse explained, in Chapter 4 section 4.1, that Ratchaphiat Hospital staff only knew about JICA when JICA visited them in 2017. The hospital did not actively seek out JICA's services, and it was the Ministry of Public Health that recommended JICA to visit the hospital in the first place. Later, only when JICA inspected the hospital and saw it to be suitable for S-TOP, were Ratchaphiphat Hospital administrators invited to adopt S-TOP. Thus, regardless of the hospital's motivations at the time of adoption, its initial interactions with JICA were brought about by an established, long-held relationship between the Ministry and JICA, with Ratchaphiphat Hospital being oblivious to this relationship.

This implies an imbalance of power between various actors of the transfer, where subtle forms of pressure have been imposed upon the hospital, from 1) the lack of transparency regarding JICA's long-standing relationship with the Ministry, and 2) the status of 'higher' agencies that represent the governments of Japan and Thailand. Together these may have indirectly influenced the hospital's decisions to adopt S-TOP. Firstly, not knowing anything regarding JICA as an organisation put the hospital at a disadvantage in negotiating the terms of the adoption in the initial stages of the transfer. Secondly, being a small community hospital, for Ratchaphiphat Hospital to refuse a project supported by both governments might lead to other missed opportunities in the future, jeopardizing its chances for future funding from the Ministry of Public Health. Overall, the possibilities for coercion through these pressures may have contributed to the hospital's decision to adopt S-TOP.

The presence of JICA experts throughout the implementation of S-TOP may also be viewed as a form of indirect coercive transfer, and an imposition on how the hospital should operate under its guidance. Policy transfer puts a particular emphasis on how senders (in this case JICA) can determine what is transferred. The emphasis here is demonstrable in the conditionalities, terms and agreements, including the introduction of incentives within the contractual agreement, written by JICA for Ratchaphiphat Hospital. A

level of self-interested reasoning is demonstrated here by JICA, through measures intended to ensure a level of participation by Thai hospitals.

As described in Chapter 4 section 4.2, the incentives involved in S-TOP include: travel funds to Japan, training and accommodation during the trip financed by JICA, as well as on-going technical assistance provided throughout the life of S-TOP. Beyond S-TOP, the hospital also receives an enhanced reputation in its affiliation with JICA. Receiving support from a Japanese governmental entity will promote the hospital as a creditable and trustworthy community hospital. In addition, the hospital has gained better relations and connections with the Ministry of Public Health, and has established stronger and wider networks of healthcare workers, as seen in figure 4 of Chapter 3. Creating positive public relations with governmental organisations may allow for lucrative opportunities for the hospital, such as through positive advertisement and greater financial assistance from the Ministry of Public Health. Further, through the work of establishing S-TOP, other potential collaborative opportunities with Japanese enterprises may come to fruition from the Japan Training visits, as well as from the hospital's now extensive connections with other Thai hospitals interested in adopting S-TOP. These are the incentives that Ratchaphiphat Hospital has gained in its work with JICA.

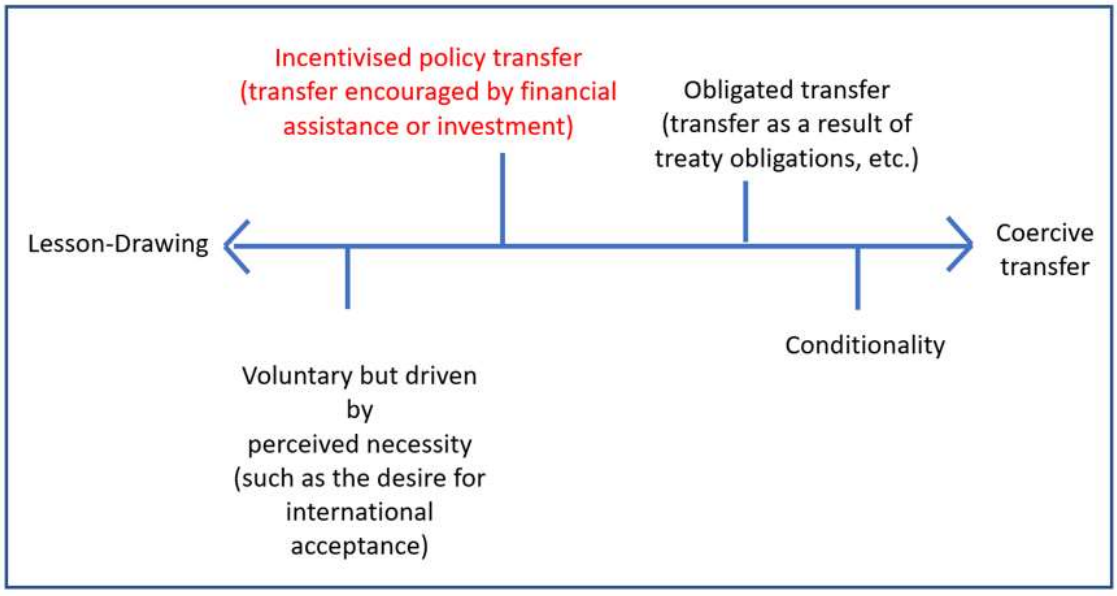
To account for situations where incentives motivate a transfer, scholars of policy transfer studies have proposed an additional category in Dolowitz and Marsh's policy transfer continuum, called the 'incentivised policy transfer'.[268] Incentivised policy transfer describes the situation when 'governments are encouraged to adopt policy change in order to secure financial assistance or investment.'[269] The continuum is an ongoing, continuous line, where there is never an absolute point of complete voluntary transfer or complete coercive transfer. This amendment accounts for types of transfers that might not fit as a voluntary transfer, as it differentiates itself from transfers that are driven by a desire for change without

[268] Amy Nethery and Carly Gordyn, "Australia-Indonesia Cooperation on Asylum-Seekers: A Case of 'Incentivised Policy Transfer," *Australian Journal of International Affairs* 68, no. 2 (2013): 184, https://doi.org/10.1080/10357718.2013.841122.
[269] Nethery and Gordyn, "Australia-Indonesia Cooperation on Asylum-Seekers: A Case of 'Incentivised Policy Transfer," 184.

incentives. Incentivised policy transfer also does not appear to fit among the more extreme or compulsory varieties, with stronger command-and-control factors involved in the transfer, such as obligated transfer and conditionality. Such situations clearly have elements of both voluntary and coercive transfer, and it becomes difficult to pinpoint exactly where 'incentive policy transfer' should be placed on the continuum.

