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In Thailand, from the beginning of this century, policies on aging, health promotion reform toward enlightening the public, and administrative decentralization have been taking place, leading to the reinforcement of biopolitics in elderly care. "Community" became a useful locus and tool to carry out governance of health and elderly care. At the same time, within state-initiated programs there is local agency at work, which mobilizes existing social networks while allowing the formation of new connections based on the old. Drawing upon observations from fieldwork in a suburban district in Chiang Mai Province, I argue that biosocial communality emerges from the interaction between the administration and local agents, and demonstrate how this operates by acting on the interface of the family and the community. I first look into how policies of health and elderly care have made use of the community or the discourse thereof. Then I introduce the case of a specific subdistrict to see how such top-down governance actually operates on the ground, how local networks can be reactivated, and, ultimately, how we find, among the participating elderly and caregivers, emerging biosocial communality at the interface of the family and community.

Keywords: aging, care, Northern Thailand, biopolitics, communality, health governance

I Introduction

In the beginning of the twenty-first century, Thailand launched its second—and more substantial—aging policy. Administrative decentralization began to take shape in the 1990s, and during the same decade Thailand launched a statewide program targeting the health promotion of its citizens. The cumulative effect of all of these measures is the conjoining of biopolitics with decentralized administration toward nationwide health promotion as well as the implementation of elderly care policy. Elderly care policy in

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Thailand states, first and foremost, that the elderly must help themselves; second, the family and community must provide support; and third, whenever these two measures fail, the state will provide support.[1] Does this suggest a neoliberal turn in policy or simply a turn back toward traditional means? What is really happening? The family or household is, of course, where care is actually first and foremost provided, and yet the changing family in Thailand (Hayami 2012) forebodes the need for alternative support. What exists to fill this role between state and family, or at the interface of the intimate space of family and the wider space beyond? What is meant when state policy nominates "community" in the above context? And how do the elderly actually participate in community programs?

Once I began to look into elderly care in Northern Thailand, I often came across discourse on the community among officials, villagers, NGOs, and researchers. They would say, with a sigh, things like "The family and community are weakening in Thailand." Yet just as often, I heard sentiments such as "in Thailand we still have community." Whether the community is equivalent to the smallest administrative unit, or some kind of an autonomous homogeneous social unit that shares a traditional culture, or some metaphor of moral ideology, and whether something corresponding to this exists in reality, the repeated emphasis made me wonder what was going on.

What is this community that both officials and grassroots people refer to? How is elderly care actually practiced, and what kinds of social connections can we find at the interface of the family and beyond? These are the questions I hope to answer in this paper.

In the present century, outside of the immediate case of Thailand, there has been an emphasis and expectation among the earlier industrialized countries on communitarianism or community, and the socialization of care. In the face of global aging, the state, market, and family have all been found to be inadequate, and the community or civil society has been regarded as the possible solution, the "third way," which seeks to reconstruct citizens as moral subjects of responsible communities within neoliberal policies (Rose 2000; Herbert 2005; Ueno 2011). The community that is the object of governance contains contradictory orientations: on the one hand it is a social space where individual self-management and self-control is constituted, and on the other it creates moral demands based on the traditional community framework (Tanabe 2008a, 108). Because of its moralistic demand, community as an idealistic discourse is criticized in the US context as being like a "trapdoor" for participating individuals (Herbert 2005). The state devolves its role by divulging it to the community with its benighted status as

1) See second national plan for the elderly (2002–21).

the locus of local agency, while demanding self-sacrifice from members of the community. Regarding the care scene in Japan, Ueno Chizuko emphasizes expectation on the role of the civic, yet points out how this is accomplished by the self-sacrifice of unpaid volunteer women (Ueno 2011).

In Thailand, especially since the 1980s, there has been much discourse on *chumchon* (community) by NGOs and researchers, as well as the administration, appraising it as the engine for development.[2] Community in this context refers to the smallest regional unit, as well as a social unit that is regarded with a firm sense of belonging and identity, a self-sufficient economic unit, and/or an autonomous social group that shares culture and value within itself (Seri 1986; Chatthip 1999). It was argued by both researchers and activists that the traditional "community culture" in agrarian Thailand was, or should be, the motor for development. Later, when *setthakhit phau piang* (sufficiency economy) was promoted in the face of the financial crisis in 1997, the community discourse was further reinforced through this ideology, which valued moderation, prudence, and self-immunity together with knowledge and morality for safeguarding local communities from adverse changes and crises. It was a rhetoric enhanced by its moralistic and normative tone, echoed and strengthened among the administration and civil society. Medical professionals, too, from the late 1970s had been involved in disseminating primary health care and enhancing district-level hospitals; and leading figures of *moo chonnabot* (rural medical doctors network)[3] such as Prawase Wasi had been involved in the community discourse from early on, effectively connecting community discourse with health concerns at the grassroots and the medical profession (Kawamori 2009, 155; Shigetomi 2013, 15).[4] In the 1980s district hospitals were referred to as "community hospitals," and the district level was considered an important autonomous unit for creating a grassroots system of primary health and medical practice at the local level. In this context, community was equivalent

2) Shigetomi Shinichi (2013, 15–22) describes and analyzes communitarianism in Thai thought, which he traces along three lines of development that influenced each other: rural development NGOs, with scholarly foundation in the work of Chatthip Nartsupha, which eventually connected well with the state sector; anti-state social movements, which advocated for the rights of the people; and social reformists led by medical professionals such as Prawase Wasi.

3) See Illan Nam for how the health care regime in Thailand was built from the 1980s through to the 1990s based on medical professionals and bureaucrats, many of whom were former student activists of the 1970s who had nurtured networks especially through the rural medical doctors network (founded in 1978) and its Sampran Forum (begun in 1986). These networks enabled a vertical alliance between NGOs and bureaucrats of the Ministry of Public Health, connecting state resources with resources of societal actors (Nam 2015).

4) Prawase's vision of the community is one where schools, hospitals, and volunteer organizations form a local and functional network for the welfare of the community, supported by a sense of unity based on religious ideals (Kawamori 2009, 153).

to the administrative unit and associated with the grassroots.

Looking back, the moralistic discourse on community was itself an effective instrument of governance from the era of development to that of post-financial crisis recovery (Kemp 1991; Rigg 1994; Reynolds 2009). Community has been an effective instrument for governance, including—and especially regarding—health governance, precisely because it is envisioned as distinct from the state, being an autonomous entity with moral overtones. The pronounced dependence on the community in the policy discourse on elderly care today can be considered as a continuation of this.

Recent scholarly discussions on community in Thailand have paid more attention to the processes by which community is formulated rather than presupposing a community with moral baggage and clear boundaries. Andrew Walker endeavors to liberate the modern Thai community from local traditional village ties, forms of subsistence, and indigenous wisdom and rather to reconsider it as a "concept that represents specific practices, meanings and political potentials that provide a firm basis for empowerment" (Walker 2009). He points out that even in the fluidity of global consumerism and the development of the nation-state, communal emotions and the significance of a sense of belonging are not lost. Walker postulates that it is unfortunate to view only the negative aspect of the state's role in community formation and cautions that negatively dismissing every involvement by the state and administration as a paternalistic and authoritarian imposition of power would be dismissing all kinds of possibilities. To be sure, Thai villages today abound with state-initiated projects undertaken as joint initiatives of both the local administration and residents, and it is from such contexts that we find emerging and sustained initiatives. This is true especially in the various health-related programs where the community has become a ubiquitous concept or tool.

