

*Labor Markets and Social Policy in a Rapidly
Transforming and Aging Thailand*

Caring for Thailand's Aging Population



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Acronyms and Abbreviations

ADB	Asian Development Bank
ADL	Activities of daily living
ASEAN	Association of Southeast Asian Nations
CSMBS	Civil Servant Medical Benefits Scheme
DSDW	Department of Social Development and Welfare
IADL	Instrumental activities of daily living
LAO	Local administrative organizations
LTC	Long-term care
MoPH	Ministry of Public Health
MoSDHS	Ministry of Social Development and Human Security
MOU	Memorandum of understanding
NCE	National Committee on the Elderly
NGO	nongovernmental organization
NHSF	National Health Security Fund
NHSO	National Health Security Office
NSO	National Statistical Office
SOPT	Survey of Older Persons in Thailand
TEPHA	Thai Elderly Promotion and Health Care Association
TVET	Technical and vocational education and training
UCS	Universal Health Coverage Scheme
VHV	Village Health Volunteers

Foreword

This report is one in a series on strengthening social protection and labor market policies in Thailand in the context of aging and economic transformation. Other reports in the series provide an overview of the social protection system, analyze the labor market implications of population aging, assess Thailand's pension schemes, and evaluate the macro and fiscal implications of aging. The reports are:

- *Towards Social Protection 4.0: An Assessment of Thailand's Social Protection and Labor Market Systems;*
- *Aging and the Labor Market in Thailand;*
- *Pension Provision in Thailand;* and
- *The Macroeconomic and Fiscal Impact of Aging in Thailand.*

The report was written by Elena Glinskaya, Thomas Walker, and Thisuri Wanniarachchi. Pam Viriyataveekul provided excellent research assistance. Dr. Siriphan Sasat, Associate Professor in the Chulalongkorn University Faculty of Nursing, reviewed the draft and provided valuable advice to the team. The report was prepared under the guidance of Yasser El-Gammal (practice manager for Social Protection and Jobs, East Asia and Pacific Region), Philip O'Keefe (former practice manager for Social Protection and Jobs, East Asia and Pacific Region), Birgit Hansl (country manager for Thailand), Francesca Lamanna (task team leader), and Harry Moroz (task team leader). The team is grateful for the excellent advice provided by two peer reviewers: Emiko Masaki and Dewen Wang. Junko Onishi, Frederico Gil Sander, and Thomas Walker provided comments at the Concept Note stage.

Introduction

Thailand is the second-fastest aging country in the Association of Southeast Asian Nations (ASEAN) after Singapore, and it is growing old before it grows rich. Thailand has already made considerable progress in recognizing the ageing challenge and has initiated policy reforms and development programs to address it at both national and local levels. The 2012–16 National Economic and Social Development Plan and, more recently, the 2017–2036 National Strategy, underscore the welfare of older persons as a government priority. At the heart of Thailand’s approach is universal health insurance, supported by a community-based primary health care system with a reliance on volunteers. Thailand is now working to expand access to long-term care (LTC) at the community level as part of this volunteer-supported primary health care system.

Thailand’s progress in developing national policies and strategies for an ageing society are an instructive example of how to move from policy to practice. One objective of this note is to document Thailand’s experiences for the information of other countries following a similar development trajectory. Thailand has set up effective institutional arrangements for cross-sector coordination and built an effective framework for community-based volunteer aged care. Its focus on involving communities in LTC provision, through volunteer and time-banking schemes, may be a useful cost containment strategy for other middle-income countries that are getting old before they get rich. Notwithstanding its achievements to date, the Government of Thailand intends to go further in developing its aged care policy framework, specifically with regards to improving accessibility to LTC services and supporting growth of the private market for LTC. Therefore, the second objective of this note is to offer some suggestions as to how policy makers can further support the expansion of the LTC sector. This note is also intended to provide background for future dialogue on how the World Bank might be able to assist in the process.

This report was prepared based largely on secondary sources, given the limitations on travel during 2020. It makes use of the comprehensive results of the Survey of Older Persons in Thailand, as well as excellent studies produced by various government, non-government, and academic authors. Nevertheless, in preparing the report the authors noted considerable data gaps, especially on private sector services, costs and usage, labor force, and projections of future demand for care. The team fact-checked the report with various country and sector experts; however, it should be considered a preliminary overview of the current situation. Additional data and consultation are needed to elaborate on the recommendations provided in this report.

Executive Summary

Chapter 1 of this report looks at the current and future demand for LTC in Thailand, starting with the country's demographic situation, the living arrangements of older persons, health and morbidity, welfare, and the overall implications for the demand for aged care. Thailand is aging rapidly: the population share of the elderly (defined in this report as over 60 years of age) rose from 5 percent in 1995 to 17.1 percent in 2017 and is projected to increase to around 30 percent by 2035. Despite having 3.5 years longer life expectancy at age 60, Thai women can expect to live 3.2 fewer years without mobility limitations than men of the same age. According to the Survey of Older Persons in Thailand, 8.2 percent of the elderly reported needing assistance with activities of daily living. One-third of these said they do not currently receive any help. Most elderly Thais age in their homes and are looked after by their families. Although the rate of elderly co-residence with children has declined over the last 25 years, more than half of Thailand's elderly live with a child, and two-thirds either live with or adjacent to a child. However, the traditional familial care arrangement is becoming increasingly difficult for many families as the ratio of elderly to working-age Thais increases. The proportion of the Thai population surviving past age 80 is estimated to rise ten-fold between 2000 and 2050. The additional years of life will come with increasing periods of frailty, chronic illness, and disability, for which routine care will be needed. In 2017, one-quarter of Thais over 80 (around 400,000 people) reported requiring some assistance to conduct their daily activities. In the next two decades, the number requiring assistance is projected to increase over six-fold to almost 2.5 million.

Chapter 2 reviews the LTC services offered by public, private, and community providers; the opportunities for growth; and the constraints on access to services. Elder care in Thailand is primarily overseen by the Department of Public Health, which operates a network of local health promotion hospitals. The hospitals interface with local government, civil society, and individual volunteers who deliver LTC services to elders in their community. Through the health promotion hospitals, the government assesses the care needs of the elderly and refers them to services, including volunteer support. This builds on Thailand's longstanding Village Health Volunteers program, through which volunteers provide basic health care and outreach to people in their community. Volunteers now provide community elder care as well, and various programs to train and promote volunteer elder care workers have been piloted and scaled up over the past decade. Senior citizens' groups also play a role in this process, including by offering day centers for socialization and supervision of the frail elderly. Through Thailand's Universal Health Coverage Scheme (UCS) and other social and employer-sponsored medical insurance programs, most Thais have insurance for acute medical care services. However, care for chronic conditions such as dementia is rarely insured. Institutional LTC costs more than most Thais can afford to pay, thus most in need of such care continue to depend on family and community care. Finding a means of filling the gaps in the supply of affordable and adequate care for elders with LTC needs will be a key challenge for the government in the years to come.

Chapter 3 summarizes the current policy and governing framework for elder care in Thailand, including the government's role, the institutional structure, and regulation. Thailand has been proactive in developing policy and programs to support its aging society. Over the past 40 years, it has developed a comprehensive policy framework comprising long-term strategic plans and shorter-

term action plans. It has taken a gradualist approach to developing its policy, one centered on the concept of universality. With a universal social safety net and universal health insurance, Thailand is already well equipped institutionally to deliver care services for a growing elderly population. The system has also emphasized the role of community services and volunteers, developed and refined through long-running pilots. While this is laudable, it may not be enough as the system needs to scale up—both physically (needing to empower lower-capacity local governments) and in order to meet the growing demographic needs. As needs continue increasing, efforts should be directed to support the development of private and not-for-profit services that can offer affordable continuum of care (at home, in communities and in institutions care). Public policies should also allow for the development of the high-end retirement community living options for the more affluent, as the development of such an industry will create jobs.

Chapter 4 describes the current financing of aged care, including the flow of funds and central-provincial linkages. The National Health Security Office (NHSO) administers the UCS, which finances the bulk of public elder care services. The NHSO makes grants to local health funds administered by the local administrative organizations (LAOs), which in turn pay for services delivered by local hospitals and other providers. While Thailand's UCS guarantees access to most health care services free of charge, the UCS does not currently cover any institutional LTC due to its high cost. The government has therefore elected to rely primarily on volunteer and community-based care services. Institutional care services, which are typically required for the elderly with high needs (that is, elderly with dementia, bedridden elderly), remain underinsured, and programs to help families with these expenses are limited in coverage. Very few elders have private health insurance. There has been some improvement in the Old Age Allowance in recent years, supported by revenues from sin taxes, but financing from contributory and recurrent sources continues to fall short of what would be required for most Thais to pay out-of-pocket for aged care in the future. Finding a fiscally sustainable financing model for LTC will be essential for developing the range of services, including meeting the needs of the small, but growing, proportion of elders with conditions that may require institutional care.

Chapter 5 briefly examines the aged care labor force. The growing demand for aged care services presents opportunities for business investment and job creation, in rural as well as urban areas. These new employment opportunities, and the time freed up for family carers to do other paid work, have the potential in particular to increase female labor force participation. At this stage, there are shortages of suitably trained aged care workers: Thailand has only 0.7 formal LTC workers per 100 persons aged 65+, compared (for example) to 4.4 in Australia. A study of LTC facilities found that staff lacked appropriate training, and only 69 percent of the care staff in the facilities studied had obtained a certificate in elder care. Recent assessments have identified several weaknesses such as lack of harmonization across ministries and agencies, poor quality instruction, lack of strong linkages with the private sector, and lack of a mechanism to monitor and evaluate program results.

Chapter 6 concludes with a discussion of the direction of reforms currently discussed by the stakeholders in Thailand, and suggested policy priorities. We make the following policy recommendations:

- **Government’s stewardship role in aged care needs to be strengthened.** This includes improving capacity to gauge and forecast care needs and develop information system with reliable data. Forecasts should be conducted regularly and shared across government and with the private sector to coordinate and inform investment decisions. This will facilitate the growth and development of non-government services, including fee-based services for those who can afford them. The government should also strengthen oversight and monitoring of private and non-government LTC providers, and systematically enforce standards for care. Through improved registration of care providers, the government can also obtain and report more comprehensive data on service providers, workforce, and the quality of services, thereby giving consumers more information. This will improve the capacity for planning, oversight, and consumer choice.
- **A fiscally sustainable system for financing LTC is needed to ensure universal access.** Those with the means can afford to pay for LTC, and should be encouraged to do so. However, the high cost of LTC means many Thais will need government support. Thailand can transition to a more formalized model of LTC financing by, for example, broadening the universal health coverage scheme (UCS) to include some LTC (while keeping costs down by negotiating prices) and targeting LTC subsidies to those most in need. In the medium term, since the numbers of elderly with needs for care are projected to increase, the government could consider introducing a dedicated LTC insurance scheme.
- **Given a supportive policy environment, the private market for LTC services has significant potential.** While it is still limited compared to that for health care, the private market for LTC services is expected to grow rapidly in the next few years given the growing elderly population and an interest in Thailand as a retirement destination for foreigners. To encourage this growth, it would be useful to explore how expatriate demand for care services can be leveraged to benefit local consumers, improve the linkage between providers and consumers by introducing an accreditation or quality rating system, provide information on registered care providers in a given locality, and facilitate the development and adoption of assistive technology. The government should look for ways to foster the development of industry associations and public-private partnerships.
- **Community support systems show promise, but need further strengthening, especially in areas with low capacity.** The government has laudably developed community support systems for LTC that are reliant on volunteers. These schemes, and the involvement of civil society in the process, have shown encouraging results. Further work may be needed to ensure sustainability of these volunteer models as they are scaled up. For example, it may be challenging to find enough volunteers to meet the needs of all elders in the community. In addition, for the devolved model of community-based care to work, it will be essential to build the capacity of local governments to manage resources, deliver services, and respond to the needs of citizens.
- **A skilled workforce will be key to addressing the growing need for elder care.** While Thailand appears well equipped to meet acute health care needs of its population, formal home-based care and LTC services are already limited relative to demand. In order to expand

services to the growing elderly demographic, care providers will need to reduce the rate of worker turnover and improve the skill levels of their staff. To assist with this process, the government should invest in enhanced training for care workers and consider how to tap migrant labor pools for jobs where local labor supply is limited.

- Finally, there is a need to **review and gradually increase the Old Age Allowance benefit amount**. Despite the presence of universal health care and a universal old-age safety net, elderly poverty remains widespread. The financial vulnerability of the elderly, and hence their access to care, is likely to worsen as rising dependency ratios diminish the capacity of families to care for their elders. This will make it more difficult for them to access care services and remain healthy in their old age.