As seen below in figure 7, I propose that incentivised policy transfer could fit between voluntary and obligated transfer on the continuum. While domestic actors still possess the freedom to choose whether to engage in policy transfer or not, there is some element of pressure and coercion intended on the recipient from the inducements proposed, thus impacting the decision to transfer. But as noted above, the dynamic in the relationship is heavily dependent on choice, and incentives are subjectively understood by the recipient. And at the same time, this choice is distorted by variables controlled by those who formulate those incentives in the first place. Therefore, the allusion to freedom of choice is a disguise. Here, JICA can be portrayed as a representative of a new form of regional and global governance that emphasizes participation and the perception of a voluntary process through choice.

Figure 7. Revised Diagram by Researcher of the Policy Transfer Continuum



Choice-based relationships in incentivised policy transfer occur when two actors, here Thailand and Japan, are witnesses to a strengthening of ties and are committed to working towards the same goals. Incentivised policy transfer can occur 'within a period in which the relationship between the two states has strengthened..,'[270] and that is normally due to their commitment in working together on a bilateral agreement, such as collaborative efforts in solving challenging issues that are shared by both counties. Ageing population is now a topic of top national interest for Thailand, and both countries are working together closely on a bilateral basis. It can be argued that the choices presented to Thailand by Japan in the case of S-TOP are in the vested interest of strengthening ties and cooperating on a shared phenomenon, where solutions would benefit the domestic political agendas of both. It is not the case that Thailand has been forced by the wealthier country into making a choice to transfer S-TOP. Although S-TOP is indeed a Japanese initiative, both parties benefit from choosing to enact the transfer through their own domestic political agendas and by strengthening ties bilaterally. Japan presents S-TOP to Thailand with incentives, and one could argue that this makes Thailand's position to accept S-TOP easier, as the country with fewer resources needs financial and technical support. In the end, policy transfer becomes coercive only when countries have no choice in the matter.[271]

S-TOP's incentives are interpreted and subjectively understood by the Ratchaphiphat Hospital staff and administrators. Referring to interview data presented in Chapter 4, for Ratchaphiphat Hospital staff, incentives proposed by JICA were s a large contributing factor to the hospital's agreement to adopt S-TOP. The incentives have been beneficial in educating staff about intermediate care. This has eventually led them to finally providing an intermediate care program for elderly patients, an objective that Dr Phurithat, Head nurse and hospital administrators were trying to create on their own before S-TOP. They have interpreted the incentives as having been advantageous to their cause of tackling the challenges of an ageing population. Bearing in mind the lack of resources to properly set up an intermediate care program,

[270] Ibid.
[271] Dolowitz and Marsh, "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making." *Governance (Oxford)* 13, no. 1 (2000): 15.

the long-term benefits as well as the short-term incentives received appear to have outweighed the terms and conditions attached to the program.

The presence of a contractual agreement in which the terms and conditions are drawn means that, for the most part, JICA has control over the nature of S-TOP, the direction of S-TOP's outcomes, and the way in which Ratchaphiphat Hospital implements S-TOP. It is important to point out that this is where imbalance of power can be seen. It allows us to understand how a foreign government can shape programs being used for local people and domestic agendas. JICA, the organisation that formulated the conditions of the transfer, controls the variables within which Ratchaphiphat Hospital is bound through its contractual agreements. This also tells us a little about the interaction between JICA and Ratchaphiphat Hospital. Control or ownership that each partner has over S-TOP is predicated on conditions signed at the beginning of 2017.

Choice-based relationships in incentivised policy transfer create the illusion of agency and freedom in that it appears as if Ratchaphiphat Hospital might refuse or accept S-TOP freely. Factors that impact this decision are determined by potential positive impact of S-TOP for the hospital and patients, as well as many other direct or indirect benefits. In this way, the decision to adopt S-TOP is based on the illusion of actors' freedom of choice that is heavily weighted toward positive opportunities to be gained, as well as the opportunity cost in action not taken to engage in it. Opportunity losses here may include the what-ifs, namely that passing on this opportunity might carry costs and consequences, such as a loss of potential patients, loss of profit, a lack of exposure and forming a working relationship with JICA may not be revisited. One way or another, adopters are influenced by both disadvantages and potential advantages, some of which have been manufactured by JICA, disguising the freedom of choice that adopters feel they have in their decision to engage in the transfer. It is possible to think of the transfer of S-TOP as a form of indirect coercion, or at the very least 'incentivised' transfer, as mentioned above.

To a certain extent, JICA's interest to transfer S-TOP to Thailand in the first place was also a risky undertaking, with potential cost and consequences for the organisation. Perhaps for JICA there is a high level of risk in investing a substantial amount of time and resources into a program that may meet varying receptiveness or even resistance among recipients. In order to capture benefits while mitigating risks in a country where technical known-how and administrative capacity are lacking, it only seems reasonable for JICA to demand more guarantees for long-term arrangements with domestic actors and assurances from its partners and stakeholders.