Komatra Chuengsatiansup (2008; 2013) questions the existing flat understanding and approach toward the community by the administration and social activists. By reflexively considering community, he encourages local society to make use of its own potentiality. As a medical anthropologist at the Health Systems Research Institute, he is in a position to connect the Thai public health administration on the one hand, and civil society on the other, and while he is critical of existing community discourse, he believes that by borrowing administrative power and intervening in the community, local connectivities can be transformed. In either case, community is envisioned as being well within and essential to the state project.

In discussing control over forests in Himalayan communities, Arun Agrawal (2001) critically examines state formation within community spaces where he sees the relationship as being "inclusive and subversive . . . [where] the management of forests is becoming a phenomenon in which state and community actors take joint part, undermining their

presumed division." He continues:

> state formation in community spaces is not just about the reproduction of state structures and logics through coercive acts initiated by states. It is as much about how this reproduction relies on the willingness of locally situated actors to use new laws to extend state control over themselves. (Agrawal 2001, 33)

While his discussion is pertinent to our case, we do not see a replication of state structures and programs on the community level, but rather multilevel involvement and articulation by various agents within the emerging network of the state's subjects. In the Foucauldian sense, as pointed out by Nikolas Rose and Carlos Novas (2006), governmentality in health care has called upon community as a convenient locus of biopower, infused with a sense of moral obligation and warmth of intimacy. Yet at the same time, can we not find within the face-to-face process self-emergent communality among the elderly who gather to share their physical, mental, and social experiences?

Tanabe Shigeharu (2008a; 2008b), who researched self-help groups formed among HIV-positive patients in Northern Thailand, examines the dynamic process of self-formation and transformation by people who share physical pain or risk and the common task of survival. These self-help groups were varied in their foundation: some were managed autonomously, while others were supported by government medical institutions, NGO support, or local organizations such as Buddhist temples or Village Health Volunteers (see below). Tanabe analyzes how this community evolves with internal and external power relations. While locals are all subject to governance from above, they also demonstrate agency through what he calls "governance from below." Intimacy that is engendered within the community, especially a community sharing concerns of life and survival, guarantees relationships of care and consideration among individual members, so that there is the possibility for HIV-positive patients to seek a new life and healthy living in a "biosocial community" (Rabinow 1996; Rose and Novas 2006; Tanabe 2008a, 129).

Among the HIV groups, then, Tanabe found an emerging connectivity in action based on this community of intimacy. In considering the case of elderly care in Chiang Mai, I have found a similar process taking place. To differentiate this from the community in the foregoing sense of a closed, bounded moral community, which corresponds to a particular geographical locus and which is the object of top-down governance, in this paper I use the term "communality." Even if it is true that this communality has emerged from processes of top-down community reinforcement, I want to differentiate the sense of actor-centered embodied connectivity that emerges among those involved.

In this paper I look at the relationship between the state and the reactivation and

formation of local connectivities at the interface of the family, in relation to elderly care. I will first demonstrate that health-related policies and later elderly care policies in Thailand have been means of state penetration into the lives of Thai subjects, backed by global slogans such as "Active aging." Thai communities are themselves reinforced by the state as receptacles and transmitters for top-down governance, which has been especially effective after administrative decentralization. The governance processes related to health promotion and elderly care are arranged through various programs that formulate and reinforce communities and health promotion programs. Indeed, health and aging is today the foremost stage for biopolitics in Thailand, most effectively through the community. In the following main section, I will introduce a case study from Northern Thailand and argue that within state-initiated programs, we see various local agents that mobilize existing social networks as well as form new connections based on the old. In local care practices that are carried out in response to the policies emphasizing community care, there is an emerging sense of communality through embodied interaction. I will argue that in response to state-initiated projects and policies, local networks for elderly care are formed from within the mutual interaction between the local administration and various agents, and demonstrate how this operates by acting on the interface of the intimate family space and community space where we find emerging biosocial communality. Ultimately, I question whether the belated (relative to the industrialized countries) "aging" in Thailand means simply that Thai society is following the foregoing experiences of the industrialized countries, or whether Thailand is following a different pathway.

II Biopolitics of Health, Aging, and Elderly Care in Thailand

Thailand is aging rapidly. A low birthrate and aging trend began to take shape in the 1990s, and by 1992 the total fertility rate had fallen under 2.0 and life expectancy had exceeded 75. It is expected that one-third of the population will be elderly (in Thailand, defined as those above age 60) by 2040. Government policies began in earnest from the first decade of the twenty-first century, accompanied by an increasing use of the formal term *phuu suung ayu* (person of a higher age) rather than the local and informal *khon tao khon kae* or, in the north, *phau uui mae uui*. Economists have declared that Thailand risks becoming an aging society before attaining a sufficient economic level to support its elderly. In other words, the government must design its elderly policy with the awareness that social security will not cover the entire population.

Policies geared toward an aging society began in 1982, the year the United Nations

World Assembly on Aging was held in Vienna.[5] Stimulated and urged on by this congress, the Thai Ministry of Interior founded the Thai Elderly Committee, with high-ranking officials from various ministries as well as medical professionals, and launched the first national plan for the elderly (1982–2001) (Piyakorn 2011, 2–30). In 1982 the Ministry of Interior ordered provincial governors to establish senior citizen clubs (*chomrom phuu suung ayu*) at the regional level (Worawet *et al.* 2014), and since then the Department of Public Welfare has called nationwide for elderly clubs to be founded locally. The department took the lead in activating these nationwide elderly clubs, and in 1987 the Senior Citizens Council of Thailand (from 1989, the Thai Senior Citizens Association), constituting mostly medical professionals and elites, was founded to oversee these elderly clubs, which in 1994 were registered in a nationwide network (Banlu *et al.* 1996).[6] In 1993 a monthly allowance for the elderly (*bia yang cheeb*) was instituted; its financial burden was later taken over by local administrations. State-initiated activities to promote community participation began in earnest in the first decade of the twenty-first century.[7]

It was after the 1997 constitution, which referred to rights of minorities as well as the elderly, that the Thai government began to tackle the issue in earnest.[8] In 2002 the second national plan for the elderly (2002–21) was laid out, and in 2003 the Elderly Act was promulgated.

The elderly clubs mentioned above function as the foundation for implementing various elderly policies locally. At present, there is at least one elderly club in every tambon. Activities of these clubs include health promotion events, sports (such as petanque and tae kwon do), cultural events, and various mutual-aid programs (funerals,

5) According to Worawet Suwanrada *et al.* (2014, 33), the first senior citizen center (formerly called senior citizen assembly) was established in 1962 by the Neuroscience Research Foundation, but its operations were quite limited. Worawet refers to it as a "senior citizen center." Due to the Thai term *chomrom*, I opt to use "club."

6) By 2008, according to the Senior Citizens Council of Thailand, there were 19,475 senior citizen centers (Senior Citizens Council of Thailand 2008, in Worawet *et al.* 2014, 33).

7) A pilot survey was conducted in 1996 to ascertain the needs and methods for community participation in providing care, services, and activities for the elderly, with the aim of setting up Senior Citizens Clubs (Centers), commissioned by the Department of Public Welfare and the Senior Citizens Council of Thailand (Malinee *et al.* 1996).

8) In the 1997 constitution, it was first stated that those above the age of 60 without any income had the right to receive state assistance. It was also specified that the state must support the elderly, the impoverished, and the disabled so that their standard of living was secured. In 1999 the Thai Elderly Declaration was announced, stating that the Thai state must make all efforts to secure the rights and living standards of the elderly. However, two of the nine articles also mention that the elderly must live with their families, maintaining ties of co-residence, love, respect, understanding, and support and that the elderly and their families must attend to each other.

etc.). The clubs' founding is led by district hospitals, local administration, or civil servants. According to recent statistics, one-third of the elderly population participate in such elderly clubs, especially those in their 60s and 70s (Knodel *et al.* 2015, 3).

