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Current Challenges and Solutions in Elderly Healthcare Access: A Comparative Study of Canada and Thailand

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Abstract

This study compares elderly healthcare access in Thailand and Canada, with particular attention to economic factors, policy challenges, and labor shortages. Drawing on Welfare State Theory and a Comparative Policy Analysis Framework, it examines how different governance models and institutional arrangements shape healthcare delivery for aging populations. Canada's publicly funded healthcare system has undergone reforms to improve quality of care and reduce wait times; however, persistent challenges such as long queues and healthcare worker burnout continue to undermine service efficiency. In contrast, Thailand's Universal Coverage Scheme (the "30-Baht Scheme") provides affordable care but faces inefficiencies and critical workforce shortages. This study identifies the main barriers in both countries, reviews government responses, and offers policy recommendations. These include strengthening community-based care, clarifying government roles, and investing in healthcare workforce development to enhance access and improve system efficiency for the elderly.

Keywords: Elderly Healthcare; Comparative Analysis; Policy Solutions

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1. Introduction

Access to healthcare services is an essential aspect of well-being, especially as people age and face more frequent and complex health needs. In the context of an aging global population, ensuring that elderly individuals have equitable access to healthcare has become a significant policy concern across nations. A Comparative study between Thailand and Canada presents a great example, as both countries implement universal health coverage. However, the differences between them make for an interesting comparison due to the distinct structures of their healthcare systems. Canada operates a decentralized system through 10 provinces, while Thailand's healthcare system is structured around three main sectors: the government, the Ministry of Public Health, and the private sector. Thailand and Canada present unique case studies in this regard, as both countries grapple with the challenges of providing healthcare services to a growing elderly population. In Thailand, according to Statista (2024), there has been a significant rise in the number of elders: 19.46% in 2022, 20.17% in 2023, and 20.91% in 2024. The prediction will be 25.5% by 2030. Also, 18.9% of the Canadian population was aged 65 and above in 2023, and the trend is going to be around 21.4 – 23.4 % by 2030 (Statistics Canada, 2024).

While both nations strive for universal healthcare, differences in economic policies, healthcare infrastructure, and labor shortages create distinct obstacles. This comparative study aims to explore the healthcare access issues faced by elderly populations in Thailand and Canada, focusing on economic and policy factors, labor shortages, and the solutions each country has implemented to address these challenges. By identifying the key barriers and examining the strategies employed by both nations, this research seeks to highlight potential pathways for improving elderly healthcare access in diverse healthcare settings. Data for this study is sourced from multiple documents and online articles and will be breakdown to three sub-topics which are the overview of problems and solutions in healthcare in both countries, to study the issues and policy implementation, including suggesting the possibility of issues that may arise in the future to strengthen the healthcare system.

2. Healthcare system

By age 65 and older, individuals are considered elderly, although this can vary depending on different definitions, with some considering age 60 and above as elderly. As aging decreases immunity, the elderly tend to respond more slowly than other age groups. Healthcare becomes a basic need for them. Healthcare has been a science has advanced significantly in the 20th century (Institute of Medicine, 2008). UHC, or universal health coverage, has been based on the WHO's constitution since 1948. "Universal Healthcare Coverage (UHC) means that all have access to the full range of quality health services they need, when and where they need them, without financial hardship" (WHO, 2023). Hence, every person, including the elderly, should have access to healthcare in their own country.

In Canada, the general healthcare system is funded by the federal, provincial, and territorial governments (Health Canada, 2005). Before 2000, the healthcare system in Canada, specifically the universal public hospital system, was introduced in Saskatchewan in 1962. Later, in 1984, "the Canada Health Act