The benefits for JICA in expanding the S-TOP program are multifaceted. Firstly, a nation-wide network of S-TOP users strengthens JICA's legitimacy within the wider medical community in Thailand. Secondly, it will allow JICA to acquire further financial support from the Japanese government to fund future projects. Thirdly, the expansion of S-TOP has broader implications for Japan's security and its influence vis-à-vis the rise of China's competing donor power in the ASEAN region. Against the backdrop of the geopolitical tensions between Japan and China, JICA's willingness to increase Japanese aid in the form of technical assistance explicitly serves Japanese national interests and takes place within the broad scope of foreign aid as discussed in Chapter 1. The dissemination of Japan's nation-branding in this area, as carried out through the S-TOP program, increases Japan's contribution to international public good in the area of ageing. And as ageing is a shared common experience among many countries, this strengthens Japan's approach towards foreign aid as a public good, thus turning its own know-how into 'soft power'.

In general, incentivised policy transfer highlights an imbalance of power in the transfer process from a developed to a developing country. The defining feature of this type of policy transfer is power asymmetry, particularly in terms of a resource imbalance between the transfer agent and the recipient. And while Ratchaphiphat Hospital may receive financial incentives and training, accounts from interviews so far overlook the fact that JICA can withhold rewards and exert some level of pressure from its relationship with the Ministry of Public of Health if conditions are not met.

5.3.2 Lesson-Drawing

By applying the concept of lesson-drawing, one can also notice that by its very nature S-TOP is an imposition on the recipient. As discussed in Chapter 3, the recurring theme was the view that the Thai staff had to 'learn' about S-TOP and intermediate care in the Japanese way. Various strategies, such as trimester reports, action plans and presentations, had to be put in place in order to inform Thai staff of how S-TOP worked, and to convince other hospitals of how necessary S-TOP is. This included utilizing existing systems, putting in place mechanisms by the hospital, pulling in human resources and training from various avenues, as discussed above in section 5.2. Therefore, in seeking to export S-TOP into Thailand, what might have started out as a simple sharing of ideas and information, ended up looking like a conscious process of policy transfer on the part of JICA, in order to create the environment that was suitable for S-TOP and served to replicate it for more S-TOP users nationwide.

In that respect, from the categories distinguished by Rose's theory of lesson drawing (categorised under voluntary transfer), discussed in Chapter 2 section 2.3.1, five possible outputs – emulation, adaptation, hybridisation, inspiration and synthesis – evidence of emulation, hybridisation and adaptation was present in the transfer of S-TOP. Emulation, as Rose posits, is the effect of using other systems as a model, 'with adjustments for different circumstances, of a programme already in effect in another jurisdiction.'[272] A

[272] Richard Rose, "What is Lesson-Drawing?" *Journal of Public Policy* 11, no. 1 (1991): 22, https://doi.org/10.1017/s0143814x00004918.

specific event that reflects this occurred during the Japan Training, discussed in Chapter 4 section 4.2, which detailed the learning of staff members at various hospitals in Japan. One could argue that hybridisation in lesson-drawing occurred where aspects of the existing health care systems at Ratchaphiphat Hospital was combined with JICA's S-TOP program, as described by Head nurse in the initial adoption stage in Chapter 4 section 4.1.

For adaptation in S-TOP, various domestic social and cultural settings prompted staff to adapt S-TOP to fit the environment of the hospital. For example, we see the need for recruiting more formal workforce and observations regarding a separate psychological assessment of dementia patients in S-TOP as discussed in Chapter 4 section 4.2. Other examples of adaptation occurred during the pandemic, as mentioned above in section 5.2, and demonstrate significant technological adaptation in the face of lockdowns, so that some form of care could continue in patients' homes. Overall, these instances of learning are inherently an ongoing process that occurs in the course of the transfer experience. Here we see that the lesson-drawing perspective explains a level of agency by the recipient, as Ratchaphiphat Hospital staff had their own experience-based learning external to JICA training, and they were able to modify their actions on the basis of their interpretation.

5.3.3 Inter-organisational Transfer

An interesting but currently under-developed aspect of policy transfer is the domestic transfer of ideas and practices at the inter-organisational level. Head nurse stated in Chapter 4, section 4.3.3, that Ratchaphiphat Hospital had an additional obligation to broadcast, showcase and recruit other hospitals within its network to adopt S-TOP. These activities are encouraged by JICA, so that S-TOP is brought to the attention of other hospitals, further spreading the efficacy and influence of its program locally and nationally. Later on in Chapter 4 section 4.3.3, Nurse Laura stated that indeed in 2021 Bang Khun Thian Geriatric Hospital, the Sirindhorn Hospital's medical research department and Wetchakarunrasm Hospital are all currently adopting the S-TOP program from Ratchaphiphat Hospital. This was not an easy feat, as in the 2019

interview, Head nurse had doubted whether this would happen at all. For Ratchaphiphat Hospital's implementers, expanding the S-TOP program within the first few years of adoption (between 2017 and 2019) might have been too challenging at the time, especially among small hospitals that would most likely also require human resource assistance and which experience a lack of administrative know-how. However, having finally achieved this, Ratchaphiphat Hospital will benefit from having a network of S-TOP users to facilitate patient transfers, share resources between hospitals and in turn to produce better outcomes for patients and families.

From international to domestic movements, S-TOP has highlighted the motivations of actors who are 'instrumental in their influence to pervade policy processes at all levels, including from transnational to inter-organisational transfer.'[273] However, what is worth noting is that the actor motivated to expand S-TOP at an inter-organisational level is JICA, not Ratchaphiphat Hospital. Ratchaphiphat Hospital doctors and nurses do the work of persuading other hospitals to adopt S-TOP, not out of their own volition, but as part of an obligatory arrangement. As outlined in section 4.1 of Chapter 4, since 2018, the initial adoption phase of S-TOP has largely been pervaded by conference presentations by doctors and nurses to promote its new program. At any opportunity, Ratchaphiphat Hospital publishes its work with JICA online, in order to publicise it. It is currently unclear whether JICA has any intentions of supporting other hospitals adopting S-TOP, or whether that responsibility is being left to Ratchaphiphat Hospital, as JICA leaves S-TOP behind in 2022. If the ultimate aim is for more hospitals to adopt S-TOP practices, it seems unlikely that JICA will be able to support every hospital with the incentives it promised to Ratchaphiphat Hospital. As Nurse Laura mentioned in Chapter 4 section 4.3, JICA's role with other recipients of S-TOP will most likely be limited to distant consultations.