Another government-initiated nationwide organization that was founded earlier and is well rooted in local society is the Village Health Volunteer system (*aasaa-samak saathaaranasuk muubaan*, best known by its acronym for *aw saw maw*, hereafter ASM). The Ministry of Public Health founded this system in 1977 to mobilize local agents to promote primary health care, and 800,000 ASMs were designated nationwide. Their role was to visit their assigned households, check on health conditions, provide information and knowledge, attend monthly meetings and seminars, and connect the households to various services. At the same time, the ASM became an instrument for rule and governance when there was a strong drive for development in the name of public health in the 1970s and 1980s. While the health and medical system was monopolized by modern biomedicine specialists, the ASMs became instruments for the government to disseminate and extend health-related governance to every corner of the country (Komatra and Paranat 2007). ASMs were appointed by the village head and often reflected local social hierarchies and political factions.

Over the four decades of their existence, ASMs have undergone considerable debate and change in their roles and effectiveness.[9] Into the twenty-first century, female ASMs have become dominant in number, and decentralized administration has given them a more substantial role. In 2007, of the almost 800,000 ASMs throughout the country, 70 percent were women, whereas in 1993 the ratio was 1.76 women to 1 man (Komatra and Paranat 2007).

In 2003 the Ministry of Social Development and Human Security instituted a system of home care for the elderly, designating Elderly Home Care Volunteers (otherwise called elderly volunteers, in Thai *aasaa samak phuu suung ayu*, or *aw phaw saw*, hereafter APS), modeled on the earlier ASMs of the Ministry of Health. This system was piloted in two

9) ASMs have often been objects of criticism (Kauffman and Myers 1997; Kowitt *et al.* 2015). It has been pointed out that they constitute and reinforce the local hierarchy, and especially since 2010, volunteers have been criticized as acting out of self-interest as they began to receive a monthly allowance of 600 baht—not as salary but to support their activities. Indeed, they can be mobilized politically since they are by definition able to go into the intimate space of each household. Since they are assigned from above (usually the village head), and now that they receive an allowance, it is rather contradictory to call them "volunteers." It was after the Indian Ocean tsunami in 2004 that citizens began to provide assistance on their own initiative, and the words "volunteer" and "volunteerism" became quite popular in Thai society. Those who participated on their own initiative began to call themselves *jit aasaa* (volunteer spirit) to differentiate themselves from the designated Village Health Volunteers (ASMs).

provinces from each of the four regions, and by 2013 the APS project for the elderly covered every district in the country. Some of the APSs are chosen from among ASMs, many of whom are younger elderly and/or caregivers for their own family members at home. Each APS volunteer is assigned five housebound or bedridden elderly persons and is expected to visit, give advice and encouragement, and provide knowledge and information.[10] The APSs connect the local administration and hospital with each household, relaying information and providing support (see next section).

In 2008, with the revision of the second national plan on the elderly, a *phuan chuai phuan* (friends helping friends) program[11]—a system of mutual assistance at the community level—was initiated in the senior citizen centers. Both ASMs and APSs were mobilized to provide integrated community-based long-term care (Worawet *et al.* 2014). The annual main budget derives from the Tambon Administrative Organization, while the budgets for specific activities derive from the tambon health fund initiated in 2006 (expanded nationwide by 2011 with support from the National Health Security Office).

As we have seen, the primary actors in executing elderly policy at the community level were local elderly clubs, district hospitals and village-level health promotion hospitals (formerly clinics),[12] volunteers (both ASM and APS), and the Tambon Administrative Organization.

Regarding health more generally, a National Health System Reform initiative was begun in 2000. It included creating a knowledge base for reform, mobilizing civil society, and creating a legal framework (Komatra 2008; Kawamori 2009). Led by the Health Systems Research Institute (founded in 1992 under the Ministry of Public Health), it

10) Their jobs are designated as follows: (1) making home visits, (2) overseeing diets, (3) taking care of medicine, (4) helping with exercise, (5) providing transportation to the doctor, (6) bringing the doctor home for treatment, (7) taking the elderly to join events in the community, (8) arranging for relaxation outside the house, (9) helping the elderly join in religious activities, (10) providing assistance in adjusting living conditions inside the home to be more suitable, (11) forming groups of elderly to conduct activities, (12) providing information to the elderly and their families, (13) advising the elderly when they have a problem, (14) providing knowledge to the elderly about accessing their rights, (15) providing information concerning services that are beneficial to the elderly, (16) coordinating with authorities that provide help to the elderly, (17) collecting data, (18) following up on problems encountered, (19) helping to take care of errands or doing errands on behalf of the elderly, and (20) conducting activities that are beneficial to the elderly (Worawet *et al.* 2014).

11) This was preceded by a similar program with the same name among people with HIV (Tanabe 2008b, 176), where home visits that included advice and gifts of food, etc., were carried out by people with HIV.

12) Located in the tambon, they were in contact with the district hospitals and involved in primary health care.

aimed to form networks among civil society and interest groups as well as local administration, connecting them to a framework of knowledge, technology, and governance for reconstructing the health system and reconsidering health conceptualization and health-related policies hitherto dominated by the specialized knowledge of modern medical professionals.[13] Toward this end, citizens of all levels—including NGOs, researchers, religious leaders, private enterprises, various associations, and local administration—were invited and mobilized with the goal of revising the legal system basic to health. Self-responsibility and management were emphasized in the making of a healthier nation. Behind this was the awareness that Thailand was undergoing an epidemiological transition from infectious diseases to non-communicable lifestyle diseases, extended average life expectancy, and soaring medical expenses. Health promotion on the individual level led to an increased awareness among Thai citizens of vital indices such as blood pressure and body fat percentage.

The Thailand Health Promotion Foundation (popularly called *saw saw saw* from its acronym or "ThaiHealth")[14] was founded in 2001 and the National Health Security Office in 2002. Health promotion programs for elderly constitute an important part within this movement, and health- and elderly-related projects are supported by such newly instituted quasi-government agencies. The local administration at the tambon level receives budgetary support by applying to these agencies. Since the foundation of ThaiHealth, some budgeting related to health promotion and elderly care has been distributed on an application basis to the tambon level, which allows local residents to formulate new activities and networks. Various policy-based schemes become open opportunities for budget application at the tambon level. One could say that the administrative decentralization that began in the 1990s[15] was a turning point in the biopolitics of Thailand.

In 2007 the Thai National Health Act was passed. From around this time, awareness spread regarding food, folk medicine, exercise, and various such health-related issues, and health-related public discourse was reinforced. Some were aimed toward the

13) Many of the medical professionals involved in the institute and the reform were bureaucrats from the rural medical doctors network who were also promoting the community approach in medical practices for the grassroots (Kawamori 2009).

14) Founded in 2001 under the Thai Health Promotion Act and funded by "sin tax" (tax on tobacco and alcohol) by the Ministry of Health as well as nongovernment specialists as an "autonomous state agency," it boasts of being the first of its kind in Asia, an autonomous quasi-government organization. It has been known for its vociferous nationwide anti-smoking and other health-related campaigns with moral overtones. For an overall view of Thai health promotion/prevention funding, including ThaiHealth and the National Health Security Office, see Watabe *et al.* (2017).