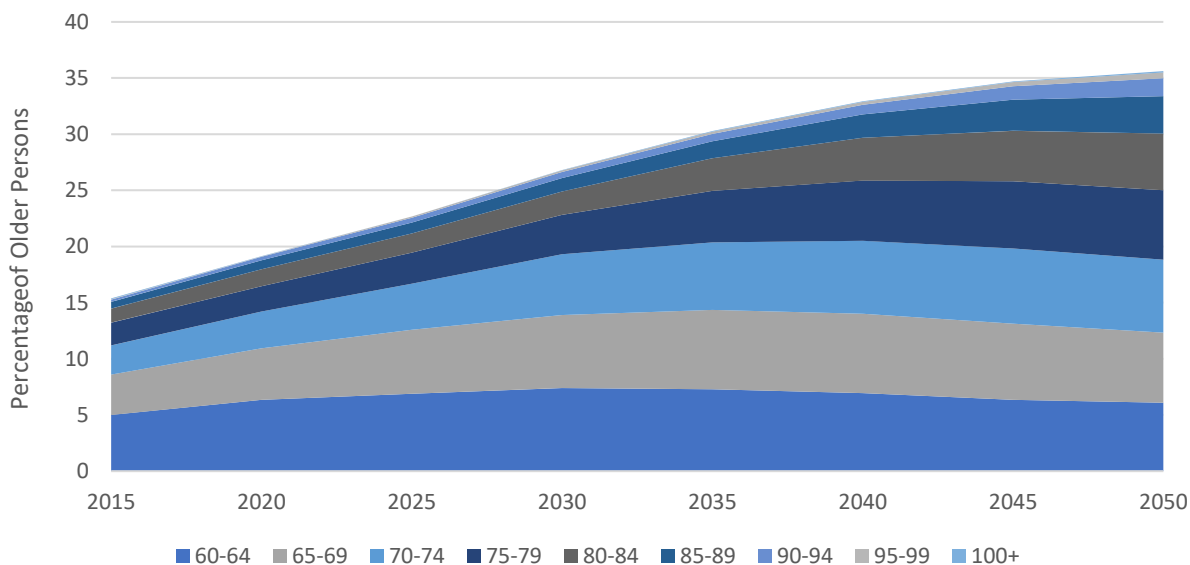
Chapter 1. Demand for Elderly Care

This chapter explores the current demographic situation in Thailand, its implications for the demand for elderly care, and patterns of family-based care. We draw primarily on findings from the Survey of Older Persons in Thailand (SOPT), a rich cross-sectional survey of the elderly conducted by Thailand's National Statistical Office. The subject of demographic change in Thailand is treated only briefly here, to orient the discussion about the living and family care arrangements for the elderly, their health status, morbidity, and disability, with a view to likely future trends in demand for formal and professional care.

Demographic Situation and Trends

Thailand is aging rapidly and is now the second most aged ASEAN nation after Singapore. The population share of the elderly (those aged over 60¹) rose from 5 percent in 1995 to 17.1 percent in 2017, and is projected to increase to around 30 percent by 2035 (Figure 1). As a result of low fertility rates, the elderly now outnumber children under 15 for the first time in Thai history. Thailand will experience the tenth fastest decline in working-age population share in the coming 30 years, but at a much lower income level than the other nine countries (World Bank, 2016a, p32). The potential support ratio will fall from 5.4 working-age adults per elderly person in 2020 to 1.9 in 2050 (Knodel et al. 2016).

Figure 1. 2015-2050 Thai elderly population share by age group



Source: United Nations (2020).

¹ Unless otherwise specified, we define 'elderly' in this note as those aged 60 or above. This is consistent with the formal definition of 'elderly person' adopted by the Government of Thailand in the Elderly Person Act (2003).

Box 1. Surveys of Older Persons in Thailand

The aging surveys conducted by Thailand's National Statistical Office (NSO) are referred to as the Surveys of Older Persons in Thailand (SOPT). The NSO has conducted the SOPT in 1994, 2002, 2007, 2011, 2014, and most recently in 2017. The 2007 and 2011 surveys include additional questionnaires for purposes of monitoring and evaluating Thailand's National Plan for Older Persons (2002–2022). For this note we were unable to obtain the underlying microdata, so report results from the SOPT are based on official tabulations published by the NSO.

The SOPT utilizes a multistage, proportionate-to-size probability design with geographic and administrative stratification. Housing blocks in municipal areas and villages in non-municipal areas are sampled based on a sampling frame derived from the latest census or intercensal survey conducted prior to the SOPT. This is followed by a random selection of households within the sampled areas and face-to-face interviews with all age-eligible people in the sampled households. If the respondent is unavailable or too physically or mentally incapacitated to be interviewed, proxy respondents (usually spouse or next of kin) are interviewed. In the 2017 SOPT, proxy interviews involved 17 percent of respondents aged 60 and older and 20 percent of respondents aged 50–59 (NSO 2018). Caregivers of respondents receiving care were probed about their sociodemographic characteristics as well as their knowledge and experience in elder care. Information related to elder care has been utilized to evaluate the outcomes of the National Plan for Older Persons (2002–2022) and numerous policy documents on eldercare in Thailand (Pothisiri and Teerawichitchainan 2019).

According to the 2017 SOPT, women make up 55 percent of Thais over 60. The proportion of women increases progressively with age as a result of their longer life expectancy, reaching 61 percent of those aged over 80. Due to sustained advancements in health care and social protection, life expectancy at age 60 is 19.1 years for males and 22.6 years for females. Thailand's rural elderly population is significantly larger than its urban elderly population (Figure 2). The population share of older persons ranges from around 10 percent in the provinces surrounding Bangkok to almost 25 percent in the Northern region (Figure 3). The regional differences have become more pronounced over time due to migration of working-age Thais from northern rural areas south to Bangkok and vicinities (NSO 2016).

Figure 2. Population by age and residence, 2017

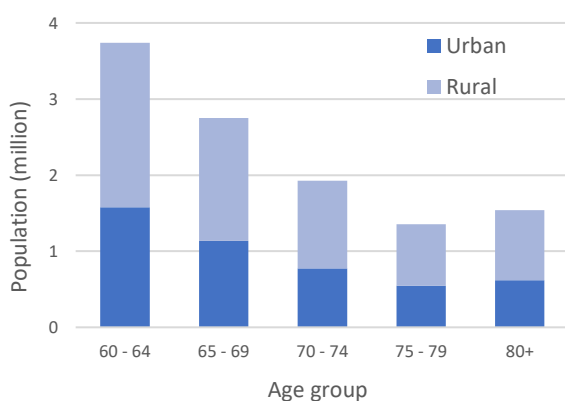
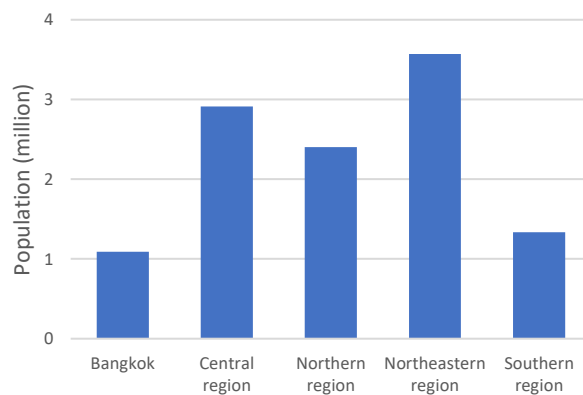


Figure 3. Older persons by region, 2017



Source: Authors' calculations based on SOPT data.

Table 1 shows that the proportion of older men who are married is almost twice that of older women, while elderly women are much more likely to be widowed. This imbalance in marital status reflects the fact that women are more likely to outlive their husbands. Furthermore, a greater proportion of women than men are single, divorced or separated. Overall, less than half of Thai women cohabit with a partner in their old age, versus almost 80 percent of men. This, coupled with their higher population share, implies that elderly women have a significantly greater need for family or professional care than men.

Table 1. Marital status of elderly persons by sex, 2017

Marital status	Male	Female	Total
Single	2.5%	6.5%	4.7%
Married	81.2%	47.9%	62.8%
Living together	78.2%	45.0%	59.9%
Living apart	3.0%	2.8%	2.9%
Widowed	13.8%	42.0%	29.3%
Divorced	1.1%	1.6%	1.4%
Separated	1.4%	2.0%	1.7%

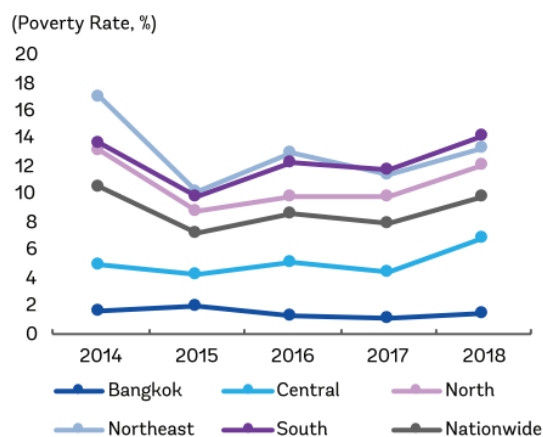
Source: Authors' calculations based on SOPT data.

Welfare

The economic welfare of the elderly is an important factor in determining the *effective demand* for and access to care. (The effective demand includes the ability to pay, in addition to measuring the need for services.) Thailand's relative poverty rate declined from 65 percent in 1988 to just under 10 percent in 2018 (at the \$5.50/day poverty line), but has recently trended upwards as economic activity has slowed (Figure 4). The poverty rate for the elderly is slightly higher than for other age groups (Brixii et al. 2012), and one in three older persons was reported as living below the national poverty line in 2015 (Prasartkul et al. 2017). Figure 5 shows the distribution of annual personal incomes for people over 60, showing a median annual income for the elderly of slightly under Bt 40,000.²

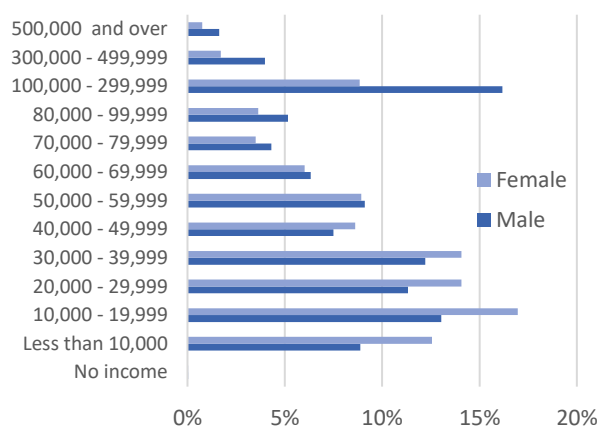
² Figure 5 excludes 0.3 percent of respondents reporting incomes as 'unknown'.

Figure 4. Poverty rate by region (US\$5.50/day PPP line)



Source: Thailand Economic Monitor, January 2020.

Figure 5. Annual income by sex for people 60+ (baht)



Source: Authors' calculations based on SOPT data.

Table 2. Income sources by age, 2017

Income source (percent reporting)	Age group			
	60-69	70-79	80+	All 60+
Employment	53.2	20.1	4.9	37.0
Pension	7.4	6.5	4.1	6.7
Social Security Fund	1.7	0.5	0.3	1.2
Old Age Allowance	80.7	90.9	92.8	85.3
Savings	44.0	39.9	33.4	41.4
Spouse	33.8	19.2	7.8	26.0
Child	73.5	84.9	88.0	78.8
Other relative	10.0	11.5	12.5	10.8
Other income	0.6	0.7	0.7	0.7

Source: Authors' calculations based on SOPT data.

Note: Figures show percentage reporting each income source, and do not sum to 100%.

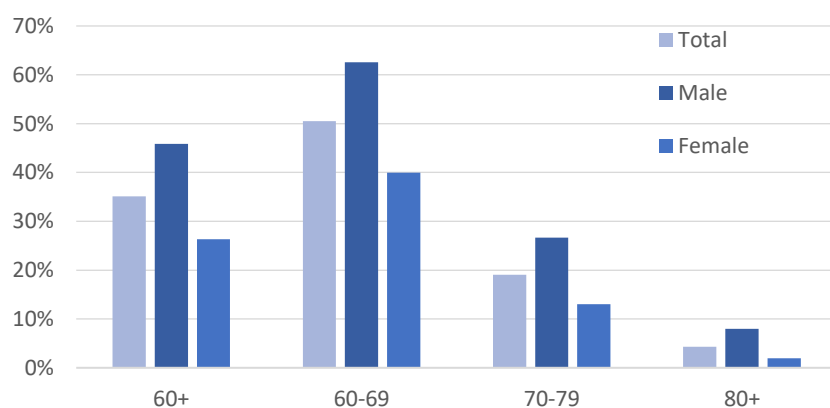
Table 2 summarizes income sources for the elderly as reported in the 2017 SOPT. The most common sources of support were the Old Age Allowance and support from children, both of which are more prevalent among those over 80. Employment income, savings, and support from spouses were the next most reported sources of income, declining in importance with age. Almost 80 percent of elderly Thais received some financial support from their children, although the relative importance of children's financial support has been declining over time from 57 percent of income in 2007 to 37 percent in 2014. Meanwhile, employment income has increased slightly as a share of overall income since 2007 as the share of elderly remaining in the workforce has increased (Prasartkul et al. 2017). Own or spouse's earnings was the principal income source for 51 percent of elders; support from children was the principal source of income for 35 percent; and 20 percent reported the Old Age Allowance as their main income source. Only 2 percent of elders were dependent solely on their

savings. A small minority (18 percent) of respondents reported their income as inadequate, and only 6 percent reported being able to save.

Most of the respondents in the 2017 SOPT reported receiving the Old Age Allowance. This monthly benefit is paid by the government to all Thai citizens over 60 who are not covered by any other social insurance program. The benefits are Bt 600 for those aged 60-69, Bt 700 for those aged 70-79, Bt 800 for those aged 80-89, and Bt 1,000 for those over 90. Since the transformation of the program into a universal social pension in 2009, the number of allowance recipients has increased from 5.9 million to 8.2 million in 2017, and the program's budget has increased nearly three-fold from Bt 21.9 billion to Bt 64.7 billion. However, the benefit amount has remained unchanged for almost a decade and now amounts to less than 4 percent of average household income. Those respondents in the SOPT who depend mainly on the old age allowance assess their situation least favorably, likely reflecting the relatively low benefit amount (Knodel et al. 2016; Lamanna and Sharpe 2021). The government recently explored the possibility of introducing a pension scheme for the self-employed, farmers, and other informal workers.