Here, the domestic movements of S-TOP also open up the discourse of inclusion, where S-TOP will be able to facilitate the unique needs of other hospitals. And as JICA becomes less involved or discontinues

[273] Rob Hulme, "Policy Transfer and the Internationalisation of Social Policy," *Social Policy and Society* 4, no. 4 (2005): 422, http://doi.org.10.1017/s1474746405002605.

completely with monitoring S-TOP, the staff at Ratchaphiphat Hospital may use S-TOP freely within that new setting. This creates an opportunity for the transfer of S-TOP to take on a form of its own, one that is less centrally-led by JICA. The implementation of S-TOP in the future may look very different from the current case study, which has been top-down policy transfer, led by a foreign institution of governance, JICA, and a domestic institution of governance, the Ministry of Public Health. Rather, the motivations for future adopters of S-TOP by third generation recipients will very likely be entirely a bottom-up policy transfer, led by teams of medical staff, in response to needs felt by adopters themselves, without requiring contracts, incentives, or conditionalities. The future of S-TOP at such levels may even by-pass the central institutions of governance completely and resemble a voluntary transfer. This highlights the positive consequences of JICA's conditions to S-TOP. In the second-and third-generation policy transfers of S-TOP, the original recipient (Ratchaphiphat Hospital), who may initially have been coerced in some form, now becomes the central driver of the transfer, with considerably expanded control over the transfer process.

If we pause to consider who 'owns' S-TOP, throughout the five years of S-TOP being implemented, my observations have been that ownership of S-TOP has been shared and rather flexible. However, as JICA's involvement approaches an end in 2022, there may be a more significant transition towards full Thai ownership in S-TOP, contractually with the departure of JICA, and emotionally for the Thai staff in being able to handle S-TOP on their own. As JICA departs from S-TOP, Thai doctors and nurses may feel a greater sense of confidence and autonomy with regard to implementing S-TOP, now that they can play a more active role in the administrative side that was once occupied by JICA. JICA's departure might also encourage the emergence of other local actors to join the cause of providing intermediate care, and thus resulting in an even more effective program, without JICA's presence as a foreign entity controlling it.

5.3.4 Convergence

To adopt the same ideas does not mean that convergence has occurred. To explore the transfer of S-TOP through the specific dimensions of the convergence theory, one must understand how it is measured. Convergence (in which the main focus is on the results of diffusion and the production of similarities or lack of them, as its dependent variable) is measured by: (a) discourse in which actors use the same language of impact to assess and describe their procedures; (b) adoption of the same guides and regulations; (c) creation of the same content of impact; and (d) embeddedness of S-TOP in different health care systems.[274] To illustrate this, one can imagine that (a) and (b) are the plates that carry food, while (c) and (d) are the contents of food that is served on the plate. Because the food produced in some cases could taste very different, or be entirely missing on the plate, there is evidence of policy transfer occurring without convergence. Thus, the tools used to transfer the S-TOP program should not be confused as convergence, as the result that it produces may be different from its original setting. For S-TOP, (a) may be the level of discussion in presentations and meetings that take place between JICA and Ratchaphiphat Hospital. And (b), the guidelines and measures that JICA prescribe for actors to adhere to, such as written reports and action plans. It seems that the context provided so far in both Chapter 3 and Chapter 4 become very important in such an analysis. The assessment made by Head nurse, Nurse Laura as well as others interviewed in previous chapters has demonstrated that gaps and barriers to transfer have caused S-TOP to be constantly reformulated by different actors, and solutions change the make-up of that model. To use Brunsson's words 'diffusion at the level of "'talk" has not yielded convergence in "actions" and "results"'.[275]

In this sense, my previous description of the inter-organisational transfer of S-TOP that was diffused by Ratchaphiphat Hospital, may be a reflection of hegemonic discourse – everyone wanting that same plate of food too. Different hospitals pursue different goals across Thailand. At the level of discourse, the adoption

[274] Claudio M. Radaelli, "Diffusion without Convergence: How Political Context Shapes the Adoption of Regulatory Impact Assessment," *Journal of European Public Policy* 12, no. 5 (2005): 928, https://doi.org/10.1080/13501760500161621.
[275] Nils Brunsson, and Nancy Adler, *The Organization of Hypocrisy: Talk, Decisions, and Actions in Organizations,* (Copenhagen: Cbs Press, 2019)

process may induce the same kind of commitments to the type of impact that actors want to achieve. However, the outcome is endlessly varied and may be creating diverging results.

5.3.5 Cultural Context in the Transfer of S-TOP

As discussed in Chapter 2, the analysis of policy transfer requires a discussion of culture. It is integral in the learning, transferring and implementing of ideas. Looking at the different approaches to care, one observation by an interviewee revealed the role of culture and its ties to care taking. A nurse recalled her experience during the Japan Training, explaining that staff in Japanese nursing homes tended to focus on independence for their residents. She noted that staff would leave a certain number of daily tasks for the elderly residents to complete on their own, in order to promote physical mobility. She viewed this positively and was inspired by the way in which the Japanese create day-to-day opportunities to promote mobility, naturally integrating exercise into daily living. She further revealed that this would never be seen to happen in Thailand, as having aged parents doing household chores is typically frowned upon, particularly when families have paid money for services to be provided.