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replaced the federal hospital and medical insurance acts" (Health Canada, 2024). In 2000, the system was reformed to focus on primary care, health information, and infrastructure, leading to the Accord on Health Care Renewal in 2003. The key elements of the renewal were aimed at reducing wait times, improving aboriginal health, enhancing home care, and so on. Currently, Canada is facing an aging population issue: "In 2021, 18.5% of the population was aged 65 years or older, an increase from 13.0% in 2001" (Health Canada, 2024). Generally, individuals contact a primary healthcare professional, such as a family doctor. After primary care, secondary services may follow. Patients might be referred to a specialist at a hospital or receive care at home or in the community, depending on the length of treatment. Most healthcare services, including emergency medical services, are free of charge. Additionally, provinces and territories provide extra coverage for the elderly, children, and social assistance recipients (Health Canada, 2023). Moreover, the government has implemented the program called PRISMA model since 2003. As Dubuc et al. (2003) explains, the model aims to integrate service delivery for frail older people, ensuring more continuous care. PRISMA facilitates coordination through multidisciplinary teams and various service providers, leading to improved care quality by reducing functional decline, delaying institutionalization, and easing the burden on caregivers. However, according to MacAdam (2011) state that the program still faces gaps between service supply and linkages among primary, acute, and community care sectors, which limit its full integration. In addition, the program remains underdeveloped in many provinces, resulting in ongoing challenges related to service fragmentation.

In Thailand, improvements to the healthcare system began in 1970, including funding for primary infrastructure at the district and sub-district levels, as well as training and deploying healthcare professionals to rural areas (Mills et al., 2018, p.1) In 2001, the Universal Coverage Scheme, also known as the 30-Baht scheme, significantly transformed Thailand's primary healthcare system through tax revenue funding. According to the WHO (2023), "Thailand is among the fastest aging countries in the world... and has been classified as an 'aged society' with people aged 60 years and above accounting for 10% of the population." Moreover, statistics indicate that elderly individuals primarily access healthcare services through health insurance 44%, with only 24% utilizing the Universal Coverage Scheme and the remaining 3% covered by the Social Security Scheme (Jirathananuwat, 2022). Thailand focuses on public, community-based care programs. Although the healthcare system in Thailand provides access through private clinics and hospitals, these services often come at a higher cost compared to public healthcare options. Additionally, socioeconomic inequalities are a significant factor contributing to accessing healthcare for the elderly. Barriers such as limited transportation accessibility, particularly in remote areas, further hinder access to adequate healthcare services (Chamchan et al., 2023). Moreover, many elderly individuals remain dependent on government allowances and family support, which are often insufficient to afford better healthcare options (Leenoi, 2024).

Canada and Thailand share similarities in providing universal health coverage and efforts to integrate healthcare for the elderly. However, their systems differ in structure and approach. Canada emphasizes service coordination, which uses the PRISMA model as a key tool. In contrast, Thailand focuses on community- and home-based care under the Universal Coverage Scheme, relying mainly on family and community support.

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Although the integrated model in Canada helps reduce functional decline and healthcare providers' burdens. Challenges such as fragmented services, long wait times, and provider shortages can delay care. While Thailand's community-based approach improves accessibility, yet it struggles with socioeconomic inequalities, limited access to rural areas, and a lack of long-term care infrastructure. In addition, financial limitations contribute to reduced healthcare quality and restrict some individuals, especially the elderly.

2.1 Economics and policy factors

Government funding is considered the main source of funding for thehealthcare system. Still, there is a barrier for the elderly in accessing healthcare.

In Canada, a lack of funding for community-based care is a critical barrier for the elderly in accessing the healthcare system. Home and community-based care is an integrative bridge between hospitals and different locations of care, long-term facilities, or community healthcare centers. As the Ontario Human Rights Commission (n.d.) explained, there are "significant investments [that] have been directed to the expansion of long-term care [and] community services designed to help people remain in their own homes for as long as possible." Additionally, $1.6 billion had been invested in long-term healthcare in 2000-2001. Though much of the funding went to long-term healthcare development, community-based care remains insufficient. Moreover, during the COVID-19 pandemic, delays in the healthcare system made it more difficult to access healthcare services in the first year of the pandemic. Around 22% of elderly individuals aged 65 and above experienced delays in contacting a medical professional (Statistics Canada, 2021). Some of them may have had to pay out-of-pocket for senior care, which could range from $1,000 to $3,000 per month due to the lack of access to healthcare (Canadian Health Coalition, 2018). Additionally, according to D'Angelo et al. (2020), other barriers to accessing healthcare include not knowing where to go for help, long wait times, etc. The government needs to increase taxes by 6% annually to cover the Canada Health Transfer (CHT), which represents 22% of the cost of providing healthcare (Zimonjic, 2023). Yet, healthcare access has been slow, with long wait times or delayed treatment. As a result, elderly patients face increased risks, including higher mortality rates, a greater likelihood of infection, and worsening of existing health conditions, which can slow recovery. These issues also contribute to reduced ability to perform daily activities (García et al., 2017).