In 2017, 35 percent of persons over 60 worked during the prior 12 months; 46 percent of men and 26 percent of women (Figure 6). Most of these were in their 60s, with the share receiving labor income dropping sharply with age. One in four survey respondents reported that they continued to work because they needed income to support their family. The share still working is significantly higher among rural elderly, reflecting their lower level of savings, lower participation in pension schemes, and a higher rate of own-account self-employment or farming work. The rural elderly generally reported being worse off than those in urban areas, as a result of much lower incomes (Knodel et al., 2016).

Figure 6. Employment rates by age and sex



Source: Authors' calculations based on SOPT data.

Educated older persons are likely to accumulate higher incomes over their lives and are therefore more likely to have savings and other assets to support daily living. Literacy also enhances the capacity of the elderly to cope on their own and navigate social and health care systems. Loichinger and Pothisiri (2018) reported evidence from Thai survey data that the incidence of poor self-reported

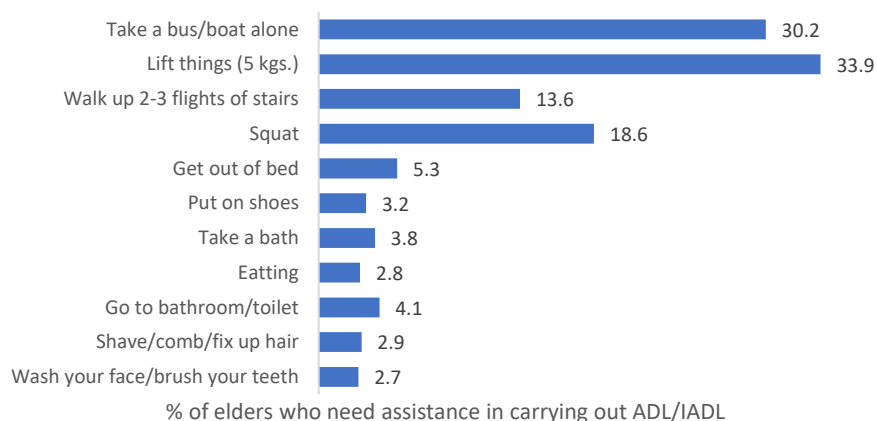
health is lower for elderly people with higher levels of education. Educational attainment in Thailand has increased sharply over time, leading to large differences across elderly cohorts. In 2017, the share of people with no education ranged from just 8.6 percent among those aged 60-69 to over one-fifth of those over 80 (Teerawichitchainan et al. 2019). Literacy among the elderly will similarly continue to improve over the coming decades: in 2017, 87 percent of those in their 60s were literate, compared with only 57 percent of those in their 80s.

Functional Limitations and Care Needs

Functional limitations and difficulties with the activities of daily living increase sharply with age, and the share of elderly with functional limitations has risen with gains in life expectancy. Despite having 3.5 years longer life expectancy at age 60, Thai women can expect to live 3.2 fewer years without mobility limitations than men of the same age (Apinonkul et al. 2016). Around 40 percent of over-60s reported at least one such limitation. Only 8.2 percent reported needing assistance with activities of daily living, however, which was less than the 11 percent reporting receiving such assistance. Around one-third of those needing assistance said they did not receive any help.

Care needs are typically measured by ability to carry out basic self-care tasks, known as activities of daily living (ADL), as well as instrumental activities of daily living (IADL). The 2017 SOPT included questions about four potential functional limitations as well as potential difficulties with eight ADL and three IADL (Figure 7). One-third of elders reported at least one of four functional limitations: 8 percent reported having difficulty with at least one ADL; and 25 percent reported difficulty with at least one IADL. Using a toilet and bathing were reported as difficult by 4 percent of respondents, while 3 percent found it difficult to shave or do their hair.

Figure 7. Share of older persons facing difficulties in carrying out activities by themselves, 2017



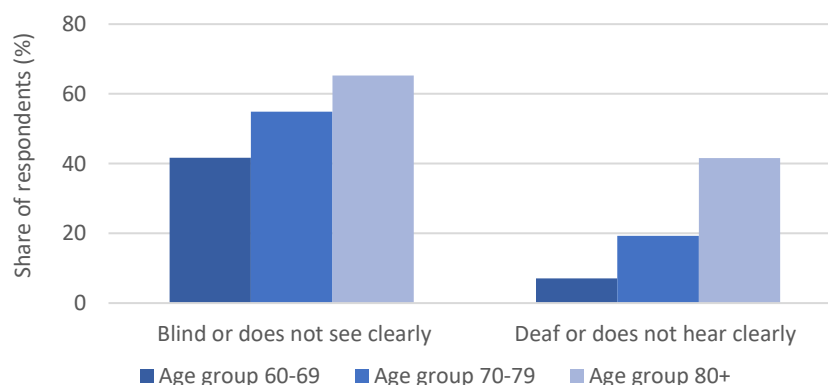
Source: Authors' calculations based on SOPT data.

Difficulties with advanced activities were more prevalent: 34 percent reported they had difficulty lifting 5 kilograms by themselves, 14 percent indicated they had difficulty walking up 2-3 flights of stairs, 19 percent had trouble squatting, and 14 percent reported difficulty climbing two or three stairs. Nearly 25 percent indicated they have difficulty using transportation, but only 9 percent

reported trouble counting change and 10 percent taking medicines by themselves. These proportions are expected to increase in the future, as greater life expectancy results in a higher average age and higher rates of morbidity.

The number of persons reporting problems with vision or hearing increases with age (Figure 8). A higher share of females reported vision impairment compared to their male counterparts. It is also notable that the number of persons who see clearly with glasses was significantly higher in urban areas and an overwhelming majority of those who reported that they do not see clearly reside in rural areas (NSO 2017). There are also noticeable gender differences in the level of care required by older persons due to the prevalence of non-communicable diseases (NCDs), disability, and other comorbidities. Because of their higher average age, elderly women tend to have greater care needs in both absolute and proportional terms. Whereas the overall disability rate in Thailand is just 3.1 percent, 16.8 percent of the elderly have a disability. Moreover, nearly half of respondents reported a chronic illness such as diabetes or hypertension. The share of elderly with two or more chronic illnesses or conditions was 36.8 percent for men and 42.3 percent for women in 2017, and one out of every three elderly people was overweight (Prasartkul et al. 2017).

Figure 8. Quality of vision and hearing of older persons by age, 2017

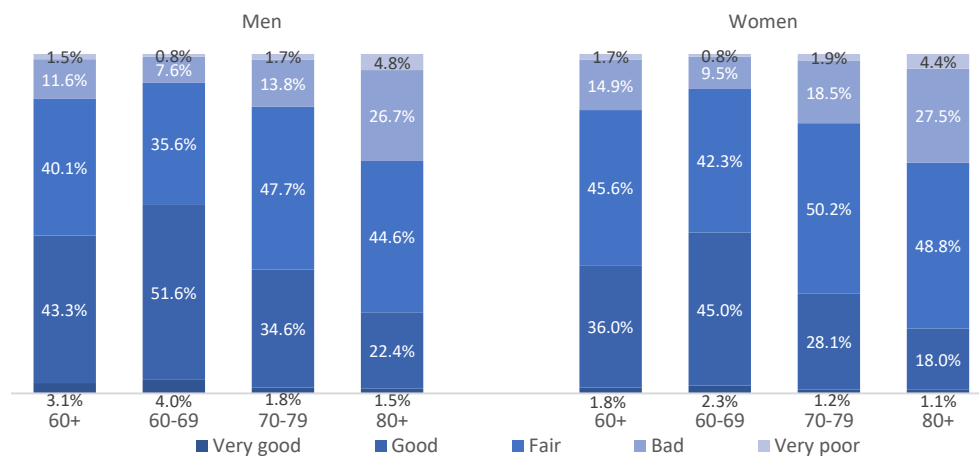


Source: Authors' calculations based on SOPT data.

In 2016, 617,000 elderly people (5.4 percent) suffered from dementia, of which two-thirds were women (Prasartkul et al. 2017). Cerebrovascular disease is the most prevalent cause of reduction in disability-adjusted life-years, affecting 10.6 percent of elderly males and 12.2 percent of elderly females. Chronic Obstructive Pulmonary Disease, diabetes, and myocardial infarction are the next most common conditions. A 30-year campaign to reduce smoking is having a positive impact on mortality rates and life expectancy. While the reduction of smoking could help lower the number of heart disease patients, lack of exercise militates against this. A comparison of the 2011 and 2017 SOPT results shows a substantial decline in the percentage of elders who exercise regularly, from 44 percent to 32 percent among persons aged 60-69, from 33 percent to 22 percent among persons aged 70-79 years, and from 20 percent to 13 percent in persons aged 80 years or older (Prasartkul et al. 2017).

Although the SOPT does not directly measure health biomarkers, several subjective questions provide substantial information to assess the health of respondents. Self-assessed well-being declines sharply as Thais age, with the share reporting good or very good health falling from 55 percent in the 60-69 age group to 21 percent in the 80+ age group (Figure 9). However, more respondents reported that their health was good or very good than poor or very poor in every age group except for those 80+.

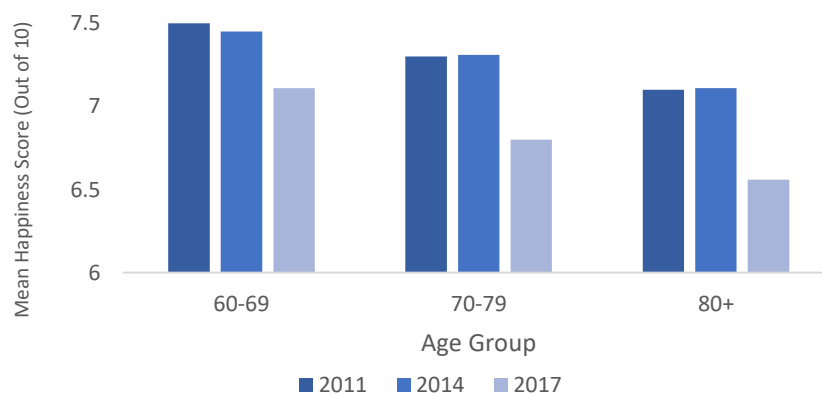
Figure 9. Self-reported health status in 2017, by age group and sex



Source: Authors' calculations based on SOPT data.

Mental health also deteriorates with age. The self-assessed happiness score declines with age and is lower for women than for men, and for rural than urban older persons. Self-esteem, social support, and family relationships are significant factors influencing the happiness of the elderly (Nanthamongkolchai et. al. 2009). The mean self-assessed happiness scores show an overall downward trajectory according to the 2011, 2014, and 2017 rounds of the SOPT (Figure 10).

Figure 10. Mean self-assessed happiness scores by age group and year



Source: Authors' calculations based on SOPT data.

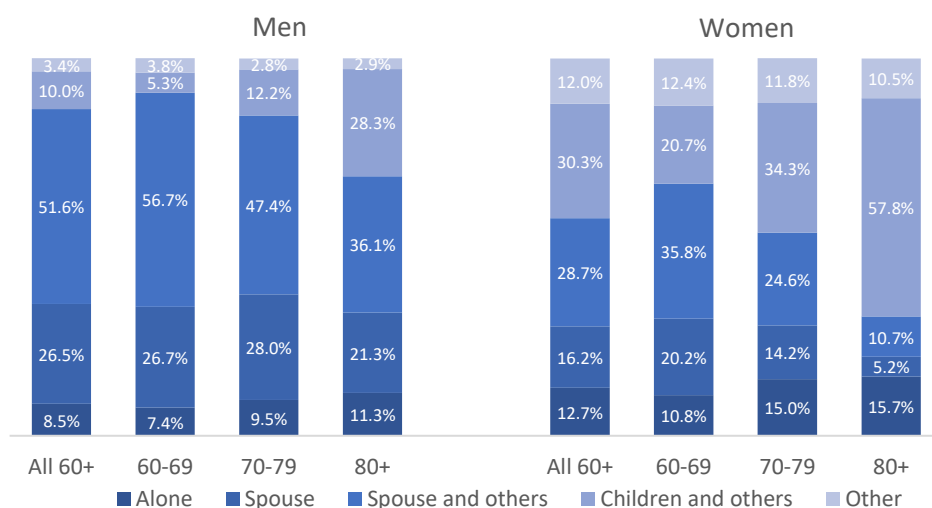
Mental health conditions such as depression are common in older persons and are more likely to affect older age groups, the poor, and those with lower levels of education. Self-assessed happiness declines with age and is lower for women and those living in rural areas. Self-esteem, social support, and family relationships are factors that significantly influence the life happiness of the elderly (Nanthamongkolchai et al. 2009). A 2016 study found that depression affected 68 percent of the Thai elderly, and two-thirds of those suffering from depression were female. Among those reporting depression, 47 percent had mild depression, while 17 percent had moderate depression, and 4 percent suffered from severe depression (Olpoc 2016). A recent study found that regions of Thailand with large elderly populations have higher suicide rates (Kleebthong et al. 2017).

Co-residency Arrangements and Familial Care

Like most Asian cultures, Thai culture has traditionally expected families (particularly adult children) to care for the elderly, and more than 60 percent of older persons still live in multigenerational households. Yet, the rate of elderly co-residence with adult children has been declining over the last 25 years. Now slightly more than half of Thailand’s elderly still live with a child, while two-thirds either live with or adjacent to a child. The share of elders living alone has been consistently increasing, and in three years between 2014 and 2017 it increased from 9 percent to 10.8 percent, respectively.