This is the general expectation by most Thais of the care in nursing facilities in Thailand, particularly high-end nursing homes, where families pay higher fees expecting the best quality of care. Having elderly residents engage in household chores would be considered a form of neglect, and a lack of professionalism. Based on this particular observation, the combined effects of commercialising care and an overpowering sense of filial piety have produced a definition of care that is different from that seen in Japan. Inadvertently, Thai nursing staff working in high-end care facilities may feel the pressure to perform acts of care in a demonstration that the client's money is being well-spent, and their actions are a reflection the family's intention, as if they were to take on the children's roles personally.

One might also look at the prerequisites of a successful transfer as being based on organisation, human resource management and work culture. As Hussain explains, the organisation's culture is omnipresent and

relates to both the management and diffusion of the thing being transferred.[276] Denison points to the need to understand the differences in organisational culture when transferring, because this has a strong impact on organisation effectiveness.[277] The important point is that while it is already clear that the transfer of S-TOP is a transfer of technical medical knowledge about intermediate care, it is also a transfer of organisational work culture, some of which is distinctively Japanese, into the Thai setting. This relates to the first research question in the study of 'what is being transferred?'. Concerning the transfer of practices, since Japan's economic recovery in 1997, many outsiders among Southeast Asian countries such as Thailand took an interest in the Japanese management 'Nihonteki Keiei' system post-1997.[278] Some of the company's human resource management had been transplanted and adapted to fit practices outside Japan. In Chapter 4 section 4.2, participants explain their learning of administrative practices from JICA. These were observed during the Japan Training, and the entire trip served as an opportunity to familiarise participants with the 'Japanese way' of doing things. It included the technical and procedural side of work, team meetings, work flow models, task management and reporting of data. Japanese-style management philosophy such as Kaizen [改善] (literal translation: change for the better)[279] and organisational work tools such as Kanban [看板] (meaning sign) have been modelled internationally to streamline work flow.[280] Other similar management practices, some adapted by Western influence are widely emphasised in various Japanese workplaces, and continue to be practiced in companies abroad.[281] JICA's action plans, for instance, are not unique to just S-TOP and have been known to be used as part of their implementation of various other projects (L-TOP, C-TOP). JICA may have realised, presumably through experience in facilitating the implementation of other programs, that it must first foster a shared awareness of working styles,

[276] Shabbir Hussain, "Technology Transfer Models Across Cultures: Brunei-Japan Joint Ventures," *International Journal of Social Economics* 25, no. 6/7/8 (1998): 1192, https://doi.org/10.11108/03068299810212676.
[277] Daniel R. Denison, *Corporate Culture and Organizational Effectiveness*, (New York, NY: John Wiley, 1990)
[278] Fredric Swierczek and Jun Onishi, "Culture and Conflict: Japanese Manager and Thai Subordinates," *Personnel Review* 32, no.2 189, https://doi.org/10.1108/00483480310460216.
[279] Robert Maurer and Leigh Ann Hirschman, *The Spirit of Kaizen: Creating Lasing Excellence One Small Step at a Time*, (New York: Mcgraw-Hill, 2013)
[280] Sing Ong Yu, *Art of modern management: applying the Chinese, Japanese and Korean management styles at work.* (Singapore: World Scientific Publishing, 2017)
[281] Fredric Swierczek, and Jun Onishi, "Culture and Conflict: Japanese Manager and Thai Subordinates," *Personnel Review* 32, no.2 189, https://doi.org/10.1108/00483480310460216.

otherwise its programs will fail. Whether or not this management style will continue to be found in the adoption of S-TOP by other hospitals will remain to be seen.

There may be something interesting to be observed here in future studies of the effects of location, team size, nationality, and ownership of the organisations and programs being transferred to foreign settings. From the observations in this study, JICA has displayed a strong sense of ownership of S-TOP, as demonstrated by its supervisory behaviour towards Ratchaphiphat Hospital.

As a final observation, we can underline how the implementation of a program across national borders has of necessity involved communication, and this has meant the use of several languages by those concerned. With a high language barrier between Thai and Japanese, the transfer of S-TOP has relied heavily on translators and interpreters throughout the life of the program, as discussed in Chapter 4 section 4.3.2. They can also point out culturally specific factors that are often invisible to actors. They function not only as the oral link between actors, but their work also has in this way contributed to the co-creation of the S-TOP narrative, between the Japanese side and the various administrators and medical staff on the Thai side. The effective use of language would seem to be a crucial prerequisite for the success of the transfer process. In conclusion, the individuals facilitating the transfer of information across languages (in this case translators and interpreters) should be acknowledged by researchers and other observers of policy transfer as key actors in the transfer, rather than just facilitators.

Chapter 6. Conclusion

6.1 Review of Research Questions

This section aims to address the five research questions that were posted in Chapter 1. It will provide brief summary answers, drawing together the material presented in the relevant discussion chapter, and considering what can be learned from the findings of this project.

1) What specific initiatives have been (are being) pursued in policy transfer related to Thailand's ageing society?
2) What factors impede/enable this policy transfer?
3) How will the case study extend our understanding of policy transfer in general?
4) What insights does this case study offer into Thailand – Japan relations?
5) How can policy transfer be viewed within a broader context of ageing population in Thailand?

6.1.1 Summary of Research Question 1

This study aimed to identify examples of policy transfer in the area of ageing population between Japan and Thailand. Based on qualitative analysis of fieldwork interviews, the study identified and examined the transfer of a Japanese governmental initiative, known as the S-TOP program, as a working example of policy transfer. The program enabled training and resource creation for intermediate care in Thai hospitals, in order to accommodate the rising demand for physical rehabilitation of the elderly population in Thai communities. Results from the data indicate that S-TOP produced some positive impact for the hospital

concerned, in that it had, to an extent, improved the capacity for hospital staff to provide intermediate care.