15) Put in motion by the Tambon Administrative Authority Act (1994).

coexistence of varied forms of medical knowledge, including Thai traditional medicine and various types of local medicine that are adopted in elderly care activities. Health policies now have come to emphasize the responsibility of communities, civil society, and individual citizens rather than relying solely on medical specialization.

To sum up, while the Thai state allegedly leaves all responsibility for elderly care in the hands of the "family and community," the elderly clubs and APSs that lead the local scene in elderly care actually constitute nationwide systems of governance. Seen in this light, both public health and elderly care are, in a sense, not only ends in themselves but also ideal tools by which governance can reach the grassroots. Health and medical policy has, in modern times, become the most effective means of governance in Thailand, enhancing the state's governing power under emerging concepts of health at the grassroots into the twenty-first century. Community becomes an effective instrument in biopolitics, and increasingly so in the present century. Health-related policies and institutions, such as elderly clubs and volunteers, are governance processes by which state power feeds into local practices, in the mutual on-the-ground daily relationship between the state and community.

How, then, is elderly care actually practiced on the local scene? We will now look into this through the case of a Northern Thai peri-urban district.

III Case of Tambon Y in S District

This section introduces the case of Tambon (subdistrict) Y in S District, Chiang Mai Province. S District is about 25 kilometers away from Chiang Mai City. It is rural but within commuting distance. It has 5,500 households with a population of 13,000, of whom 3,000 are elderly (amounting to 23.1 percent, which is quite a bit higher than the national average of 13 percent). In the Thai administration, elderly are classified into three primary groups: the bedridden (*tit tiang*), who constitute 1.56 percent of the elderly in S District; those who stay in their homes (*tit baan*), 5.37 per cent; and the socially active (*tit sangkhom*), 93.05 percent. In this district, elderly activities are designed primarily according to these three categories.

Elderly activities in S District began in 1989, when the village-level elderly club was founded by the head of the local cooperative. In 1999 the club was publicly registered with the provincial branch of the Senior Citizens Council of Thailand, under the guidance of the district hospital. Subsequently, the district elderly club came under the charge of the original founder's wife, Mae B (Mother B, as the villagers call her), an 84-year-old former primary school teacher. In 2007 the elderly club's funding from ThaiHealth

increased,[16] so under the *phuan chuai phuan* program the elderly club, together with the hospital and the local administration, was able to initiate APS volunteer activities. The budget from ThaiHealth was then taken over by the tambon administration. Below, we shall take a look at the activities at the time of my fieldwork in 2016.

Elderly School for the Socially Active

Activities for the socially active elderly began in 2012 as a "school for the elderly" (*rongrian phuu suung ayu*). The school holds classes every Friday at the tambon meeting center. Around 20 participants, mostly women, gather weekly. They sit at several tables making handicrafts, then gather in the hall for aerobics and exercise or dance, after which they listen to lectures and talks. After sharing lunch prepared by volunteers, they disperse. The handicrafts are sold at various local events. Mae B leads the participants, who are former teachers and/or wives of local administrators, i.e., mostly rural and suburban middle-class women.

Elderly schools of various types have become popular in Thailand in the current decade. They have been founded in many localities, with varying formats and sizes. Membership ranges from 40 to a few hundred, and activities include physical activities, handicrafts, excursions, and/or lectures and classes. The management of these schools also varies in the way the administration and civilian members connect.

To demonstrate the variation, I will introduce a case from Tambon D, north of Chiang Mai City, which was the liveliest of the several elderly schools I visited. In 2014, C, a community development worker in the tambon, mobilized volunteers, mostly themselves elderly people who were retired teachers. Participants were not only former white-collar professionals but had also been laborers, traders, and farmers. This tambon (population 15,000) has an elderly population of 1,700 (11.5 percent of the population, of whom 70.29 percent are socially active, 28.46 percent housebound, and 1.25 percent bedridden). Every week they gather at a meeting hall in a local temple. In Tambon D, the elderly school is called a "university." The class has a familial and lively mood throughout. An open-air bus (a repurposed truck) starts from the town hall and makes its rounds from house to house picking up elderly participants and taking them to the temple. As each elderly participant steps onto the bus, there are cries of welcome, and C leads the jovial mood.

16) From 2011 to 2013, the tambon elderly club was awarded 560,000 baht for its home care program. Through the founding of the rehabilitation center and the elderly school in 2013, Tambon Y was elevated to "advanced-region" status in terms of its public health and home care. As a result, from 2015 to 2017 ThaiHealth and the Senior Citizens Council of Thailand selected Tambon Y to join the potential development plan for elderly clubs promoting active aging (*phaawa phrutipalang*).

C explained that the purpose of the school was to gather the socially active elderly to form a network, and to provide them with a place for economic activities, such as selling vegetables and various products, and social and cultural activities, while fostering a spirit of volunteerism. By joining in such activities, the elderly become conscious of helping other elderly who are housebound or bedridden and activating the lives of the elderly in the locality. As with Tambon Y above, they mobilize ASMs and APSs, the hospital, local administration, civilian groups, and elderly club members. The curriculum at the school comprises four subjects: religion (Buddhism), health (bodily, mental, and social), recreation, and social welfare. Every semester the school issues a certificate of completion, although "students" can enroll as many times as they like. When participants arrive at the school, volunteers measure their blood pressure, weight, height, and pulse and hold simple health interview sessions to record their health status. Then, out in the yard, they gather to observe the raising of the national flag. Once they return to the hall they start prayers and sutras, followed by the monk's sermon, and then classes begin, mixing physical exercises, lectures, and much fun and games.

A 74-year-old woman said the elderly school was the highlight of her week. She lives at home with her family but often feels left out, as she is slow to catch onto the conversation, but here she feels younger. By the end of the school gathering, participants all look animated and satisfied.[17)]

These elderly schools promote the global ideal of "active aging"[18)] (*phaawa phrutipalang*),[19)] encouraging the elderly to get out of the house and be active in the community. What is notable, however, in the case of Tambon D, is that the school promotes social activities and networks among the elderly, so that rather than simply promoting individual health, it encourages the formation of elderly networks of mutual assistance.

Rehabilitation Center for the Housebound

Coming back to S District, the district's most notable elderly activity is the rehabilitation center, which was founded before the elderly school. In 2007, the local elderly club applied for funds from ThaiHealth, adding to its budget to train local APS volunteers for

17) During visits to similar elderly schools and elderly clubs within Chiang Mai City and its outskirts, I met many middle-class women who participated in more than one such clubs and schools set up on different days of the week to keep themselves busy.

18) Active aging as defined by the WHO is "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO 2002, 11). There have been criticisms of active aging, from both industrialized countries for its neo-liberal overtones, and later aging regions questioning its applicability (Moulaert and Biggs 2012; Van Dyk *et al.* 2013; Lamb 2014).

19) There are different Thai terms for "active aging," such as *phruto phalang*, *Suung wai yang mi sukhaphaap*, and *phuu suung ayu thi mii sakhayaphaap*.

home care. When the state administration chose 10 elderly clubs from each province to enhance home-care activities, Tambon Y was one of the selected localities in the province. The plan was to hand over budget responsibility to the local administration after two years. With this funding, the elderly club, with the support of hospital staff and the local administration, first trained 30 members as home-care visitors. These members were recruited from among the ASMs as well as APSs. These trained members began to visit the bedridden and housebound elderly, together with other club members, at least twice a month. However, after a few years of this, Mae B, the club's representative, consulted with Dr. P, a former professor and medical doctor at Chiang Mai University—who was an executive member of the National Elderly Committee and a representative of the northern region—and decided that rather than merely visit house by house, they might gather the elderly in one place for rehabilitation activities, at least those elderly who could be persuaded to step out of the house. Thus, in 2010 Mae B consulted with the abbot of a local temple and founded the rehabilitation center using the temple meeting hall. Every Wednesday morning the center opens for a gathering supported for the first two years by ThaiHealth funds, and subsequently by the local administration. In the afternoon, APS volunteers visit the housebound elderly. Mae B and her husband's connection with Dr. P could have been a factor in the tambon and district's success in being chosen as a model case and receiving funds. The activities at the rehabilitation center are supported by the local administration and other donations, and the management is assisted by the district hospital. The main purpose is to bring the housebound elderly out for physical rehabilitation activities so that they become as self-supporting as possible.