In terms of the gender differences, in 2017, 12.7 percent of women and 8.5 percent of men lived alone (Figure 11). Rates are almost identical in metropolitan and non-metropolitan areas, although slightly lower in Bangkok for both sexes. Most in the “younger elderly” cohort continue to live with their spouses, but the share declines in the older cohorts as spouses pass away. Since men tend to die earlier, older women are more likely than men to live alone or with adult children or other relatives. Older people living alone report facing similar levels of financial difficulty to those who co-reside with a spouse or family (Knodel et al. 2016).

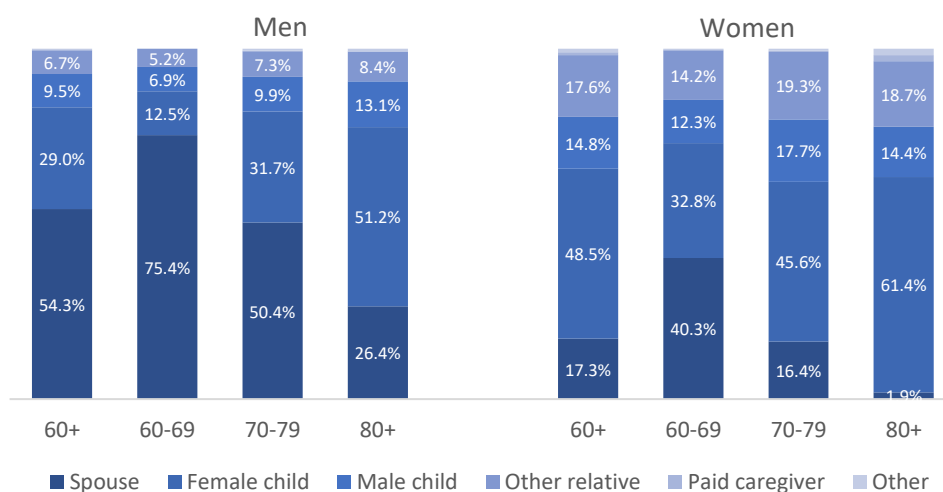
Figure 11. Living arrangements of the elderly by age and sex, 2017



Source: Authors’ calculations based on SOPT data.

The 2017 SOPT found that 8.8 percent of those in their 60s, and 16.6 percent of those in their 70s, reported needing assistance with activities of daily living (Teerawichitchainan et al. 2019). This share increases as individuals get older and among those over 80, around one in four reported requiring some assistance to conduct their daily activities. Consistent with the pattern of co-residence, most elderly continue to be cared for primarily by family, and women tend to be the primary carers. Around 1 percent of elderly women and 0.1 percent of men reported having a private nurse or paid caregiver, with the highest share being 1.7 percent among women over 80. This can be seen clearly in Figure 12: men receiving care are disproportionately likely at all ages to be cared for by their spouses, while three-quarters of Thais who care for their elderly parents are women.³ The share of women being cared for by their husbands is only 40 percent in the 60-69 age group, falling to 1.9 percent in the 80+ group. Daughters are also three to four times as likely as sons to care for dependent elderly women. In addition to social norms, this is likely to reflect higher survival rates among women, coupled with greater likelihood of daughters to co-reside with parents and to be available to serve as primary carer. The share of elderly relying on outside help, paid or unpaid, is still very small, rising to 3.5 percent of women over 80.

Figure 12. Percentage of older persons receiving care, by main source of care support, 2017



Source: Authors' calculations based on SOPT data.

Note: Data represent main carer for those receiving care only.

Since the traditional model of family-based care remains the norm, there is evidence that a lack of family support can have negative implications for the emotional well-being of the elderly. Quashie and Pothisiri (2018) found that elderly Thais without children experienced significantly higher rates of psychological distress than those with children, and levels of distress were even higher for elders without a spouse or children. Even those with children may be at risk of emotional distress if their

³ The data in Figure 12 summarize the “main source of care (for those who receive it).” This accounts for 13.8 percent of the elderly population; the remainder reported that they take care of themselves. Unfortunately, we do not have access to the raw data and cannot determine what proportion of the 8.6 percent needing care do not receive it.

family is unable or unwilling to help. In a 2013 study, many near-elderly Thai parents expressed concerns about becoming a burden to their children and expressed a wish to maintain their independence as long as possible (Knodel et al. 2013). However, most respondents still assumed that they would either live with or close to their children, and that their children would continue to be the main care providers. In the same study, adult children expressed a general willingness to live with and care for their parents, even though this comes at a cost to their own career objectives and occupational mobility. Working-age people with elder care responsibilities (most of whom are women) are sometimes compelled to leave the workforce or reduce the scope of their work, which in turn diminishes their capacity to save for their own retirement. Expanding access to affordable community-based care (including day care) and developing respite care programs can therefore help reach all those needing care, and ensure that fulfilling the needs of the elderly does not come at the cost of the careers of the younger generation.

Future Trends in Demand for LTC

The future demand for LTC will be driven by both demographic factors such as fertility rates and dependency ratios as well as non-demographic factors such as changes in income growth, migration, labor market opportunities for prospective family carers, and Thai society's attitude toward formal LTC services. The proportion of the Thai population surviving past age 80 is estimated to rise ten-fold between 2000 and 2050 (Knodel et al. 2016). The additional years of life will come with increasing periods of frailty, chronic illness, and disability, for which routine care will be needed (World Bank 2016a, p227). In 2017, 25.5 percent of individuals over 80 (around 400,000 people) reported requiring some assistance to conduct their daily activities. In the next two decades, the number requiring assistance is projected to increase over six-fold to almost 2.5 million. Around 180,000 people were bedridden in 2017, and this number is also projected to increase to almost 500,000 in the next two decades (Kumagai 2019). Caring for those with degenerative conditions such as dementia requires skills and training that family members normally do not have, implying increased demand for formal LTC. These statistical projections, coupled with cultural change in attitudes towards formal LTC, are reflected in optimistic industry projections for growth in the aged care sector, highlighting the urgency of developing supporting regulatory and financing structures. In Chapters 3 and 4, we examine these structures and how they are being developed to meet this need.

Chapter 2. The Supply of Elder Care Services

In Chapter 1, it was noted that while most Thai elders continue to rely primarily on family for support, the demand for formal long-term care (LTC) and support to family carers is increasing. This is being driven not only by population aging, but also by a declining capacity of families to fulfill the care needs of the elderly. In this chapter, we examine Thailand's current supply of elder care services and conclude with a discussion of some factors limiting access to care services.

Overview

Most elderly Thais continue to live with family and remain relatively independent. Those who need LTC mostly receive it from their families, in accordance with traditional norms of filial piety. Nevertheless, a small but growing proportion of elderly Thais needing care do not receive it, and this gap is only partially filled by current public provision. As will be discussed in detail in Chapter 3, government policy has gradually developed strategies for LTC provision, and the primary approach has been to rely increasingly on the community for service delivery. The *Second National Plan on the Elderly (2002–2021)* aims to promote and support informal care within the family; provide health and social services within the home, community, and institutions; develop shelter services for the destitute; and adapt the built environment to the needs of the elderly. It prioritizes providing community support to families so elders can be cared for in their homes (Kespichayawattana and Jitapunkul 2009). In this chapter we will examine the available care services—both free and paid—available to elders in Thailand. We first consider care services that are accessible in the home and/or community, before turning to institutional and commercial care services.

Home and Community-based Care Services

In Chapter 1 we illustrated how family members remain the primary caregivers for the elderly in Thailand. Adult children (predominantly daughters) constitute 51.9 percent of caregivers in urban areas and 54.3 percent in rural areas. Coming in second are spouses, accounting for 31.5 percent of caregivers in urban areas and 32.2 percent in rural areas. Within the community, government and non-government agencies offer various care services for the elderly, including elderly clubs, volunteer home-based care, preventive clinical services, and a system to ensure care for the elderly who are home- or bed-bound (Prasartkul et al. 2017). There are three main actors in this space: the health promotion hospitals (primary health care centers at the sub-district level), the LAO, and Senior Citizen Centers.

Village Health Volunteers

The Village Health Volunteers (VHV) program was established over four decades ago. Around 1 million VHVs work nationwide under the Ministry of Public Health (MoPH) as change agents of good health and hygiene in their community. VHVs are selected based on their public spirit, concern for health, and willingness to help those in need. They are paid a Bt 1,000 (US\$32) monthly allowance by the LAO for delivering primary health care services to a defined group of around 10-15 households in their community. In some provinces VHVs also operate clinics that dispense basic medical supplies and provide basic care when health promotion hospitals are not accessible. The impact of VHVs

depends on the effectiveness of local government and the availability of resources. Those that receive regular supervision by health promotion hospitals and local administration organizations tend to perform better (Knodel et al. 2011).

While not dedicated to caring for the elderly, the VHVs play a critical role in linking elders to the community health care system. They conduct home visits, run awareness programs, and organize community activities that encourage physical exercise (World Bank 2016a, p24). VHVs also disseminate knowledge and support family caregivers, especially those with disabled or bedridden members, and encourage the elderly to socialize to prevent depression. VHVs assess the condition of the home and can organize house cleaning or improvements. They also help the elderly obtain medical services, such as applying for a disability card for medical treatment and requesting medical equipment such as wheelchairs, walkers, walking sticks, and beds (Suwanrada et al. 2014). VHVs have been a crucial part of the government's response to COVID-19 and other epidemics, making use of their physical presence as residents of the community and close relationships with other residents. During the pandemic, the government has given VHVs a Bt 500 supplement to their monthly allowance.

Home Care Volunteers

The Home Care Volunteers for the Elderly program was established in 2003 by the Ministry of Social Development and Human Security (MoSDHS). The program provides 18 hours of training over three days to volunteers, who each take care of five elderly people at least two days a week. The volunteers: (i) care for the neglected elderly, such as those living alone; (ii) provide knowledge on various matters that are beneficial to the elderly; (iii) educate family and community members on how to care for the elderly; and (iv) link elders to social welfare services. The program continues to face challenges, including lack of volunteers, lack of financial support, varying degrees of support from local governments, and lack of interest from some elders (Whangmahaporn 2018).

The Community-based LTC Program was introduced in 2016 and provides 2-8 hours of home-based care support a week based on the level of need of the older person. The project pilot began in 2016 with a target of 100,000 beneficiaries in 1,000 of Thailand's 7,776 sub-districts, and has since been scaled up to cover most of the country. In 2018, the project had a budget of Bt 1.25 billion and covered 0.3 percent of the total elderly population. Further details on the program are provided in Box 2 and in the Health System section below.

In 2018, Thailand launched the Time Bank Initiative, under which volunteers provide care to the elderly in exchange for credits that entitle them to equivalent help in the future. The initiative was inspired by a successful time banking program in Japan. By June 2019, the Initiative covered 2,300 elderly participants in 28 provinces. Various charities also provide home care, including HelpAge, which trains community volunteers on basic health care, social care, and other relevant skills to support older people, especially those who are disadvantaged or bedridden.

Box 2. The Community-based LTC Program pilot

The Community-based LTC Program aims to improve the quality of life of bedridden and homebound older people through home-based care and support. The project pilot began in 2016 with a target of 100,000 beneficiaries in 1,000 of Thailand's 7,776 sub-districts, and by 2018 the program had been expanded to cover 5,639 sub-districts. The remaining sub-districts have been unable to participate due to constraints imposed by the deregulation law on financing new programs.

Care is provided by the families of older adults, supplemented by help from a community caregiver under the supervision of the care manager. Care managers in this scheme are specially trained nurses, physiotherapists, or social workers. They assess the eligibility of older persons and prepare a care plan.

The target beneficiaries are bedridden and homebound older people. The program aims to provide assessment, case management, and provision of in-home visits by home caregivers for 2–8 hours a week depending on the need and availability of care support. A range of medical services are listed in the benefits package, which depend on the needs of the beneficiary. These services are broadly grouped into three categories: care management, social care, and health care. Care management includes care assessment, development of a care plan, case conferences, and monitoring and evaluation. Social care services include support for activities of daily living and instrumental activities of daily living, transportation, social support, legal support, improvements to home environment, and economic support including provision of assistive devices. Health care services include treatment, nursing, medicine, rehabilitation services such as physical therapy and occupational therapy, palliative care, provision of medical equipment, and falls prevention.

The program is implemented by the NHSO in coordination with LAOs. The responsibility for managing LTC is assigned to local governments, with the support of the district health system. The Local Health Fund is employed as a strategic mechanism to drive the development of this system. Funding for the program comes from the UCS managed by the NHSO. In its first year, the central government provided Bt 600 million (US\$19 million) through the NHSO, and this amount (and the case load) was approximately doubled in the second year. The bulk of this financing went to the Local Health Funds to support care provision at home and the remainder went to the district hospitals and health centers to support capacity building and volunteer caregiver training.

Source: Adapted from Asian Development Bank (2020).

Senior Citizen Centers

Senior citizen centers (or clubs) operate across Thailand and serve as a platform for community service delivery and day care for the elderly at the local level. The centers are registered with and supervised by the National Senior Citizen Council and receive a subsidy from the sub-district health fund of the NHSO. In 2016, there were almost 26,000 registered senior citizen centers outside Bangkok and approximately 391 in Bangkok.⁴ Most are co-located in sub-district health promotion hospitals or LAOs. They serve an important preventive care function, offering multidimensional health assessments (nutrition, mental health, medication, sight, hearing, memory, walking, and balance), nutrition counseling, and wellness plans. In addition, the centers provide advice on how to set up the home environment to be elder-friendly and accessible. Centers organize activities such as music, folk art, handcrafts, planting, and field trips, as well as income-generating activities such as handcrafts.