The data collected on the transfer of S-TOP has demonstrated the potential for intervention in domestic agendas in international settings. Apart from the area of healthcare, there are other possibilities to extend the use of policy transfer and to apply it to a broader range of areas in ageing. Heightened international interest from both governmental and business perspectives has focused on various sticking points in the lived experience of the elderly, such as the design of public spaces, housing, pensions and livelihood, occupations for the retired and so forth. In this sense, the transfer of S-TOP is not enough. However, projects such as S-TOP mark a fruitful step towards recognising the need for governments and institutions to adapt. In doing so, this is an auspicious beginning for improving the quality of life for a large segment of the population that will remain active and independent well into their 80s and 90s.

6.1.2 Summary of Research Question 2

Firstly, there are many external and internal factors that have facilitated the transfer of S-TOP. From my investigation, Ratchaphiphat Hospital's connections with the Thai Ministry of Public Health facilitated the circumstances through which JICA chose to engage in the co-creation of S-TOP. Internally, Thai staff already demonstrated resolve in their attempts to provide aged care related medical services, predating the adoption of S-TOP. Internal and external factors together played important roles during the three stages of the transfer process analysed in the study. The case of S-TOP in this way shows that the top-down approach, when met with a bottom-up approach, facilitates success and ease of transfer, as they meet in the middle.

Secondly, the process of transferring required actors to adapt and balance out what should be kept from the original S-TOP model, and what should change in keeping with the needs of patients. Certain aspects of the original program were kept, such as the practical techniques learnt during the Japan Training,

systematic management of communication and feedback loops, and how intermediate care should be incorporated in acute treatments. These are some of the traits adopted from Japan that were retained by actors, and remained a part of the Thai S-TOP program. On the other hand, other technical aspects were critiqued, such as the use of ADL on assessing dementia patients and others with mental illness. Further, certain elements of the program were also deemed to be insufficient for use in Thailand, requiring much more support to match the needs of patients in the community, such as the training of community volunteers in home-care. These pivots and changes make S-TOP transferrable into the Thai setting. At the same time the process of customizing S-TOP and choosing what is right to keep proved that policy transfer processes may result in preventing an uncoordinated mess. This was a necessary part of the transfer that required much more local input from doctors and nurses of S-TOP than JICA's, in order to improve the 'fit' of S-TOP with the local conditions. This proves that policy transfer in the case of S-TOP was essentially a process of mixing and matching, whereby the end product is a hybridisation of ideas that can be traced from both cultures.

Thirdly, the way in which S-TOP was perceived as already being successful in various settings in Japan facilitated the conceptualisation of S-TOP for the Thai staff during the Japan Training. This contributed to easier adoption in the initial stage of the transfer, where a sense of ownership of S-TOP by Thai staff was required. Moreover, as the partnerships within S-TOP have been created entirely through public networks, there is something to be said for the convenience that the public sector has afforded to the implementation of S-TOP. Without public networks and local government support, opportunities for foreign governmental agencies to integrate themselves into the local communities and become accepted would be limited to private connections that depend critically on profits and the monetary worth of S-TOP. As seen in many cases in Australia and elsewhere, the commercialisation of aged care by private ownership has often been a festering source of potential elder abuse, poor quality of service-provision, and the

likelihood of maximising profit over investing in care.[282] In this way, JICA's S-TOP could also be viewed as counterbalancing the trend toward the commercialisation of age-related products and services in Thailand.

One of the factors that impeded the transfer of S-TOP were observed by actors as: the lack of physical space that did not allow for effective care. There is potential for Japan, as a space-saving country, to advise further on how to tackle this issue, and one wonders whether or not future iterations of S-TOP could incorporate this challenge into their implementation process. Secondly, the bureaucratic systems in the national healthcare schemes continued to be a barrier for some patients of S-TOP to access intermediate care or further treatment while transferring to other hospitals. Through the existing policies, the heavily bureaucratic national healthcare scheme could be considered as an obstruction that people need to navigate around, and a hindrance to S-TOP fully integrating into the Thai healthcare system on a national scale.

6.1.3 Summary of Research Question 3

The analysis of S-TOP has offered a better understanding of how policy transfer works in a real-world setting. The study has shown that policy transfer is a progressive learning method for transferring foreign ideas. The policy transfer framework helps analyse the process of transfer, but in addition to that, it witnesses the transfer of values and the co-creation of new systems. S-TOP is not simply a healthcare model, but is also a set of culturally driven ideas about how to approach the provision of care for an ageing population. S-TOP and the work that went into it are a testimony to the values shared between donor and recipient organisations, with culturally assimilated goals. Their agreements were built on aid and conditionalities, formed through existing diplomatic arrangements. S-TOP also represents how policy can be a product of international cooperation among countries experiencing common challenges.

[282] The Royal Commission into Aged Care Quality and Safety, 2021, https://agedcare.royalcommission.gov.au/publications/final-report.

While policy transfer is a rational process, there should be some recognition for the complex contextual realities of the day-to-day use of S-TOP by doctors and nurses in their work with patients. Interviews included anecdotes from doctors and nurse who share the complex experiences of care: the patients' conditions, family situations, and the physical, emotional and mental sufferings involved in care by staff and patients. While JICA provided the structure needed in the procedural aspects of S-TOP's operations, it becomes clear from interviews that the direction of the program was heavily influenced by local applications on the part of those using S-TOP in daily life. Here, the study acknowledges the contributions of actors on the front line, namely the doctors and nurses making critical decisions to pivot S-TOP and to tailor it to their patients' needs. This makes the process of policy transfer less strictly rational.

Further, our understanding of ownership in policy transfer is complicated by the co-creation of S-TOP by various actors. The study points to JICA's ownership of S-TOP as the donor, the original facilitator, and through contractual agreements JICA provides supervisory guidance for the Thais. While this is true, JICA's role is also limited within its managerial role, as doctors and nurses create changes that ultimately steer the direction of the program. In addition, translators and interpreters also have agency in communicating for the transfer, holding a key role in bridging language barriers and playing their part in the creation of S-TOP. Therefore, the question of who owns S-TOP is not straightforward. One could say that ownership is vague, and the work of each party represents some part of the ownership that it has in creating S-TOP. In this way, everyone owns a piece of S-TOP and ownership is not a tug-of-war contest.