At the same time, Thailand's healthcare system is partly insurance-based. The 30-baht scheme seems to be helpful for the elderly by providing affordable services in public hospitals. According to Jirathananuwat (2022) mentioned, "It's been shown that 61.6% of older adults used Universal Coverage Scheme rights, which affects accessibility to health service". Additionally, using health insurance often results in higher treatment costs compared to regular services, particularly for outpatient care. However, the elderly still struggle to access healthcare because a lack of support for non-medical costs, such as transportation fares, makes it more difficult to commute for the elderly who live remotely. With transportation barriers, it leads to missed or delayed appointments and contribute to higher levels of unmet healthcare needs, especially among the elderly with chronic diseases, who require regular medical attention. Due to the unclear roles of central and local governments in healthcare. There is an ambiguous division of responsibilities among government agencies, public insurance schemes, and local governments due to overlapping systems, which

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makes the system inefficient (World Bank Group, n.d.). Such as the Ministry of Public Health (MOPH) overlaps with the National Health Security Office (NHSO), which also takes charge of healthcare service provision and quality control. Also, Local Administrative Organizations (LAOs) overlap with MOPH in community health promotion and local health center management. The overlapping leads to fragmentation and inefficiency in services and administration, including budgeting and resource allocation issues. Apart from that, the rising cost of healthcare. World Bank Group (n.d.) stated, "Government health spending as a share of GDP has nearly doubled from 1.5% in 1995 to almost 3% in 2008". The cost has been increasing as the government continues to spend on the 30-baht scheme and other health programs due to the increasing number of chronic diseases, aging populations, etc. Also, the limitation 30-baht scheme does not offer the same coverage as the Civil Servant Medical Benefit Scheme (CSMBS) of the Social Security Scheme (SSS), which provides higher cost treatments, specialist care, and be able to access to private hospitals.

2.2 Shortage of labor

The shortage of healthcare professionals is an issue of growing global concern. The World Health Organization (WHO) has estimated that by 2030, there will be a shortfall of 11 million healthcare workers, which is expected to severely impact low and lower-middle-income countries (WHO, n.d.).

In North America, including Canada, longer working hours are causing burnout among healthcare professionals, which further exacerbates the healthcare system's challenges. According to Zimonjic (2023), "The CMA says family physicians work an average of about 52 hours a week but only spend 36 hours caring for patients. The rest of their time is taken up by administration and other non-medical tasks." Despite the presence of many immigrant healthcare professionals in Canada, they are often unable to practice because they have not obtained Canadian licenses. Obtaining such credentials can be a long and difficult process, and while short-term courses exist for some healthcare fields, training typically takes 5 to 10 years. For example, foreign-trained doctors must pass the Canadian Medical Exams (MCCQE), the process is a time-consuming and costly process. As a result, immigration healthcare professionals end up facing a long waiting period while their credentials are assessed. Even if their credentials are recognized, many foreign-trained professionals must undergo additional training to meet the standard. This makes addressing the shortage a long-term endeavor. In 2022, there were approximately 96,000 unfilled healthcare positions in Mississauga, Ontario (Government of Canada, 2023). Furthermore, the number of registered nurses, who form the largest group of regulated nurses, has declined from 44 per 1,000 elderly adults in 2013 to 36 in 2022 (Canadian Institute for Health Information, 2024, p.6). This leads to long hours waiting because healthcare workers need to work longer to meet the demand of patients. This illustrates the pressing shortage of healthcare workers, particularly in elderly care.

Similarly, Thailand is also facing a shortage of healthcare professionals as the country approaches an aging population, with a rising number of elderly individuals suffering from chronic diseases. The ratio of healthcare workers between 2007 and 2013 stood at 24.7 per 10,000 people (Mills et al., 2018). Many healthcare workers opt for positions in private hospitals, attracted by higher salaries or better working conditions. The migration of healthcare professionals to other countries in search of better opportunities,

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a phenomenon known as “brain drain,” which deteriorates Thailand’s healthcare system. Also, the National Health Security Office (2023) stated that WHO recommends a standard of one physician per 1,000 population. However, “Thailand has between 0.5 and 0.8 doctors per 1,000 people according to Thailand Development Research Institute” As Jirathananuwat (2022) explained, “In Thailand’s capital city, there are a total of 4,687 health services, and only 141 units can admit patients in the facility overnight. Approximately 56% of the units are in the public sector and 44% are in the private sector.” Moreover, the growing influx of foreigners into Thailand has increased the demand for healthcare services, further exacerbating the labor shortage, particularly due to the increase in medical tourism.