⁴ There are many more senior citizen centers that are not formally registered (Suwanrada et al. 2014).

The senior citizen centers also play an important role in reaching out to the bedridden and families caring for the elderly. A program called Friends Helping Friends provides preventive care and health promotion through a network of volunteers. The volunteers conduct home visits, during which they perform basic physical health checks and advise on health practices such as diet and exercise. They also link the elderly with VHVs, the sub-district health promotion hospitals, and the LAOs. Some communities have programs to provide end-of-life care, and some set up funds to provide emergency financial support to members (Suwanrada et al. 2014).

Although most sub-districts in Thailand have a senior citizen center, a 2011 evaluation study found that just half of these associations held activities at least once every quarter in the previous year and that only 24 percent of members participated in activities in the previous three months (Suwanrada et al. 2014).

Institutional Care Services

Health System

As described above, the MoPH, through the health promotion hospitals, plays a key role in community-level care services. The hospitals work with the VHVs to provide primary and preventive care to the elderly, referring them to a district or provincial hospital for more intensive treatment if required. Home visit teams, including a VHV, give advice to the relatives of the patient and empower the VHV to provide ongoing care for the patient under the supervision of the sub-district health promotion hospital. Some hospitals have also established elder care clinics at the community level, which provide services such as free health check-ups, vaccinations, behavior change interventions, and cataract surgery.

The hospitals also coordinate the Community-based LTC Program described earlier. Based on the results of a needs assessment, a care plan is developed by a multi-disciplinary care management team at the district hospital, comprising a doctor, family nurse, palliative care nurse, psychologist, physiotherapist, occupational therapist, nutritionist, and the plan officer. The multi-disciplinary team also provides technical support and supervision on community-based care for the care assistants and volunteers attending to the patient. Elders are referred by the team for a range of home care and in-home rehabilitation services as well as residential rehabilitation programs in LTC centers.

The NHSO finances community-level health and transitional care services for older persons through the UCS. This is achieved through grants to the municipal Health Security Fund and to primary care units to pay for care managers to conduct a diagnosis of the elders' needs.⁵ Health care costs are charged against the National Health Security Fund as part of the UCS, while social care costs are borne by the LAOs and charities. Various non-health related services are also provided by volunteers, such as carpenters who make assistive devices and modify homes to be more accessible.

Home-Based Care

While it is still uncommon for families to hire paid caregivers, the practice is growing. In 2017, 0.6 percent and 0.2 percent of the elderly reported paid professional caregivers as their main source of

⁵ The role and reporting structure of the care manager is described further in Chapter 3.

assistance in urban and rural areas respectively. Between 2012 and 2017 the home care market grew by an average of 7 percent per year. Comparing monthly expenses between the two types of services, home care is around 10 percent cheaper than a nursing home, and more in line with the Thai cultural preference for taking care of elders at home (Laosopapirom 2017). However, at this point the UCS does not cover private home nursing, so the cost of such services is borne fully by the patient.

Assisted Living

Thailand is well established as an elder care hub for foreigners. Chiang Mai has been a popular retirement destination for many years and has one of the largest selections of dedicated assisted living in Thailand. Many of the facilities in Chiang Mai are specifically targeted towards expatriates, with air-conditioned garden villas, 24-hour care support, and English-speaking staff. The number of foreigners over 50 who have received retirement visas to stay in Thailand doubled between 2013 and 2018 to nearly 80,000, according to Immigration Bureau data. While neighboring countries such as Singapore and Japan have a growing interest in Thailand as a destination for affordable elder care, European retirees are the target clientele. At the top of the list are Britons: in 2017, the government launched a campaign specifically aimed at British pensioners, anticipating that competing destinations such as Spain would become less attractive once Britain leaves the European Union. The attractiveness of Thai retirement living facilities to foreigners is likely to continue to fluctuate with currency movements, the global health situation, and alternatives elsewhere. However, Thailand's established market and natural beauty work in its favor.

With the growth in the local aged population, private hospitals have moved into the sector, targeting wealthier Thais. Services include geriatric hospital care and residential care homes located in Bangkok and popular tourist areas such as Chiang Mai, Phuket, and Prachuap Khiri Khan (Ninkitsaranont 2017). Dusit Thani has announced plans to develop *Dusit Devalana* resorts for wellness focusing on customers interested in their health, such as active retirees. There are various senior assisted living facilities in the seaside town of Pattaya, such as the Mabprachan Garden Resort, Namthip Nursing Home Pattaya, Zbreeze Elderly Resort, and Golden Years Hospital (Zander 2017). These facilities cater to upper-class and upper-middle-class Thais with health concerns such as Alzheimer's, Parkinson's, stroke, pressure sores, incontinence, and so forth. Some private nursing homes based in Bangkok are staffed with medical doctors, licensed nurses, therapists, nurse aides, and dietitians and provide a wide range of services including assisted living, memory support for dementia patients, ventilator care, post-operative care, and palliative care.

Institutional Long-Term Care

The nursing home business in Thailand is mainly dominated by small and medium operators with no market leader (Kasikorn Bank 2018). Only a few large firms engage in the sector (Table 3). Most small operators serve the middle-income segment, whereas medium and large operators serve upper-middle- and high-income segments (Table 4). Even though there are good prospects across all segments, large operators mainly aim to invest in the high-income segment. Thailand's market for assisted living is still at a nascent stage, mostly run by government and non-profits. Thailand has approximately 800 nursing home operators, most of which are small-scale firms serving lower or middle-income markets in the local area. Many new projects are being planned, and Kasikorn Bank (2018) estimates that capacity will expand to 2,600 privately operated places and 4,000 government

or non-profit places within the next few years. It is not clear how the COVID-19 pandemic might affect this forecast.

Table 3. Summary of nursing home operators

	Small and Medium Operators	Large Operators
Number of operators	Approximately 760	Approximately 40
Most common form of business	Sole proprietorships, run by medical professionals	Private hospital groups
Business scale	Maximum 30 beds in a single branch	Over 30 beds in many branches
Target group	Mostly Thai seniors	Both Thai and foreign seniors
Annual revenue	Bt 4 million-Bt 16 million	Over Bt 30 million

Source: Kasikorn Bank (2018).

Table 4. Nursing home market segmentation

	Lower Middle Income	Upper Middle Income	High-End
Price	Bt 15,000-20,000/month Bt 700-900/day	Bt 20,000-40,000/month Bt 900-1200/day	Bt 40,000-80,000/month Bt 1,700-3,600/day
Facility Type & Monthly Cost	6-8 beds/room	5-6 beds/room: Bt 20,000 3-4 beds/room: Bt 25,000 2 beds/room: Bt 30,000 Single VIP room: Bt 40,000	2 beds/room: > Bt 40,000 Single VIP room: > Bt 60,000
Location	Nationwide	Mostly Bangkok	Bangkok and resort cities (e.g. Chiang Mai, Hua Hin, Pattaya, Phuket)
Operators	Mostly small operators in the local area	Mix of medium and large operators	
Business trends	Considerable and fast-growing demand as average incomes of people 50 and over continue to rise; not many large players plan to invest in this segment		Niche demand but high growth potential; large private hospitals are planning to invest or have started investing in this segment

Source: Kasikorn Bank (2018).

In 2020 there were 385 registered businesses providing elder care in Thailand, based on data from the Department of Business Development (ADB 2020). Of the registered businesses, 160 are in Bangkok, 100 in the Central region, and only 60 in the North and Northeast regions (where most elderly live). Some shelters are also operated by nongovernmental organizations (NGOs). The MoPH estimates there are more than 1,000 elder care centers that are not registered medical facilities under the Health Establishment Act 2016. Almost 90 percent of private nursing homes are small- to medium-sized operations, and there are only a few large-scale operators (Ninkitsaranont 2017).

There are 25 public residential homes for older people, 12 operated centrally by the Department of Social Development and Welfare (DSDW), and 13 under the management of the provincial administrative organizations (PAOs). As of September 2020, there were 1,295 permanent residents

in DSDW homes, while the number of residents in homes operated by the PAOs is unknown. Despite the growth in institutional care services, residential care options reach only a small number of those with care support needs and are typically limited in the degree of medical care they can provide. Current government policy is focused on building community-level systems to care for older persons in their homes, rather than building new public nursing homes.

Transitional and Hospice Care

The government's policy on transitional care is under development. Lam Sonthi Hospital, in Lopburi province, has piloted a model of 'seamless care', in which the LAO collaborates with community hospitals and communities to prevent the frequent hospitalization of the chronically ill and dependent older persons. Under the program, the LAO pays for care assistants to help the elderly with bathing, dressing, mobility, and household chores. The care assistants receive training in basic elder care, receive on-the-job training, and work under the supervision of health professionals from the local hospital (Sasat and Sakunphanit 2018).

Thailand has several for-profit transitional care facilities for patients with complex medical needs to receive continuous care and rehabilitation before they are sent home. These centers assist patients with rehabilitation and provide preventive care services. Chiva Transitional Care Hospital offers wellness check-ups for prices ranging from Bt 4,200 to Bt 27,000, and longevity check-ups costing around Bt 49,000.

Palliative care is provided by public and private hospitals. MoPH hospitals have special centers for cancer patients or medical school-based hospitals. Palliative care is integrated with community-level care services and is covered under the UCS. The National Cancer Institute and regional cancer centers, both of which are under the MoPH, started a home care program in 1998 in which management of pain and supportive care were the focus.

Faith-based charities are also active in providing palliative care, with many having developed hospices initially to care for HIV/AIDS patients. These actors promote public awareness of palliative care and end-of-life issues. A good example is Buddhika, an NGO that has organized workshops on peacefully facing death for over 10 years and published several books on Buddhism and death (Sittiwantana 2015).

Other Specialized Services

Free cataract surgery and other types of eye care are provided by the MoPH through community hospitals (Knodel et al. 2016). Dental care is available in all levels of the public health service, but utilization is low and there are significant regional differences in dentist availability (Sasat and Sakunphanit 2018).

The Thai Red Cross also has a program that provides free eye care and cataract surgery for the poor and underprivileged older persons since 1995. Under this program, about 130,000 were treated and about 30,000 older persons received the cataract or eyelid surgery. The Thai Red Cross has also operated programs to provide free eyeglasses to elderly persons in rural areas.

The MoSDHS manages Social Welfare Development Centers, which are public homes that provide shelter and care services for elderly people (ADB 2020a).

Cost and Access to Services

Figure 13 provides a summary of the care options and approximate costs depending on the level of dependency. Considering the income and assets reported in Chapter 1, private care services are unaffordable to most Thais. Khongboon and Phongpanich (2018) measured the average care spending by 837 elderly persons in Phichit province in northern Thailand. The total annual LTC spending for rural and urban residents was almost the same, averaging US\$7,285 and US\$7,281 respectively (Table 5). Since this measure includes indirect costs, it can be interpreted as the willingness to pay for commensurate private services. The costs of services available in the market is summarized in Figure 13, and, generally, these are higher than the averages in Table 5. Therefore, the growing private market for care services will still not be widely affordable to most elders in need, and government subsidies are likely to be needed for them to access these services, if the publicly provided system described above does not fully meet their needs.

Table 5. Average annual reported cost of LTC for elderly survey respondents, 2017

Average spending on	Rural			Urban		
	Male	Female	Average	Male	Female	Average
Formal care (US\$)	3,309	2,612	2,845	4,006	3,135	2,380
<i>Share using (%)</i>	37.4	38.7	39.1	42.7	41.2	32.7
Informal care (US\$)	2,065	2,145	2,114	2,192	2,021	2,089
<i>Share using (%)</i>	23.4	31.7	29.0	23.3	26.6	28.7
Day/night care (US\$)	2,717	1,269	1,591	2,438	1,742	2,090
<i>Share using (%)</i>	30.7	18.8	21.8	26.0	22.9	28.7
Daily supplies (US\$)	681.2	664	668.7	724.7	663.3	680.6
<i>Share using (%)</i>	7.7	9.8	9.2	7.7	8.7	9.4
Home renovation (US\$)	34.6	42.3	42.7	21.5	22.6	22.4
<i>Share using (%)</i>	0.5	0.6	0.6	0.2	0.3	0.3
Medical devices (US\$)	25.0	23.8	24.3	10.5	20.7	18.4
<i>Share using (%)</i>	0.3	0.4	0.3	0.1	0.3	0.2
Total expenditure (US\$)	8,841	6,757	7,285	5,387	7,605	7,281

Source: Khongboon and Phongpanich (2018).

Note: Computed at exchange rate of US\$ 1 = Bt 34.45 (March 31, 2017).

The average cost of elderly care services ranges from Bt 20,000 to Bt 36,000 per month, or an average of Bt 900–Bt 2,000 per day, depending on levels of care and elderly symptoms. This amount only accounts for daily care such as eating, taking medication, bathing, cleaning, and turning to prevent pressure sores. For cases of elderly who begin to have pressure sores, more skilled caregivers are required and cost an additional Bt 500–Bt 1,000 per day depending on the severity. Some may pay up to Bt 65,000 per month without including drugs, reagents, and other materials (Thai Post 2019).