While it is the case that wealthy countries may sometimes have imposed policy on poorer countries through coercive policy transfer, the transfer of S-TOP was not an example of this. In this study, policy transfer offers an explanation for how wealthier countries like Japan may influence the transfer of policy to less developed countries, without the use of coercion, and to the political advantage of both. Using incentivised policy transfer, Japan had the power to entice the engagement of the Thai government into a new initiative. Rather than being a case of each country dealing with its own challenges, there is a shift that can best be explained as burden-sharing and cross-cultural sharing through diplomacy as a foundation, and

the policy transfer framework can be used as a tool in this process. Ultimately, the relationship between Thailand and Japan is one of bilateral cooperation with incentives, as seen through the work of S-TOP. However, based on the interactions presented in the case study, the use of incentives by JICA (technical support and educational trips to Japan) to entice consent to their program suggests that policy transfer is not devoid of power. It is important to understand that there are forces at play between Japan, being the wealthier country that is attracting recipients through influence, and Thailand, and that the transfer of S-TOP hinges on the presence of economic disparity, where Thailand is the poorer country with more to gain from the arrangement.

My study of S-TOP complicates our view of policy transfer by illustrating that although the idea of policy transfer can be observed as a rational process, the actual implementation on the ground involves human emotions and deals with precarious issues such as health and mortality in the case of S-TOP. The social and cultural variables described in the interviews also indicate that policy transfer is dynamic, and may at times be messy. The transfer of S-TOP was not a facile copying of the Japanese S-TOP program. Rather it relates directly to the narrative of patients' emotions, needs, their families' perceptions, and the work of Thai doctors and nurses, all of which are tied culturally to values that are located within the setting and environment of the Thai hospital. In recognising this, the transfer of S-TOP deals with structured processes at the top, as well as fluidity through feedback loops from the bottom.

6.1.4 Summary of Research Question 4

Over the past five years, the S-TOP program has offered significant benefits for Thailand's diplomatic relations with Japan, bilaterally as well as multilaterally in the region of South-East Asia. First, since its inception, the reception of JICA has been endorsed by Thai governmental stakeholders, and the transfer of S-TOP was predicated on positive evaluations from JICA with regard to the hospital. This suggests that at the governmental level Thailand-Japan relations are ones of mutual cooperation, but also that Japan was taking on the supervisory, older-brother role. While the transfer of S-TOP contains within it conditionalities

that may suggest some elements of incentivised policy transfer, feedback from hospital staff otherwise demonstrated a sense of coordinated teamwork with JICA, as well as an understanding of and a liking for the Japanese way of thinking and management of aged care. For the most part, we see that S-TOP has strengthened rather than weakened cultural and institutional ties between the two countries.

Second, in the broader geopolitical context, the transfer of S-TOP can also be considered as one of Japan's modern-day diplomatic tools, and its activities in technical support are motivated by an interest in increasing Japan's soft-power potential in the region of South-East Asia. In an attempt to balance the rise of China's influence in developmental investments, the Japanese government's efforts through the work of JICA are to maintain, reconnect and consolidate Japan's relevance in the region. As with almost all bilateral governmental relationships, Japan's donations to Thailand provide the opportunity to remind Thailand of its cooperation and good deeds. Japan is also able to build on this positive perception for the further cultural appeal of Japanese products and services in all areas that Japan is well-known for, including know-how from its ageing population. Japan's role as a dominant aid donor and JICA's presence in Thailand will most likely continue for several years into the future, and there may be various other projects to further enhance these connections. The dissemination of Japan's initiatives, such as S-TOP, are pieces on the diplomatic chess board that Japan uses to create dependency, security and alliance in exchange for future cooperation.

6.1.5 Summary of Research Question 5

The S-TOP program is a strong testimonial to the resilience and strength of actors and the value of partnership. The way in which the institutions with similar aims combined and negotiated their strengths to implement a program that would benefit many Thais, exemplifies what benefits can be born out of partnerships in the field of policy transfer. The very real implications of S-TOP are felt by those who work with patients, doctors and nurses on the front line, as well as the patients and families who require the care.

I hope that the accounts of the project in the study will enable and inform similar programs to occur in the future, on a larger scale with multi-sector partners, solving issues in ageing policies and other areas, in collaboration with other countries. Further, the positive results in the anecdotes from doctors and the observations during home visits show the need for S-TOP and the uptake of other similar programs. The long-term effect that such a program as S-TOP has had so far indicates the value of the transfer. The wider influence of S-TOP also has the potential to be extended into other communities. Policy makers should look to S-TOP as an example for future policy transfer initiatives.

Ultimately, we must see that the demographic transition and the phenomenon of ageing population are having profound economic, social and even psychological and ideational implications for societies. Countries should begin to see that this is an undeniable period of enormous change that must be followed by transitions of their own. The case study of S-TOP exemplifies how actors in developing countries such as Thailand are seizing the opportunity to reconceptualise their own realities in the face of negative factors by looking to foreign cooperation. For the developed countries, becoming donors to extend support provides economic leverage to developing countries, as well as raising their status as donors and their case as an ally and foundation for future economic partnership. For Japan its position as an ally in the region of South-East Asia is contested against China's movements and investments in developments that may disrupt Japan's role. Japan's domestic economic growth and social change no longer look so promising, as their populations shrink in the face of a super-ageing society. Yet, the pioneering efforts from Japan to expand their know-how, putting the experience of ageing to good use, are a sign of resilience in the face of calamity. At the very least, Japan's outcomes may be able to forewarn other ageing countries of their own prospective future, like a magic mirror for others to look into.