At the rehabilitation center, the housebound elderly gather every Wednesday at around 9am. Also in attendance are ASMs, APSs, nurses, medical therapists, Thai family doctors, the driver of the "taxi" (a cart attached to a motorbike hired by the center to transport the elderly), a masseuse, and other members of the district hospital. The elderly have at their disposal a variety of herbal treatments, massages, and locally devised exercise equipment. They can attend advice sessions with hospital staff as well as traditional specialists. Participants choose their own activities and talk to each other as well as the specialists. Every week there are about 30 to 40 elderly and disabled participants. They are able to rent wheelchairs and other equipment, as well as various exercise appliances. Some of these have been purchased and others donated. Some are brought in from similar centers in other districts that are known for their rehabilitation activities.[20)]

20) There were frequent mutual visits in the name of training, to observe other successful local organizations with similar programs. Tambon Y also received many observers from as far as the northeastern provinces.

Each participant does his or her own exercises, and then from 10:30am there is communal activity.

Everyone is seated facing the front of the hall, where the Buddha statue is situated, and the elderly leader Mr. W begins to chant sutras. The attendees participate in whatever posture that their bodies allow, some standing, some seated on the ground or on chairs, and some lying down. After the exercise session, announcements are made, guests are introduced, and information is disseminated, and there is a short talk on health issues. This is followed by lunch, prepared by volunteers along with Mae B, with carefully chosen food and organic ingredients for a health-conscious menu using locally produced vegetables. After lunch the participants go home: some are picked up by their family, some walk slowly using walking aids, and others make use of the "taxi."

Mr. W, the jovial man leading the chanting, is 64 years old. He used to work as a guard for a company in Chiang Mai but became bedridden after a traffic accident. He recounted to us how he became a regular participant at the center. After the accident, he was taken to the district hospital, and after returning home he received regular visits from the hospital medical team. The team members realized that he had not only physical but also mental problems. He had iron bars placed in his legs, so initially he was unable to walk and also suffered from severe depression. He needed help in his daily life, but his wife had left him, his son was in prison, and he was left to fend for himself, relying on help from his neighbors. L, a hospital nurse and public health worker, repeatedly invited him to come to the rehabilitation center. Initially he was unwilling and lacked the confidence to leave his house, but the team brought him out for rehabilitation activities a few times. Gradually he recovered, and once he learned how to help himself he became more mobile. His mental state improved, and he was able to live on his own. He said, "If it hadn't been for Nurse L and the team, I would have been dead by now." Currently, he participates in rehabilitation center activities, takes care of other participants, leads the sutras, and works as a volunteer.

Another regular participant, 74-year-old Grandma A, who always sits on the bed nearest to the front altar, recounted her story. She used to work at the village co-op, but then she was afflicted with Parkinson's disease and became bedridden. She was socially isolated and did not want to meet anyone. Since her family members all worked during the day, they left her necessities around her bed so she could spend the day on her own. Her niece, who is an APS volunteer, consulted Nurse L at the hospital and persuaded Grandma A, who was initially unwilling, to go to the rehabilitation center. She took Grandma A in the communal "taxi," and Grandma A began to go regularly. Gradually she regained her strength and progressed from bedridden to housebound, moving about the house on a wheelchair. Now she willingly comes to the center, enjoying the oppor-

tunities to meet and talk with other elderly people, and she joins in the exercises in her own way. Not only physically, but also mentally and socially, the center's activities contributed to her recovery.

These stories suggest how initially some elderly were unwilling participants, but through prompting and soliciting and after initial tentative participation where they experienced mental and physical improvement, they became active participants in the center's activities, assisting and volunteering where able. The major role of the rehabilitation center is to bring more elderly out of the house and connect them with one another.

The hospital team emphasizes how the center's activities have helped to reduce the percentage of bedridden and housebound elderly. Participating in the center's activities gives the elderly strength, especially through meeting and exercising with others who also spend most of their days alone at home. This is the primary reason they want to come here. They find their own solutions and, in a way, perhaps even discover a path to transformation in the presence of other elderly. While the experience is individual, it would never happen if there was no communal gathering. While the purpose of the center's activities is to provide effective rehabilitation exercises and advice, the actual effect is wider, providing social and mental care. It nurtures a new communality beyond the simple physical effects of the rehabilitation. In this sense, I apply the term bio-social communality (Rose and Novas 2006, 442) to understand what is taking place here.

Supporters of Elderly Activities

There were several regular participants who showed up for all the elderly activities in S District. They were the elderly club leaders, core members among the volunteers, district hospital personnel, and public health specialists in the local administration. These people, all of whom happened to be women, worked in close coordination with each other, with Mae B functioning as the nodal person.

Nurse L, a public health specialist at the district hospital, is herself a resident of Tambon Y, and her mother is also a housebound elderly. Nurse L has worked as a public health specialist for over 30 years and is a leading figure in all of the district-level activities for the elderly. There are also young elderly volunteers who are former pupils of Mae B, such as V (64 years old). V is a former primary school teacher and an APS. She participates in the rehabilitation center's weekly activities and the elderly school. As the accountant of the elderly club, she sits weekly at the hospital club office to receive the club members' annual payments toward the mutual accumulative aid fund, which is used primarily for funerals. H, the younger social worker in Tambon Y's local administration, also participates in these activities and is in close contact with Nurse L and Mae B.

Mae B, as the head of the elderly club, spends her time and energy in the district's

elderly activities. She lives with her bedridden 86-year-old husband (the original founder of the elderly club) and her daughter's family. Many of the volunteers helping in the activities are her former pupils, so there is a strong network formed around her that functions as the engine for these activities. She was born in one of the established local families, and many of her relatives are high-ranking officials or professionals. She was educated in Bangkok, a rarity at the time of her youth, and both she and her husband have long been involved in the elderly club and are close to Dr. P. Through their joint efforts, S District has been receiving budgetary support as one of the model tambons and districts in the north for piloting projects. Mae B took over from her husband the role of elderly representative of the district, and she serves as the secretary of the subdistrict elderly club. She is often called upon by the local administration to attend meetings at all levels, from the district down to the village. She participates in all activities—including lunch preparation—at the rehabilitation center, which was founded by her own initiative. She has a wide personal network, is a good orator, and has a strong personality. She said, "We want the elderly here to be high quality. That is, rather than be *phaara* (a burden), they should have *palang* (power)." In an interview, she clearly stated that she advises everyone to be an elderly person with quality (*phuu suung ayu mii kunnaphaap*), and that the three factors contributing to this are exercise, food, and *aarom* (affect or emotion). This is perhaps her own version of the active aging concept. At 84, she works hard and is the nodal point of the network and the emerging communality. No doubt there are political factions involved in the formation of such a network, and she is definitely at the top of the traditional local social strata, yet the members involved in the activities cross political and other divides. Furthermore, the personnel involved are fluid, never stable or permanent. Since Mae B has a bedridden husband, she is aware that she herself may one day be in need of care.