Figure 13. Summary of formal care services for the elderly in Thailand

Level of Care Needs			
	High Independence	Moderate Independence	Low Independence
Cost of care	<u>Home-based care</u>		
	Bt 8,000–10,000 per month (US\$225–280)	A full-time registered nurse costs around Bt 20,000 per month	A live-in nurse with a degree and training, available 24/7, with English language fluency, can cost up to Bt 35,000 per month (US\$1,082)
	<u>Community-based care</u>		
	State-funded VHV and LAOs		
	<u>Residential care</u>		
	Private nursing home care is not covered by UCS, and costs around Bt 230,985 per year		
<u>Preventative care</u>			
Some Thai national hospitals host longevity centers which conduct wellness assessments and provide wellness plans. Annual checkups are covered by UCS, but Wellness plans are not. Wellness check up costs range between Bt 4,200 and 27,000. Longevity check-ups cost approximately Bt 49,000			
<u>Disability care</u>			
Assistive devices are provided through the LTC pilot program and the UCS package			
<u>Parkinson's, Alzheimer's and Dementia care</u>			
Covered by UCS			

Source: Authors' compilation from various sources.

While Thailand offers a range of fee-paying and subsidized services for the elderly, levels of access vary geographically. There are still significant disparities concerning non-medical costs and social support to facilitate access to and utilization of health care services. Aside from differences in ability to pay out-of-pocket, variations in program coverage also induce inequality of access. The Civil Servant Medical Benefits Scheme (CSMBS) provides a much higher rate of reimbursement than the UCS, which means former civil servants can access a broader range of services than other elders (Prasartkul et al. 2017).

Another reason for differentials in access to services is the lack of affordable transportation to health facilities. Recent analysis shows that rates of health care utilization increase up to age 80, then fall off; this appears to be explained by difficulties finding and paying for appropriate transportation (World Bank 2016b, p70). Utilization also tends to be lower among the poor, likely reflecting affordability and access to transport. The higher cost of care in urban areas is an issue for the poorest elders. While some LAOs finance community transport services for the elderly, the availability is uneven given a lack of clarity on the LAO's responsibilities in this regard (Prasartkul et al. 2017). As

might be expected, those in rural areas face greater difficulties accessing care services. A recent study found that those who live far from major highways and roads struggle to access public buses and taxis (World Bank 2016c). The routes and frequency of public bus services are limited, and although they may serve the needs of those who need outpatient services, they are not suitable transport for health emergencies. Even where transport is available, its cost can be prohibitive for low-income households.

Chapter 3. Policy Framework and Market Regulation

Given the complexity of the market and vulnerability of elderly, the government has a duty of care to be a steward to address market failures, oversee and regulate formal care providers, and step in where there are gaps in provision. In this chapter we summarize the history and current status of government policy on aged care, the systems by which care is provided, and the regulations applying to public, private, and non-profit service providers.

Policy Framework

Thailand was proactive in establishing a policy framework for elder care long before the population began aging. In 1982, the year of the first UN World Assembly on Ageing, the Thai government established a National Elderly Council to formulate a policy framework for issues faced by the country's elderly. The *First National Elderly Plan (1982–2001)* emphasized the importance of the elderly co-residing with their families, and the culture of children respecting and taking care of their parents. It promoted social protection measures for those unable rely on themselves or their families. The First National Elderly Plan led to formation of the National Committee of Senior Citizens in 1991, and catalyzed a process of dialogue and policy development throughout the 1990s. The revised Thai Constitution of 1997 states that elderly persons who earn no income have the right to receive aid from the State, and that the State has an obligation to support the elderly, the poor, and disabled (Jitapunkul and Wivatvanit 2009).

The *Declaration of Thai Senior Citizens* was launched in 1999, the International Year of the Elderly, to underscore the commitment of the government to improving the quality of life of the elderly and to safeguarding their rights (Box 3). The Elderly Act, passed in 2003, articulated the rights of the elderly to social, health, and economic protection and access to public services and facilities. It defined the elderly as persons aged 60 or older, and granted elderly people the right to protection, promotion, and support. The Elderly Act also made provision for establishing programs for the financial and physical support of the elderly, annual reporting, and a system for care of the elderly (including tax incentives for children who care for their parents).

In 2002, the year of the Second UN World Assembly on Ageing, the Thai government adopted the *Second National Elderly Plan (2002–2021)*. The goals of the Second National Elderly Plan were wide-ranging, aiming to promote positive attitudes toward the elderly; strengthen health and economic services; and engage families, communities, and the private sector. In the domain of economic empowerment, the Plan laid out the process for establishing the Elderly Fund (which was introduced in the Elderly Act), as well as a pension fund for civil servants and a provident fund for private sector employees. It introduced an Old Age Allowance for the elderly poor. In the domain of health, the Plan made a commitment to quality health and LTC, with universal free health care, priority ('green lane') access to outpatient services for the elderly, and establishment of dedicated elderly clinics in hospitals. The Plan introduced multidisciplinary home health-care teams; initiated the Community Volunteer Caregivers for the Elderly project; established multipurpose Senior Citizen Centers, homes for the elderly, and community learning centers; and initiated development of a community-based, integrated health care and social welfare services model for the elderly. It also provided for emergency assistance to the elderly for temporary or emergency housing, food, clothing, medical

Box 3. Declaration of Thai Senior Citizens

Approved by the Cabinet, March 23, 1999

The *Declaration of Thai Senior Citizens* is the commitment to elevating the standard of living of the elderly and protecting them from abandonment and violation of their rights. The declaration states:

1. The elderly will receive basic necessities of worthy and esteemed life, and be protected from abandonment and violation of rights without any discrimination, especially in the case of the elderly who cannot rely on their families and the disabled.
2. The elderly ought to live with their families with love, respect, care, understanding, support and mutual acceptance of the family member roles so as to cherish the bond of contented co-residence.
3. The elderly should be offered the opportunity for continuing education, learning and developing their potential, access to information and social services beneficial to their living, and understand the changes in their surroundings so as to adjust their roles proper to their age.
4. The elderly should pass on their knowledge and experiences to society, have the opportunity to get the position suited to their age with their own willingness, and be paid fairly to create self-worth and pride.
5. The elderly should be taught about appropriate self-care of health, obtain insurance, have equal access to complete health services, and be taken care of until the end of their lives.
6. The elderly should have roles and take part in activities of families, communities and societies, especially uniting with their peers and other age groups for exchange of knowledge and goodwill.
7. The State, with the participation of private sector, citizens and social institutes, shall set the main policies and plans for the elderly, and promote as well as cooperate with the concerned organizations to carry on until fulfilling the goals.
8. The State, with the participation of private sector, citizens and social institutes, shall enact the law of the elderly to be the warrant and enforcement of right and well-being protection and allocation of the welfare for the elderly.
9. The State, with the participation of private sector, citizens and social institutes, shall make campaigns and cultivate the social value of respect to the elderly following Thai tradition, which represents gratefulness and kindness to one another.

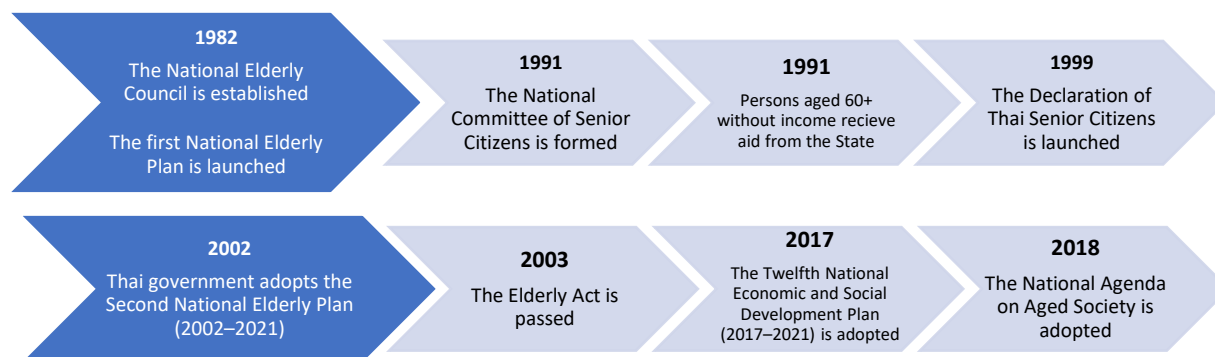
Source: Adapted from Jitapunkul and Wivatvanit (2009).

treatment, care and rehabilitation, legal services, counseling services, and elderly home costs. Finally, the Plan introduced initiatives to support the economic empowerment of the elderly, healthy living, improvements to building accessibility, and protection of the rights of elders (Jitapunkul and Wivatvanit 2009).

The subject of aging is prominent in the current *National Strategy (2017–2036)*. The *Twelfth National Economic and Social Development Plan (2017–2021)* aims to develop elder care service delivery systems with a priority focus on the Northern Region, which has the highest share of elderly people. The plan's three-pronged strategy focuses on economic empowerment of the elderly, innovations in LTC, and strengthening family institutions and communities as part of the social safety net. The 2018 *National Agenda on Aged Society* provided a vision and specified the roles of line ministries in improving the quality of life of older people with dignity, autonomy, and security. It aims to further improve the quality of life of older people by developing welfare and social protection, economic empowerment and health programs for the elderly, modifying housing and public spaces, and setting up a time bank system for volunteer aged care. Laws and regulations to support elder employment will be revised, the national data system will be reformed to support policy making on aging, and innovations will be pursued to minimize inequality in an aging society. The Agenda prioritizes

community-based care, with the elderly encouraged to age in their homes and to seek institutional care as a last resort.

Figure 14. Key policy developments on aged care in Thailand



Source: Bureau of Elderly Health (2019).

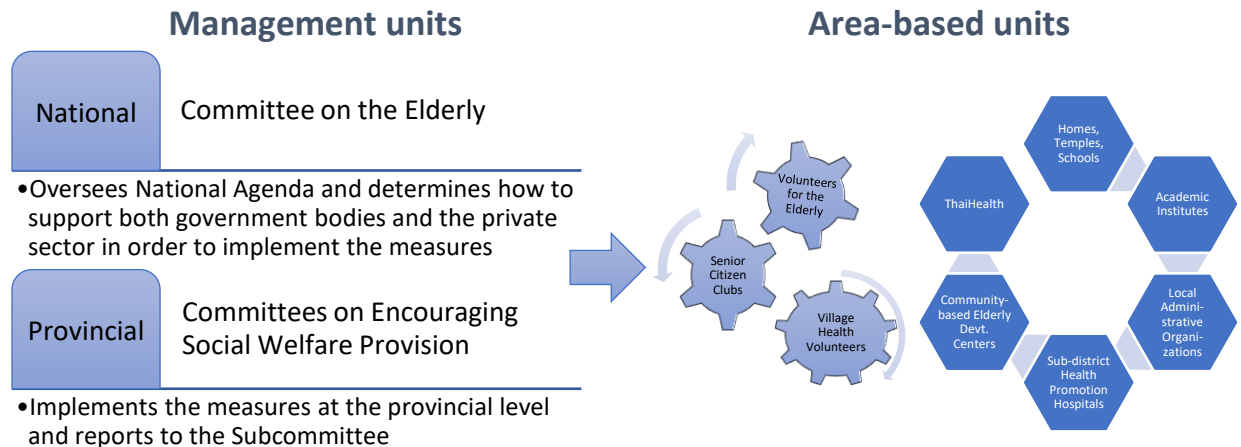
Administrative Responsibilities and Institutional Setup

The National Committee on the Elderly (NCE), chaired by the Prime Minister and vice-chaired by the MoSDHS, is responsible for overall policy leadership and oversight. The NCE was established in 2003 under the Elderly Act. The NCE’s powers include developing policy for the protection and promotion of elders; proposing further laws and regulations for programs relating to the elderly; establishing regulations for the administration of government funds for the elderly, and procurement thereunder; and monitoring, evaluation, and reporting for programs for the elderly. The Subcommittee on Operating Policies for an Aged Society coordinates implementation of different sectors and provinces and reports back to the NCE. Provincial-level committees in turn coordinate activities in their domains and report to the Subcommittee.

Responsibility for elderly programs is held jointly by the MoSDHS, MoPH, Ministry of Interior, Ministry of Labour, Ministry of Education, and Ministry of Finance. The Bureau of Elderly Health, under the MoPH, plays a lead role in policy making related to health services, while the Department of Older Persons in the MoSDHS manages income support, economic empowerment, provision of assistive devices, and social care services through its provincial offices.

Over time, the government has pursued decentralization of elder care services to the district and sub-district level (Suwanrada et al. 2014). This decentralization has relied heavily on LAOs to take on responsibility for developing and implementing services, with the health promotion hospitals playing a key role. The Second National Elderly Plan made the LAOs responsible for elderly services in the community, including multi-purpose centers, day care centers, elderly home visits, home health care services, local transportation services, systemization of the promotion of elderly care, elderly care volunteers, and training for caregivers and volunteers (Teerawichitchainan et al. 2019). Devolution has taken place gradually as authority is not transferred until the LAOs display sufficient capacity (Sasat and Sakunphanit 2018). The roles of community institutions in aged care are summarized in Figure 15.