6.2 Contribution of this Study

My study makes several contributions. The main contribution has been to shed light on the different aspects of the policy transfer process through the case study of S-TOP, using Dolowitz and Marsh's policy transfer framework. My examination of S-TOP's implementation at multiple levels reveals the multifaceted nature of inter-institutional transfer activity, and structures that help spread S-TOP. This is an extension of previously understood examples of the traditional one-to-one, unidirectional movements of policy transfer. This leads to a greater appreciation of state and non-state actors at the very bottom of the transfer process, who are mostly unrecognised in the chain of operation, and their activities under the control of state actors. The study has been able to showcase the activities of various actors in their efforts to provide for better healthcare in ageing communities, specifically in underprivileged areas of Bangkok.

Interview data in this study contributes significantly to understanding new forms of transfer occurring today. Data gathered from interviewing nurses and doctors exposes us to the realistic, day-to-day operation of what actually occurs when policies are adopted on the front-line. This offers a unique and confronting coverage of Thailand's current population challenge and the cultural and social environment that actors must operate in during policy transfer. In turn, the study unfolds details that may depart from some traditional examples of policy transfer as presented in the policy transfer literature, which has tended to focus on policy-makers rather than those engaged in on-the-ground implementation.

The study is novel in that it serves as a rare opportunity to view policy transfer in motion, from top-down and bottom-up, across multiple stages of a newly-implemented program, and across several languages. We know far more about the network of people behind establishing the foreign ideas, and see how expectations of a program may not be aligned with the reality of the place, people and culture. By understanding these aspects of policy transfer, we witness S-TOP as it unfolds, and are essentially opening

the case study up to examine its 'black-box' to reveal the pieces of the policy transfer process. As opposed to a study into an established, well-polished program, that could not have encapsulated the experience of implementing S-TOP, my examination of S-TOP in motion has provided a significantly nuanced understanding of policy changes that occur on a day-to-day basis.

Within the current global demographic climate, where most countries around the world are experiencing an ageing population, Thailand's experience is relevant and should be explored in the light of reflecting the need for other countries to adopt foreign policies, in preparation for their own demographic transition. Within the policy transfer studies literature, Eurocentrism weighs heavily and my study helps researchers to reassess certain assumptions and constructs developed through Eurocentric research. The investigation into two non-Western societies at the centre of my study offers an alternative insight, as well as contributing some academic merit to research into ageing population and policy transfer. My study has also helped fill in the gaps in our understanding of what intermediate care and rehabilitation for the aged look like. By doing so, the study sheds light on the importance of these skills and the need for training human resources to fulfil such roles. The inspection of S-TOP as a case study of policy transfer will also encourage others to investigate the evolution of elderly care further.

6.3 Limitations and Directions for Further Research

It should be noted that within the study of S-TOP there are a number of limitations and challenges. The first of these issues is that of the scope of the study, in which the focus of the activities and people covered in the study is limited to what can be seen at Ratchaphiphat Hospital. The findings reported in this study reveal that the policy transfer framework focuses more on the processes of transferring and implementing foreign programs than results and outcomes of S-TOP. Future research, building on other aspects, such as measuring the effects and outcomes of S-TOP by employing data from interviews with family and patients, might help broaden our understanding of the impact on users at the end of the chain of consumers. And

while the study already looks at the actors of S-TOP, namely nurses and doctors, the study misses the perspectives of participants who are further away from the decision-making process, namely volunteers, family members and the patients themselves. Reporting on individuals with less power or involvement in the creation of S-TOP might bring to light meaningful comparisons between consumers and service providers, showcasing possible irregularities, and open up the opportunity to inspect outcomes of S-TOP on another level. Further research might also engage more deeply with the notions of family structures, kinship, class structures and domestic chores. A more nuanced cultural comparison of these subjects between Japan and Thailand may reveal how these variables affect the reception of S-TOP in the host country, in contrast to the donor country.

Since the present thesis focuses heavily on the institutional environment of the hospital, an analysis of the home environment as a focus for future research on policy transfer might well tell another tale in the story of S-TOP. Taking the home environment into account, future research could analyse the uses of S-TOP and the reception of the program by families and patients at home, and this might enable us to make different observations about the transfer, which this thesis was not able to do.

Moreover, while the data gathered in this thesis has been mainly concerned with discovering what Thailand has learned from Japan in the transfer of S-TOP, further research could possibly ascertain what lessons Japan has learned from Thailand in its experience of ageing. This is because JICA may have gained useful insights from Thai doctors and nurses which could ultimately modify its strategies for transferring other programs and implementing them in other developing countries. This aspect of S-TOP might usefully be considered as a topic for future research.

Further, as Ratchaphiphat Hospital is one of these eight sites that have adopted S-TOP, comparative study between the eight pilot sites might also reveal what variations of S-TOP exist across the country. This may assist with questions of whether the transfer of S-TOP creates location-specific solutions to meet the needs of each pilot site, and then measure what factors make each program different.

While it would be enriching and valuable to study these unexplored dimensions of S-TOP, they are beyond the scope of the current study and require further investigation on the ground. Future study may be able to pick up what outcomes occur years after the implementation of S-TOP, and see its developments within the Thai health care sector in the years to come.

6.4 Final Remarks

The findings reported in this study are certainly limited to the context of the Japan-Thai policy transfer. But they are a step in the direction of showing that it is possible to evaluate other transnational cases of policy transfer, relating to efforts to get to grips with the problem of ageing in other countries. Similarities and differences in the processes of transferring age-related initiatives and strategies may exist and be well worth investigating.

In much of the rest of the world, regional demographic pressures are causing a demand for policy changes to be made, and with it the search for solutions will brighten future prospects. However, improvements may prove too slow. The demographic realities facing the developed countries can inspire expedient solutions, or at the very least be a predictor of future prospects. Here, much more could be achieved, so that the future course of fertility will help shape the lives of our children and grandchildren during the decades of the mid-twenty-first century.

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