Thus, care at the district and village levels activates older relationships and existing traditional ties upon which are formed new ties and networks. Locating the rehabilitation center at the temple, a feature of the traditional social-cultural base, makes it easy for the elderly to gather. Mae B is somewhat like a patron figure of the old system, but centered around this figure is a new network of civilian groups, district hospitals, the administration, as well as the temple, all of which work in coordination without boundaries. The elderly school and the rehabilitation center both provide an impetus for the elderly to step out of the household and their daily lives and motivate and encourage them to become not only physically but also mentally and socially active.

It should be noted that a significant number of active members supporting the community elderly care, as we have seen, are themselves elderly. This suggests that many of the top-down policies and projects are taken on not only by local administrators and

hospital staff, but also by local elderly, who in turn mobilize other elderly. Such elderly activities are supported also by professionals from the hospital, administrators from the local tambon office, volunteers (both official and unofficial, such as the "taxi" driver), local traditional healers, and monks on occasion. The knowledge that is exchanged is varied, from biomedicine to traditional medicine. Another notable factor is that much of the work is shouldered by local women (e.g., paid administrators, hospital workers, volunteers, and unpaid local leaders).

Bedridden Elderly and Home Care: On the Interface with Family

One afternoon after the rehabilitation center activities, I joined a team of elderly volunteers and Nurse L to visit a housebound elderly couple not far from the temple where the center activities are held, bringing some home-made sweets as gifts. Grandma T, 83 years old, and her husband, 79, live with their adopted daughter and her son. The daughter works as a nurse's aide in a hospital near Chiang Mai, and her son is in high school; so during the day, the older couple need to take care of themselves. Grandma T broods that her walking aid is too heavy and makes her feel exhausted. The visiting team members propose exchanging it for a lighter one from the rehabilitation center rental facility. They measure Grandma T's blood pressure and talk to her about her daily life. Upon their request, she reluctantly rises and walks with the walking aid with a little difficulty. The team members watch and encourage her, telling her she is doing well and that she should visit the rehabilitation center (which is a few hundred meters away) with her husband. Nurse L compliments her that her eyes, ears, and mind are good and strong, telling her she would improve even more if she could come to the center. Grandma T lights up on hearing these words. She says, with tears in her eyes, "No one told me I could do things like you say. But if you tell me so, I think I can, and I'll try." A few weeks later, we found her at the rehabilitation center with her husband.

On another occasion, I joined a home care unit visiting 10 households in two days.[21] In some households there were family members, especially daughters, looking after the

21) While volunteers had collected data on the households of the elderly, in 2017 the district received support to renew and refine the existing data on bedridden elderly needing care so that further necessary measures could be taken. A team of professionals (hospital staff, namely, the family care unit comprising social welfare workers and nurses) together with volunteers made rounds to the bedridden cases for this purpose. The economic strata of the households were varied, from middle class to impoverished (at least as judged from observation). The main purposes of this particular round of visits were to make inquiries about the elderly's physical abilities, memory and mental abilities, medicine administration, meals, living conditions, sleeping quarters, physical accessibility inside the house (steps, slopes, etc.), and posture during the day, and to give advice on these aspects. The team used a checklist developed in Japan and provided by the Japan International Cooperation Agency.

elderly, while in 4 of the 10 cases an elderly person was looking after a bedridden spouse—at least on the day that we visited.[22)]

The case of Grandma K and her husband provides some insight into the kind of stimulus such visits can bring to family care. Grandma K is 89 years old, and her youngest daughter is the main caregiver. Due to glaucoma, her eyesight is very weak, so she stays immobile on a bed in the living room of her daughter's newly built house. Since her eyesight began to fail before she moved into the new house, she is afraid to move around by herself and depends on her daughter. Her daughter places drinking water near her bed, and Grandma K calls her when she needs to go to the bathroom. Grandma K has no other health problems and has a clear mind and memory. During our visit we found out that her husband, 90-year-old Grandpa P, lives in the old house, which is in the same compound. He is completely blind and refuses to move to the newly built house as he feels confident moving about only in the old house, where he spent many years of his life while his eyesight was good. He spends his days on a bench in front of the old house, and at night he goes up a ladder to sleep. Since his eating habits are different from Grandma K's, he is taken care of by an older daughter who lives in the neighborhood.

The distance between the new house and the old one is only about 30 meters, yet Grandma K and Grandpa P have not been together for three years—since the building of the new house. Our team persuaded Grandpa P to visit Grandma K in the new house. Initially he refused, saying that he had not stepped out of the old house since he lost his eyesight and that even the 30 meters was too far for him, which was why he had refused to go for three years. There were surely other reasons unbeknownst to us for his stubbornness on this matter, and his daughters had not been able to persuade him, so the couple had been spending their lives apart in these two houses. Our team encouraged him to attempt the walk and accompanied him to the new house, supporting him on both sides. When he safely reached the new house, the couple sat side by side on Grandma K's bed and held hands with tears in their eyes. It may have been that there were some family issues, and the couple's vision problems, their own fears and refusals, and the caregiving daughters' concern for efficient care had resulted in the three-year separation. As the visiting team brought the couple together, the daughters discussed how they

22) According to the district record, the distribution of caregivers for the elderly was as follows: those who were capable of taking care of themselves (88.5 percent); those who needed care but did not have a regular caregiver (1.1 percent); and of the remaining 10.4 percent, those cared for by daughters (40.5 percent), spouses (28 percent), sons (12 percent), a child's spouse or niece, nephew, or grandchild (10.2 percent), siblings or other kin (5.2 percent), and others (4 percent). Even those who lived with their children were cared for during the day by their elderly spouses.

might bring their parents together during the day from then on.

In both of the cases above, the elderly continued to live in their habitual closed circle of relationships and practices, where the law of inertia seemed to take hold in the family care setup. The team's visit broke into this closed circle. While I had no chance to discuss the visit itself with the receiving family members, I can say at least that the visit intervened in the habitual circle of care, even if temporarily. I was told a few months later that Grandma K had an eye operation after which she was able to regain her eyesight. In this way, family care was activated through the interface of interaction with the visiting home care team.

The team visit was an occasion to access the household and not only assess the conditions of the elderly but also give advice to caregivers. Daily care is, after all, in the hands of the regular caregivers in the family, while volunteers and occasional visits such as this one constitute an interface with the outside world. The visits bring opportunities to change and improve the daily care routine in the household by creating an interface between family care and the outside, and acting on it.[23)]

IV Discussion

As we have seen, when Thai state policies and programs emphasize community in elderly care, it is enabled by the mobilization of apparatuses such as local volunteers, elderly clubs, and other measures that have been instituted nationwide in every locale. Health promotion campaigns have raised health consciousness nationwide to a level totally unexpected prior to the 1990s. Various programs are supported financially and morally by state institutions such as ThaiHealth and strengthened by decentralized administration. Thai governmentality in elderly care has thus constructed a national network of professionals and administrators as well as civilian networks, promoting national health consciousness and disseminating funds. While the network was formed in response to governance from above, from there it was able to draw upon local participation and initia-

23) Admittedly, among the 10 cases we visited, there were extreme caregiving situations too, such as a wife immobilized in bed with an injured backbone, taken care of by her husband who suffered from dementia. In another case, an elderly man was taken care of by a daughter who had chosen to place him in a child's pen due to his faltering legs and dementia, since she could not keep watch over him 24 hours a day. In two cases, elderly wives were taking care of their husbands during the day. Unable to lift their husbands to a seated position, they were feeding them lying down. The team gave advice and encouragement to the caregivers on how to administer medicine, how to feed, what posture was optimal, and how to arrange the bed, etc., encouraging the elderly to stand up and walk whenever possible.

tive. Elderly care is thus becoming—and will increasingly be—a crucial locus of biopolitics, along with other public health issues, through the everyday lives and health of the elderly population. Newly designated APS volunteers constitute another attempt at social welfare penetrating not only the community but also the household level, enhancing surveillance and normalization of elderly care (Biggs and Powell 2001).