Moreover, Asteco Immigration Consulting Limited (2024) explains that labor shortages are closely linked to budget issues. In Canada, labor shortages lead to increased costs because of higher-paid temporary or contract workers and overtime payments. For instance, a single physician role can result in around $200,000in lost revenue monthly. Additionally, the process of filling such a position is time-consuming, further prolonging budget strain. Budget limitations also restrict the ability to offer competitive salaries and retain staff, thereby reducing hiring capacity. The shortage of staff leads to increased overtime, creating a recurring cycle of strain on the system. Similarly, in Thailand, insufficient funding limits both the capacity to hire and the ability to expand training programs. As Boonmavichit and Hobbes (2023) note, this affects the ability to provide competitive wages and incentives, especially in rural areas. Moreover, the Thai healthcare system still relies on volunteerism, a model that is not sustainable in the long term.

In both Canada and Thailand, the shortage of healthcare workers is a major issue, but the causes are different. In Canada, the problem stems from burnout due to long hours and administrative tasks, plus hurdles with licensing for immigrant professionals. Even though Canada has many qualified immigrants, the process to get licensed is lengthy, adding to the shortage. On the other hand, Thailand faces a shortage because of brain drain, with many healthcare workers moving abroad for better pay and conditions. The aging population and rising medical tourism also increase the demand for healthcare services, putting more pressure on an already strained system. So, while Canada’s issues are more about systemic problems and licensing delays, Thailand’s are tied to economic migration and growing service demands.

2.3 Solutions

2.3.1 Solution to policy and economics

In 2023, Canada committed over $198.6 billion over the next decade to improve healthcare services by building a more sustainable health workforce, reducing wait times, and enhancing mental health services, among other priorities (Health Canada, 2023). On January 31, 2023, the Canadian government also introduced two independent long-term care (LTC) standards aimed at providing safe, reliable, and needs-oriented services for the elderly. As people age, they are more likely to depend on institutional care, particularly in nursing homes (Milligan & Schirle, 2023).

Several LTC programs across Canada reflect efforts to make care more accessible. For instance, in Ontario, there is a program to reduce rates for low-income residents in long-term care facilities. To qualify, residents must live in basic accommodations or be spouses or partners living together in a semi-private room converted into basic accommodations. The rate reduction depends on the resident’s

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income (Ontario Medical Association, 2024). Similarly, in New Brunswick, there is a financial subsidy program through which individuals can apply for assistance in securing nursing home care.

In Thailand, the Universal Coverage Scheme (UCS) is crucial to elderly access to healthcare, with 61.6% of seniors covered under this policy. Expanding and enhancing UCS is a strategic direction for Thailand's healthcare system. The National Health Security Office (NHSO) has introduced new health benefits specifically for the elderly. These benefits include free eyeglasses, adult diapers, dentures, and dental implants. Approximately 500,000 pairs of eyeglasses have been distributed to the elderly throughout 2023. In addition, seniors can access comprehensive healthcare services, including medicines, cancer treatments, heart surgeries, joint replacements, cataract surgeries, and care for chronic diseases such as diabetes and hypertension.

Thailand's Local Administrative Organizations (LAOs) are actively improving healthcare accessibility for older adults by promoting services and providing health emergency vans, along with transportation for elderly residents in rural areas. To enhance efficiency and avoid overlaps between central and local governments, Thailand needs to clearly define and assign specific responsibilities, such as disease prevention, health promotion, and other healthcare initiatives (World Bank Group, n.d.). Also, the recommendation, NHSO should take the lead in elderly care since NHSO manages the Universal Coverage Scheme, which covers the majority of elderly people in Thailand.

2.3.2 Shortage of labor

Both Canada and Thailand have implemented policies to increase healthcare professionals.

In Ontario, Canada, the Ontario Medical Association (OMA) identified 11 pragmatic solutions to address key healthcare challenges. The three most urgent priorities are: 1) resolving the crisis in primary care, 2) reducing the growing burden of unnecessary administrative tasks, and 3) increasing community capacity to alleviate hospital overcrowding (Ontario Medical Association, 2023). In addition, the Canadian government has allocated $200 billion in its 2023 and 2024 budgets to improve healthcare through retention, recruitment, and strategic planning (Health Canada, 2024).