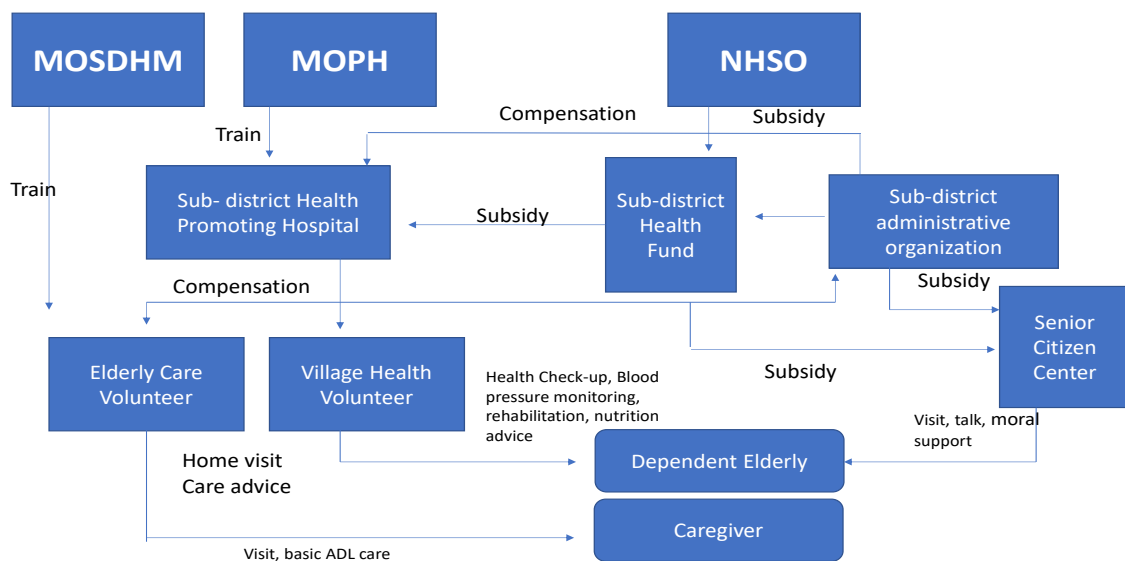
Figure 15. Roles and responsibilities for aged care and services



Source: Bureau of Elderly Health (2019).

Delivery of LTC services relies on coordination between the MoPH, the MoSDHS, the Ministry of Finance, the Ministry of the Interior, and the Commission Board of Insurance. At the central level, an interdisciplinary memorandum of understanding (MOU) coordinates the preparation of the legal framework and resources for local-level service delivery. The NHSO transfers financing for health care to a Local (or Sub-District) Health Fund in each LAO, following a formula based on the level of dependency of older persons in that local authority. The Ministry of Interior finances the salaries of paid caregivers and environmental modifications through transfers to the LAOs. The funding model is summarized in Figure 16, and more details on the flow of funds are provided in Chapter 4.

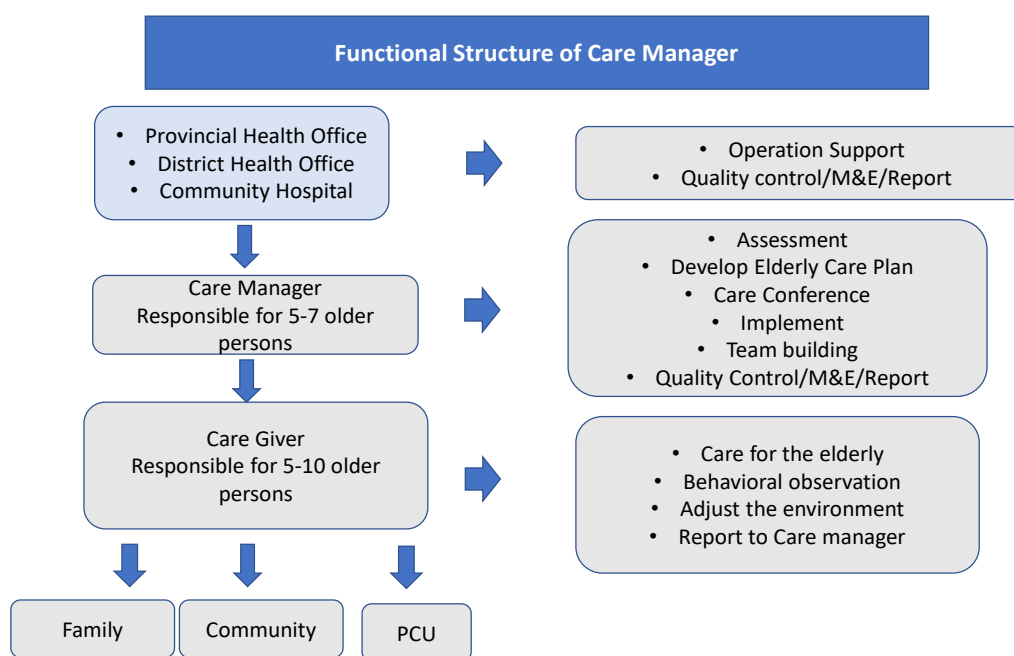
Figure 16. Structure of community elder care services



Source: Suranwada et al. (2014).

The district health system of the MoPH is central to LTC provision in the community (Jitapunkul and Witvanavit 2009). Community hospitals provide treatment, while sub-district health promotion hospitals focus on preventative and restorative care. Care managers—trained nurses from community hospitals or health centers—conduct a needs assessment and develop a care plan for older people in their locality. The assessment determines the level of care needs based on the Barthel ADL index and is recorded in a health information system. The elderly are then referred for LTC services, including home care, which are described in detail in Chapter 2. The care needs assessment process is summarized in Figure 17.

Figure 17. Functional structure of community care diagnosis and referral



Source: Bureau of Elderly Health (2019).

Private investment in the aged care sector is concentrated on acute hospital care, assisted living, and nursing homes. Although demand for private care is still low in Thailand, the sector has significant potential for growth. At least 247 NGOs and faith-based organizations also have active roles in health care, and 6,364 NGOs are registered as social welfare entities. Their activities range from health advocacy to service provision of various kinds, to selected target populations.

Regulation and Standards

The government defines elder care service providers as health establishments, classified into three categories: day care; residential and rehabilitation; and palliative care. Health care standards are monitored by the Standard and Quality Control Board established under Chapter 6 of the National Health Security Act (2002). The Board is made up of senior officials from the MoPH and the Food and Drug Administration, representatives of private hospitals, municipalities, medical practitioners, and non-profit groups. These regulations apply only to acute health care service providers, however, not

to LTC or community care. However, on July 31, 2020, the MoPH passed regulations to set standards for providers of LTC services.

Regulations also exist relating to safety, service quality, customer confidentiality, and service rates in nursing homes. The regulations cover (i) health care operations relating to the care of the dependent elderly; (ii) location, safety, and service of these operations; and (iii) fees, payment, and exemption of fees for elder health care services. They stipulate requirements in terms of accommodation layout and accessibility, condition of facilities, availability of fire safety and resuscitation devices, and worker training (including in fire safety and first aid). A license fee for health establishments is levied based on the nature and size of the facility (Bangkok Biz News 2019).

Some efforts are underway to develop an industry-led system of accreditation. The Thai Elderly Promotion and Health Care Association (TEPHA) has about 200 registered member companies (60–70 percent nursing homes and 20 percent retirement homes) and expects this to increase to 500 companies within the next three years (Bangkok Post 2019). Given the many players in the market, TEPHA aims to raise the standards of the industry by joining with the Commerce Ministry to rate nursing homes or related businesses to ensure the quality of service standards and prices and bolster the number of professionals in the industry.

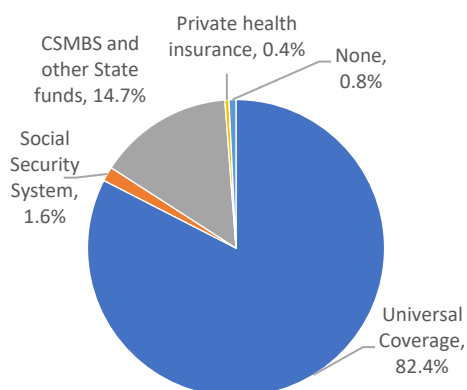
Chapter 4. Financing of Aged Care

Chapter 3 laid out the policy and regulatory framework for aged care. As discussed in Chapter 1, a significant portion of the Thai elderly population faces functional limitations and deteriorating health conditions. A country's health care system plays a vital role in care for elders. Thailand's health system is centered around the principle of universal health coverage, which was achieved in 2001 with the introduction of the UCS. This chapter summarizes the financing of aged care provided through the UCS and other retirement health insurance schemes covering the elderly, and the out-of-pocket costs to consumers.

Financing of Medical Care

Figure 18 shows the main sources of health insurance among the elderly in Thailand. Most citizens are covered by the UCS, a comprehensive, publicly funded health insurance program that covers both outpatient and inpatient services, rehabilitation services, high-cost medical procedures, and

Figure 18. Type of health insurance among the elderly, 2017

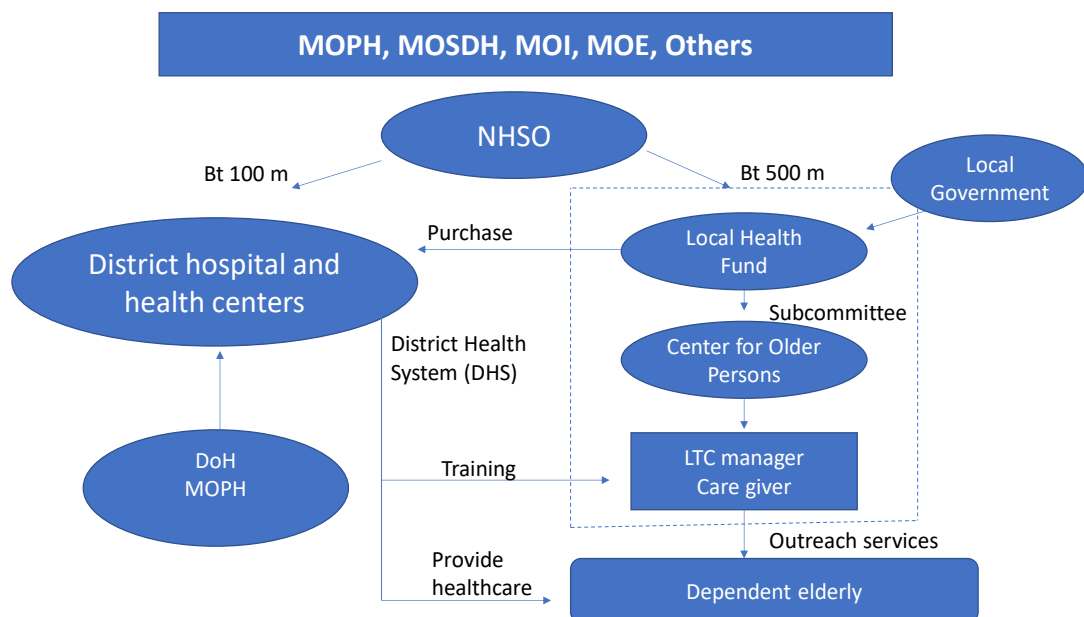


Source: Authors' calculations based on SOPT data.

emergency care. In 2017, the UCS covered 82 percent of the elderly population. Around 15 percent were covered by the CSMBs and other State employee insurance funds, and 1.6 percent by Social Security. Only a very small share reported coverage by private insurance, and 0.8 percent were uninsured.

The flow of funds in the UCS is shown in Figure 19. The system is fully tax-financed and free at the point of service (aside from a Bt 30 copayment). The cost of services is paid by the National Health Security Fund (NHSF), which is managed by the NHSO. The NHSF has a fixed annual budget that caps the provider payments. The budget is determined by applying a defined capitation rate to the number of scheme members (HISRO 2012). The NHSO transfers annual allocations to sub-district health funds (which are managed by the LAOs), and a small amount directly to the hospitals and health centers. The UCS does not cover private LTC costs, but does finance community-level LTC services (such as public health services and small allowances for volunteer carers). The budget dedicated to community-level LTC services was Bt 917 million (0.5 percent of UCS spending) in 2019. Further details on the UCS are provided in Box 4.

Figure 19. Flow of funds to district health system



Source: Adapted from Bureau of Elderly Health (2019).

Financing of LTC

The health system is focused on acute care, while LTC requires integrated health and social care (WHO 2015). While the UCS covers most acute care costs, it does not cover ongoing LTC costs for elderly with the greatest needs (that is, bedridden patients), which is considered unaffordable. Overall, the government has over the past decade designed and piloted a mechanism by which eligibility for medical and social care services is assessed by a care manager and team under the district health system. If an individual meets the eligibility criteria (which includes those with special care needs due to debilitating diseases), they are linked with appropriate support services. For those with Alzheimer’s, Parkinson’s, dementia, and other severe conditions, medical services including physiotherapy and rehabilitative and assistive devices are paid for by the LAO and the UCS (Zander 2015).

Since the UCS only covers limited community-level care diagnostics and care services, the NHSO has set up three funds: (i) a Rehabilitation Fund; (ii) a LTC Fund; and (iii) a Health Promotion Fund. The NHSO allocates budgets to LAOs following a sustainable and predictable approach. LAOs allocate their own administrative budget as well as mobilize funds for LTC services from donations from local communities and users. Residual needs are met by family members, the MoSDHS, NGOs, and volunteers, as described in Chapter 2.

Box 4. The Universal Health Coverage Scheme (UCS)

The UCS is administered by the NHSO. The National Health Security Act 2002 (Section 26) empowers the NHSO with the following responsibilities:

1. Perform administrative tasks for the National Health Security Committee and the National Committee for Quality Accreditation.
2. Compile and analyze data on health services.
3. Organize systems for registration of beneficiaries, service providers and their networks.
4. Administer the fund according to the regulations.
5. Pay service expenses to health providers and their network.
6. Process claims for medical services provided by the service providers.
7. Register people for services and allow them to change their registration as required.
8. Monitor and control service standards and provide a convenient complaints mechanism.
9. Process authority, ownership, and assets.
10. Organize rights and legal procedures concerning its assets.
11. Collect fees and service fees.
12. Authorize other organizations to carry out activities under the responsibility of the office.

The UCS budget has increased steadily since 2015 (see table below), but LTC costs have fluctuated and made up only 0.5 percent of total spending in 2019.