We have seen how this operates on the local level. Top-down programs have fostered local networks founded on existing ties. In this aspect, community is a locus for enhancing the elderly's self-management through their own participation in elderly schools and volunteers' home visits. Moreover, as we have seen, where networks are thus formulated, they nurture emerging communality and empowerment among the gathered elderly.

How sustainable is this network, and who is supporting it? The success of top-down policies depends on mobilizing local inhabitants, who, as we have seen, are mostly local women. Being well connected with the everyday lives of residents, tambon level officials, social workers, and nurses—especially women—are in a position to form and be part of civil society networks.[24] So far these networks are sustainably based on the newly formulated connections that have fed on existing local social relationships.

In S District, at the nodal point of the network are local figures such as Mae B, whose position in local society suggests that her family has always been at the top of the local social hierarchy. The activities at the elderly club, the district, and the tambon surrounding the elderly could be said to be feeding on the blessings brought about by that social status. Mae B's connection with Dr. P is an important link to the national network of medical professionals in key positions in the elderly care program, and this facilitates the effective management of the public care network and application for funding from ThaiHealth. Traditional local patron-client relationships and various local ties, especially the women's networks, are reactivated and reformulated while new networks are formed, connecting them to medical as well as administrative institutions. The dynamism between state governance and local society is what has formed this emerging network. The local elderly club is managed by people such as Mae B and others in her network, behind which are both the nationwide elite organization of the Senior Citizens Council of Thailand and its branch, as well as the local network.

The network, especially in the rehabilitation center, is indeed based on local social

24) After administrative decentralization, 65 percent of tambon-level officials in the country are women. They constitute a large portion of the local staff working on public welfare and health-related activities, together with volunteers and networks of elderly people, who are also in large part women, as I observed in my fieldwork (see also Etoh 2019). Juree Vichit-Vadakan (2008) analyzes local women's political leadership after the localization of administration.

ties and initiative. Mae B herself is quite advanced in age. She is extremely active and energetic in the center's activities but is nevertheless aware that at any point she might become housebound or bedridden, and she herself, along with her family members, is taking care of her bedridden husband. Participating in local elderly activities is, for her, deeply connected to her own daily life and future. The volunteers surrounding her are younger elderly women who also are not participating simply out of sympathy and compassion. Rather, they also provide care in their family or neighborhood while aware of their own near future. The activities are in keeping with the recommended state program where elderly help other elderly, and as they do so, they are able to support each other physically, mentally, and socially. Mae B's emphasis on exercise, food, and emotion is an important aspect of biosocial communality that emerges among the elderly at the interface of family care and community-level care.

By taking a step out of their own domestic sphere and family life to join in elderly schools and rehabilitation centers, participants find their daily lives reactivated. Those coming to the rehabilitation center seek mutual interaction through which they find connectedness in life, acquiring power that they cannot find in their daily family care. The elderly participants find that they are empowered and transformed through joining in the communality.

While the activities conform to the global active aging ideals, the elderly participants are much more concerned with finding connections that make them feel confident. It is not the self-managing, self-responsible individual who comes to the fore here, but rather elderly individuals who find renewed strength through intersubjective relationships with other elderly folks. In turn, at home with the receiving of volunteers and home care teams, daily care practices are modified and reactivated. The care and cooperation or collaboration reactivate family care. Thus, through these activities, the interface of the intimate family space with community-level activities is reactivated. Participating elderly and caregivers each have their difficulties and distress over their own conditions, with their families, etc., and find themselves enlightened and transformed through the communal activities, where they find ways to transform themselves.

In S District, housebound elderly become involved in the rehabilitation center activities, and socially active elderly are mobilized to visit housebound and bedridden elderly. At the interface of the intimate family caregiving situation and community activities, we see empowerment and transformation occurring through various interactions, the process of which I have termed biosocial communality. Meaning is formed in shared activities of care, where the issue is not so much individual autonomy, self-management, or responsibility, nor a return to traditional intimate spaces for care such as family, but a newly formulated communality. This biosocial communality locally forms an effective

interface from the bottom up, between the family care space and the persons and network outside.

Concluding Remarks

Earlier industrialized parts of the world are now seeking alternatives in communitarianism and socializing care. In the neoliberal politics ascendant since the late twentieth century, the community has been a most useful policy-bearing institution, where moralistic demands are made by idealistic discourse, so that local members experience the community as a "trapdoor" imposed by the state (Herbert 2005).

Thailand came later on the scene, although the aging process is taking place rapidly and simultaneously with industrialization and economic development. Experiencing aging while still midway in economic development might mean a severe burden as well as an opportunity. In spite of the rapid rate of aging, we have seen that so far rather than a trapdoor, there is potential for the emergence of biosocial communality at the interface of family and society, in the process of both top-down governance and bottom-up networks.

We need to be wary of overburdening locally active women, and about the existence of elderly at home in dire conditions beyond the reach of such care activities and that care in the family is already precarious in many cases. Even so, there is also the potential for communalizing practice in its supporting network. This might lead to the enhancing of new and old social potential in Thai society. Therein, we find the possibility of formulating governance into the future while also nurturing communality.

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Bibliography

Agrawal, Arun. 2001. State Formation in Community Spaces: Decentralization of Control over Forests in the Kumaon Himalaya, India. *Journal of Asian Studies* 60(1): 9–40.

Banlu Siriphanich บรรลุ ศิริพานิช *et al.* 1996. *Chomrom phusungayu: Kansueksa rupbaep lae kandamnoenngan thi mosom* ชมรมผู้สูงอายุ: การศึกษารูปแบบและการดำเนินงานที่เหมาะสม [Elderly club: Study on the proper model and operation]. Bangkok: Senior Citizens Council of Thailand.

Biggs, Simon; and Powell, J. L. 2001. A Foucauldian Analysis of Old Age and the Power of Social Welfare. *Journal of Aging and Social Policy* 12(2): 1–20.

Chatthip Nartsupha. 1999. *The Thai Village Economy in the Past*. Translated by Pasuk Phongpaichit and Chris Baker. Chiang Mai: Silkworm.

Councils of the Elderly of Thailand. 2008. *Situation of the Thai Elderly 2008*. Bangkok: T.Q.P. Company Ltd.

Etoh Sae 江藤双恵. 2019. "Josei ni yasashii komyunitei fukushi" wa kano-ka 「女性に優しいコミュニティ福祉」は可能か [Is "community welfare that is kind to women" possible?]. In *Tonan Ajia niokeru kea no senzairyoku* 東南アジアにおけるケアの潜在力 [Potentialities of care in Southeast Asia], edited by Yoko Hayami 速水洋子, pp. 411–441. Kyoto: Kyoto University Press.

Hayami, Yoko. 2012. Introduction. In *The Family in Flux in Southeast Asia: Institution, Ideology, Practice*, edited by Yoko Hayami, Junko Koizumi, Chalidaporn Songsamphan, and Ratana Tosakul, pp. 1–26. Chiang Mai: Silkworm.

Herbert, Steve. 2005. The Trapdoor of Community. *Annals of the Association of American Geographers* 95(4): 850–865.