Thailand has also adopted a model to strengthen its healthcare workforce. The country is working on educational reforms designed to better serve the healthcare system. A key aspect of this reform includes offering scholarships to high-performing students from remote areas to encourage them to become future doctors. This approach has already proven successful in training nurse partners through a program with Khon Kaen University.

To improve accessibility for older adults, Thailand's Local Administrative Organizations (LAOs) are promoting healthcare services and providing health emergency vans and transportation for elderly residents in rural areas. To prevent overlap between central and local government roles, Thailand must systematically assign responsibilities for areas such as disease prevention, health promotion, and other healthcare initiatives (World Bank Group, n.d.).

Lastly, domestic GDP growth in both countries play an important role in generating funding for improved healthcare services and pensions, which directly impact life expectancy and quality of life for older people (Luga et al., 2024). Implementing effective policies can help ensure equitable healthcare access for the elderly. Such policies should aim to provide healthcare support through pension schemes

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and consider informal options. For example, spouse or family members can help alleviate long-term care issues and should be integrated into residential long-term care planning in the future.

Moreover, to address the shortage of healthcare personnel, expanding healthcare training is essential for ensuring a well-distributed workforce. In Canada, SELC College (2025) suggests that Health Care Assistant (HCA) programs provide a faster route into the workforce, requiring only 6-12 months of training compared to traditional programs. Implementing similar initiatives on a broader scale could yield long-term benefits. Likewise, Thailand should focus on strengthening its community-based workforce, particularly by enhancing the role of community nurses in remote areas, to reduce transportation barriers and improve access to care.

Table 1

Comparison of Healthcare Systems: Canada and Thailand

Feature	Canada	Thailand
Structure system	Decentralized; 10 provinces and 3 territories oversee delivery and administration of health services	Centralized national program with three main sectors: government, Ministry of Public Health, and private sector
Funding	Primarily tax-funded through federal, provincial, and territorial government revenues	Predominantly tax-financed, supplemented by government initiatives and the Universal Coverage Scheme (UCS)
Service Delivery	Mostly public sector delivery: doctors and hospitals are publicly funded and operated; some private and out-of-pocket services exist	Large public hospital network, significant role for community- and family-based care; some medical tourism/private
Access	Generally good, but challenges include long wait times and provider shortages, especially in rural or remote regions	Good basic access via UCS, but persistent socioeconomic and urban-rural disparities
Workforce Issues	Physician and nurse shortages due to burnout, administrative burdens, licensing delays for immigrants	Shortages from “brain drain” (migration of providers), high demand from aging and medical tourism
Elderly Healthcare Focus	Emphasis on care coordination and integration (e.g., PRISMA), but gaps remain in community support and long-term care	Increasing benefits for elderly under UCS (free eyeglasses, dentures), home- and community-based care prioritized

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3. Conclusion

Both Thailand and Canada face challenges in providing healthcare to their growing elderly populations. While each country has made progress, they struggle with issues related to funding, labor shortages, and healthcare infrastructure. In Canada, the lack of support for long-term care, long wait times, and overworked healthcare professionals are key problems. In Thailand, overlapping roles between government agencies, limited rural healthcare access, and the migration of medical professionals to other countries create significant barriers.

Despite these challenges, both countries are actively working on solutions. Canada has committed to improving long-term care, mental health services, and the healthcare workforce. Thailand is enhancing its Universal Coverage Scheme and improving healthcare services in rural areas.

This study shows that while the approaches differ, both countries are focused on finding ways to improve healthcare for their elderly populations. Although the two systems differ in structure and scale, there is value in observing one another's experiences, particularly in the design and implementation of integrated care models and community-based programs within distinct economic and administrative settings. Sharing best practices, such as Canada's PRISMA model and Thailand's localized health initiatives, can provide mutual insights for improving service delivery. Continued policy reform by monitoring the impact of these changes and adapting strategies accordingly, along with sustained investment in workforce development, will be essential. Ultimately, strengthening elderly healthcare will depend not only on reform and resources but also on each system's ability to continuously adapt to change. With these efforts, both Canada and Thailand can continue making progress towards ensuring equitable healthcare access for their aging populations.

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