Juree Vichit-Vadakan. 2008. A Glimpse of Women Leaders in Thai Local Politics. In *Women and Politics in Thailand: Continuity and Change*, edited by Kazuki Iwanaga, pp. 125–167. Copenhagen: NIAS Press.

Kauffman, Karen S.; and Myers, D. H. 1997. The Changing Role of Village Health Volunteers in Northeast Thailand: An Ethnographic Field Study. *International Journal of Nursing Studies* 34(4): 249–255.

Kawamori Masato 河森正人. 2009. *Tai no iryo fukushi seido kaikaku* タイの医療福祉制度改革 [Medical welfare system reform in Thailand]. Tokyo: Ochanomizu Shobo.

Kemp, Jeremy. 1991. The Dialectics of Village and State in Modern Thailand. *Journal of Southeast Asian Studies* 22(2): 312–326.

Knodel, John; Bussarawan Teerawichitchainan; Vipan Prachuabmoh; and Wiraporn Pothisiri. 2015. The Situation of Thailand's Older Population: An Update Based on the 2014 Survey of Older Persons in Thailand. Population Studies Center Research Report No. 15–847. Ann Arbor: Institute for Social Research, University of Michigan.

Komatra Chuengsatiansup. 2008. *Deliberative Action: Civil Society and Health Systems Reform in Thailand*. Bangkok: National Health Commission Office.

Komatra Chuengsatiansup โกมาตร จึงเสถียรทรัพย์; and Paranat Suksut ปารณัฐ สุขสุทธิ์. 2007. Asasamak Satharanasuk: Sakayaphap lae botbat nai boribot sangkhom thai thi plianpai อาสาสมัครสาธารณสุข: ศักยภาพและบทบาทในบริบทสังคมไทยที่เปลี่ยนไป [Health volunteers in the context of change: Potential and developmental strategies]. *Warasan wichai rabop satharanasuk* [Journal of health systems research] 1(3–4): 268–279.

Komatra Chuengsatiansup โกมาตร จึงเสถียรทรัพย์ *et al.* 2013. *Withi Chumchon Khrueangmue 7 chin thi thamhai nganchumchon ngai, daiphon, lae sanuk* วิถีชุมชน เครื่องมือ 7 ชิ้น ที่ทำให้งานชุมชนง่าย ได้ผล และสนุก [Community way: Seven instruments to make community-work easy, fruitful, and fun]. 11th edition. Nonthaburi: Suksala Books.

Kowitt, S. D.; Emmerling, D.; Fisher, E. B.; and Tanasugarn, C. 2015. Community Health Workers as Agents of Health Promotion: Analyzing Thailand's Village Health Volunteer Program. *Journal of Community Health* 40: 780–788.

Lamb, Sarah. 2014. Permanent Personhood or Meaningful Decline? Toward a Critical Anthropology of Successful Aging. *Journal of Aging Studies* 29: 41–52.

Malinee Wongsith; Siriwan Siriboon; and Achara Entz. 1996. Community Participation in Providing Care, Services and Activities for Thai Elderly. Preliminary Report. IPS Publication No. 244/96. Institute of Population Studies, Chulalongkorn University.

Mizuno Koichi 水野浩一. 1981. *Tai noson no shakai soshiki* タイ農村の社会組織 [Social organization in Thai villages]. Tokyo: Sobunsha.

Moulaert, Thibault; and Biggs, Simon. 2012. International and European Policy on Work and Retirement: Reinventing Critical Perspectives on Active Ageing and Mature Subjectivity. *Human Relations* 66(1): 23–43.

Nam, Illan. 2015. *Democratizing Health Care: Welfare State Building in Korea and Thailand*. Houndmills and New York: Palgrave Macmillan.

Piyakorn Wangmahaporn ปิยากร หวังมหาพร. 2011. *Phusungayu thai: Phattanakan choeng nayobai phakrat chak adit su patchuban lae naeonom nai anakhot* ผู้สูงอายุไทย: พัฒนาการเชิงนโยบายภาครัฐจากอดีตสู่ปัจจุบันและแนวโน้มในอนาคต [Thai elderly: Development of state policy from the past to the present, and the future trends]. Bangkok: Sripatum University Press.

Rabinow, Paul. 1996. *Essays on the Anthropology of Reason*. Princeton: Princeton University Press.

Rabinow, Paul; and Rose, Nikolas. 2006. Biopower Today. *BioSocieties* 1: 195–217.

Reynolds, Craig J. 2009. The Origins of Community in the Thai Discourse of Global Governance. In *Tai Lands and Thailand: Community and State in Southeast Asia*, edited by Andrew Walker, pp. 27–43. Singapore: NUS Press.

Rigg, Jonathan. 1994. Redefining the Village and Rural Life: Lessons from South East Asia. *Geographic Journal* 160: 123–134.

Rose, Nikolas. 2000. Community, Citizenship, and the Third Way. *American Behavioral Scientist* 43(9): 1395–1411.

Rose, Nikolas; and Novas, Carlos. 2006. Biological Citizenship. In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and S. J. Collier, pp. 439–463. Oxford: Blackwell.

Seri Phongphit. 1986. Introduction. In *Back to the Roots: Village and Self-reliance in a Thai Context*, edited by Seri Phongphit, pp. 13–21. Bangkok: Rural Development Documentation Centre.

Shigetomi, Shinichi. 2013. Development and Institutionalization of Communitarian Thought in Thailand. IDE Discussion Paper 423. http://hdl.handle.net/werr/1252, accessed July 30, 2019.

Suehiro Akira 末廣昭, ed. 2005. *Shinko kogyokoku no shakai-fukushi* 新興工業国の社会福祉 [Social welfare in newly industrializing countries]. Tokyo: IDE.

Tanabe Shigeharu 田辺繁治. 2008a. *Kea no komyunitei: Kita-Tai no Eizu jijo-gurupu ga kirihiraku mono* ケアのコミュニティ——北タイのエイズ自助グループが切り開くもの [Community of care: What the northern AIDS self-help group opens up]. Tokyo: Iwanami Shoten.

————. 2008b. Suffering, Community, and Self-Government: HIV/AIDS Self-help Groups in Northern Thailand. In *Imagining Communities in Thailand: Ethnographic Approaches*, edited by Shigeharu Tanabe, pp. 161–188. Chiang Mai: Mekong Press.

Ueno Chizuko 上野千鶴子. 2011. *Kea no shakaigaku: Tojisha shuken no fukushi shakai e* ケアの社会学——当事者主権の福祉社会へ [The sociology of care]. Tokyo: Ohta Shuppan.

Van Dyk, Silke; Lessenich, S.; Denninger, T.; and Richter, A. 2013. The Many Meanings of "Active Ageing": Confronting Public Discourse with Older People's Stories. *Recherches sociologiques et*

anthropologiques [Sociological and anthropological research] 44(1): 97–115.

Walker, Andrew. 2009. Introduction. In *Tai Lands and Thailand: Community and the State in Southeast Asia*, edited by Andrew Walker, pp. 1–23. Singapore: NUS Press.

Watabe, Akihito; Weranuch Wongwatanakul; Thaksaphon Thamarangsi; Phusit Prakongsai; and Yuasa, Motoyuki. 2017. Analysis of Health Promotion and Prevention Financing Mechanisms in Thailand. *Health Promotion International* 32: 702–710.

WHO. 2002. *Active Ageing: A Policy Framework*. WHO Non-communicable Diseases and Mental Health Cluster, Non-communicable Disease Prevention and Health Promotion Department, Ageing and Life Course.

Worawet Suwanrada *et al.* 2014. *Older Persons' Long-term Care in Thailand*. College of Population Studies, Chulalongkorn University.