UCS Budget, 2015–2019 (Bt million)					
Item	2015	2016	2017	2018	2019
Medical services capitation	140,718.75	147,772.90	155,628.60	160,205.75	166,445.23
<i>of which salaries</i>	<i>38,188.02</i>	<i>40,143.14</i>	<i>42,307.23</i>	<i>44,840.54</i>	<i>47,314.96</i>
HIV/AIDS patients	2,811.90	3,011.90	3,122.41	3,218.25	3,046.32
Chronic renal failure patients	5,247.22	6,318.10	7,650.71	8,165.61	8,281.80
Chronic disease control, DM-HT, psychiatric care	908.99	959.00	960.41	1,080.70	1,135.03
Additional budget for hardship areas	464.80	1,490.29	1,490.29	1,490.29	1,490.29
Incentive for UCS health care providers	3,000.00	3,000.00	-	-	-
Long-term care for dependent elderly	-	600.00	900.00	1,159.20	916.80
Additional budget for primary care clusters	-	-	-	240.00	268.64
Total expenditure	153,151.66	163,152.18	169,752.42	175,559.80	181,584.09
Medical services per capita	2,895.09	3,028.94	3,188.92	3,283.11	3,426.56

Source: Adapted by the authors from NHSO Website, http://eng.nhso.go.th/view/1/Organization_Structure/EN-US, and National Health Security Commission.

Financing of Other Programs

Other community programs for the elderly are financed through the Elderly Fund, which was established under the Elderly Act 2003 with a grant from the government and replenished annually by the treasury. The fund can also receive payments from donors and foreign entities. A bill passed in 2017 allocated 2 percent of sin taxes, capped at Bt 4 billion, to the Elderly Fund each year. Of the

Bt 4 billion from the sin taxes, Bt 2.6 billion finances a top-up of Bt 100 per month to the regular Old Age Allowance payment to low-income seniors (see Chapter 1). The remaining Bt 1.4 billion is used to repair elderly people's houses, provide care for bed-bound people, and fund activities for senior citizens.

Some large public hospitals also operate social welfare schemes, financed by donations and the hospital's budget. These schemes provide financial support to the poor who cannot afford the out-of-pocket costs for care. Due to the limited budget, some doctors and nurses are selective in terms of which patients they inform about the schemes (World Bank 2016c).

Out-of-Pocket Costs

Most out-patient and in-patient care provided by lower-level health facilities, such as health promotion hospitals and district hospitals, are free for UCS members. However, the costs of treatment for some diseases are not fully covered by the UCS and require a copayment. Such conditions include severe chronic renal disease, certain types of cancer requiring treatment and drugs outside the UCS cancer treatment protocol, and dementia (World Bank 2016c). Estimates from the 2011 Socio-Economic Survey indicate that the incidence of catastrophic health costs (those exceeding 10 percent of the patient's total consumption) was 1–2 percent among households in the two poorest quintiles with an elderly resident, rising to 8–9 percent in the richest quintile. The incidence was slightly higher in rural than urban areas. However, some of this difference could be explained by lower utilization rates among poorer quintiles. Elderly individuals who live with adult children across all wealth quintiles were observed to have lower catastrophic health expenditures compared with their peers who do not live with adult children (World Bank 2016c).

The costs of private home-based care can differ greatly depending on the amount of care required. Full-time caregivers without a nursing degree cost at least Bt 8,000–10,000 (US\$225–280) per month in Chiang Mai, and slightly more in urban centers like Bangkok. The cost of a full-time registered nurse is around Bt 20,000 (US\$618) per month; in comparison, a live-in nurse with a degree and English language fluency can cost up to Bt 35,000 (US\$1,082) per month (Zander 2017). This is very high compared to the average incomes of the elderly discussed earlier, and these costs are not covered by the UCS. At the same time, there is a large differential in LTC costs between Thailand and Western countries, and this partly explains why Thailand attracts foreign retirees.

Supporting the development of social LTC insurance could be a useful strategy for distributing and containing the fiscal burden of elder care. Chandoevvit and Wasi (2019) found that most Thais are prepared to pay LTC insurance premiums. The study found that 86 percent of older persons would support a public LTC insurance system if the annual premium was up to Bt 500 for a lower-tier package (without day care) and Bt 2,000 for a higher-tier package (with day care and caregiver subsidy).⁶

⁶ There is also no private LTC insurance offered in the Thai market. While some major insurers appear interested in entering the LTC insurance market, a lack of statistical information and cost data needed to determine premium rates and policies remains a deterrent. It is also unclear whether the product would be affordable to most consumers.

Chapter 5. The Aged Care Labor Force

As discussed in detail in Chapter 1, population aging is fueling a rapidly growing demand for LTC services. The most important issue concerning LTC in any country is the extent to which those who need or want care currently receive it. Chapter 3 discussed how a well-regulated elder care market can help address the growing needs of the Thai aging population. For such a market to work, a skilled labor force is required. This means ensuring enough workers, with enough incentives to obtain and maintain skills and stay in the job. This chapter briefly summarizes the gaps in the current Thai elder care labor force; the issue of workforce development is treated in more depth in a companion policy note.

Workforce Trends

Thailand's overall labor force participation rate has been in decline, due to population aging. Companies in Thailand are responding to this workforce shrinkage by using automated production systems and digital technologies to improve their productivity and outsourcing to neighboring countries with younger labor forces (Kumagai 2019). The unemployment rate is low at around 1 percent in 2018, even though job growth has been weak. The country's labor market is mostly informal, and its current elder care sector is made up of predominantly informal caregivers. A vast majority of the caregivers receive no compensation for their services. In accordance with preferences for aging at home and cultural norms regarding filial piety and gender roles, the majority of LTC is provided at home by female family members. Some female children and spouses abandon their occupations to do so. The female labor force participation rate is 20 percentage points lower than that for men, as has been the case for two decades.

Despite the preference for family care, we showed in Chapter 1 that a small fraction of the elderly require some form of professional care. Demand for professional care workers is therefore increasing rapidly as the population of elderly grows. There is a shortage of workers willing and able to do this work in Thailand, as is the case in many other middle- and high-income countries. The global LTC workforce (that is, formally employed elder care workers) is estimated at 11.9 million workers. With 4.5 million LTC workers, the Asia-Pacific region contains the majority, followed by Europe with 3.9 million workers and the Americas with 3.4 million. The fewest LTC workers are found in Africa; only 0.1 million LTC workers are available on the continent. Globally, a critical shortfall of 13.6 million formal LTC workers is observed, with the largest deficit seen in Asia and the Pacific. Thailand has only 0.7 formal LTC workers per 100 persons aged 65+, compared to 4.4 in Australia (Scheil-Adlung 2015).

Estimates of Market Demand, Skills Shortages, and Skills Mismatch

There is a clear shortage of LTC staff in Thailand; it is estimated that there are only 0.7 formal LTC workers per 100 persons aged 65 years and over. As a result, an estimated 83.9 percent of the elderly are excluded from formal LTC services (Scheil-Adlung 2015). According to current MoPH data, as of September 2020 there are 85,733 caregivers and 13,706 care managers providing care to 301,765 elderly people under the UCS. More than 225,000 workers would be needed to fill the existing coverage gaps (Sasat and Sakunphanit 2018). Preferences for caregivers differ by type of support. Kin caregivers are preferred to neighbors, and female caregivers are preferred for more intimate

assistance tasks. In rural areas, 94 percent of caregivers co-reside with the care recipient and others are likely to live adjacent or very nearby (Knodel et al. 2016). Since the capacity of institutional care facilities in rural areas is extremely limited, and the private LTC services are costly and located in distant urban centers, the need for LTC in rural areas is mostly met by informal LTC workers within the family (Rittapol 2013).

Many care recipients in institutional care facilities need high-level care, but these facilities are not able to meet these needs, due to the shortage of skilled nursing staff (Scheil-Adlung 2015). The growing proportion of older persons with conditions such as Parkinson's disease, Alzheimer's disease, and dementia has created the demand for a larger supply of skilled care workers. One recent study of 21 LTC facilities in Thailand found that the institutions lacked the necessary staff such as nurses, physiotherapists, and occupational therapists (Sasat and Sakunphanit 2018; Moroz and Naddeo 2021).

Firms face several challenges recruiting, deploying, and retaining qualified workers. Care work is often done in poor working conditions, with long and unpredictable hours, and is physically and emotionally demanding. Workers are paid poorly relative to the nature of the work, and lack job security and employer-based social protection (Moroz and Naddeo 2021). Retention rates for care workers are accordingly low, as workers either transition to better-paying and easier work in the health sector or sort out of the profession.

Government-provided home and community-based care in Thailand is predominantly volunteer-driven (Moroz and Naddeo 2021). Volunteers serve as a strong linkage between the elderly in communities and health care professionals at health promotion hospitals and high-level health facilities—particularly through home visits, and organizing health education and physical exercise sessions for the elderly in the communities (Knodel et al. 2016). Volunteers are complemented by government health employees, who assist with diagnosis and referral to services. The volunteer system has a long history in Thailand, and attracts a large number of committed workers. However, the system will face challenges in coming years in meeting the demand of a growing elderly population. The government is exploring measures such as time banking to encourage more 'young old' people (aged 60 to 69) to contribute their time to care for others on a reciprocal basis.

Training

Caregivers employed in LTC facilities are required to complete at least 70 hours of training in a program accredited by the MoPH. To be eligible, the caregiver must be at least 18 years old, have completed primary education, and have the physical and mental capacity to take care of the elderly. The caregivers work under care managers who are nurses, physiotherapists, or social workers. All nursing professionals are required to register with the Thailand Nursing Council and care assistants and paid caregivers must register with the Department of Health Service Support, MoPH, Department of Skill Development, or the Ministry of Labour (Sasat and Sakunphanit 2018).

The standard curriculum for non-professional carers has three courses. The first is an 18-hour basic care training course for family members or volunteers. The second is a 70-hour intermediate care training course for volunteer and paid caregivers. There is a 120-hour advanced version of this course that specializes in social care, pressure ulcers and wound care, and caring for dependent older

persons. Lastly there is a 420-hour advanced training course meant for career caregivers. Other course options available to caregivers and nurses include a 70-hour care manager training for community-based LTC caregivers, a 70-hour training course for volunteer caregivers focusing on home care, and an 18-hour family caregiver training course. All of these courses are provided in collaboration with the Geriatric Education Research Institute of Singapore (Sasat, n.d.).

The government recognizes the need to further improve the technical and vocational education and training (TVET) system for caregivers. Despite the many training courses available for prospective caregivers, there are major skills shortages in the Thai LTC sector. A study of LTC facilities found that staff lacked appropriate training, and only 69 percent of the care staff in the facilities studied had obtained a certificate in elder care (Sasat and Sakunphanit 2018). Recent assessments have identified several weaknesses, including lack of harmonization across ministries and agencies, poor quality instruction, lack of strong linkages with the private sector, and lack of a mechanism to monitor and evaluate program results (Moroz and Naddeo 2021).

Chapter 6. Summary and Policy Directions

Thailand is aging faster than most east Asian nations. Being in the vanguard of the demographic transition, it is likely to serve as a role model for its neighbors. The first objective of this note was to describe the achievements of Thailand's elder care policy to date. Despite considerable progress over the past 40 years, the availability of formal LTC services—especially at a cost affordable to most Thais—is still limited. A secondary objective of this note is to serve as a guide for future dialogue on Thailand's aged care sector, by highlighting areas where more work needs to be done. In this chapter we summarize these findings and propose some ways in which the gaps can be filled.

Summary

The nature of demand for aged care in Thailand is changing. Thailand's traditional family care model is coming under increasing pressure due to changes in household structure and increased migration of younger family members. In addition, Thailand's shrinking working age population means that the country will no longer be able to afford to have prime-aged workers, many of them skilled, drop out of the labor force to take care of family members. At the same time, gains in life expectancy are being accompanied by increases in morbidity, leading to an increased demand for medical care. Formalizing the LTC system presents opportunities to improve the quality of care, free up other family members (especially women) to participate more in the labor market, and create jobs for care workers.

Thailand has been proactive in progressively developing policy and programs to support its aging society. It began before aging became an urgent challenge, establishing advisory and policy making bodies, developing a strong research capacity, and generating data on the elderly and their needs. Thailand now has a comprehensive policy framework that links rights enshrined in the Constitution through legislation to a long-term strategic agenda and shorter-term action plans. It has taken a gradualist approach to developing its aging policy, starting with universal access to income support and health care services. With this universal social safety net, Thailand is well equipped to manage the further expansion of LTC services for its aging population. However, containing the cost of these services is a growing challenge.

Driven by a philosophy of 'healthy aging,' formal elderly care in Thailand has its origins in the country's strong primary health care system. There are many positive features of this system that should be preserved and enhanced, including diagnosis and referral based on assessment by a health practitioner and service delivery coordinated through the primary health care system. This system will encounter capacity constraints as the elderly population grows, and it cannot meet the needs of the bedridden elderly. It will therefore need to be complemented by the development of social care with dedicated delivery systems. Private and charitable provision, coupled with combined public and private financing, can most reasonably be expected to form the core of this delivery system.

Thailand's UCS plays a significant role in facilitating access to health care, having substantially reduced the incidence of ruinous medical bills. The government could consider expanding the UCS to include an LTC package, which carries a high cost but would only be needed by a small share of the insured. Those who would like access to an expanded package of services and have the capacity to

pay for it could be expected to cofinance their care. Key issues needing resolution are how to ensure access to care for those in remote areas, provide specialized care (including residential) for those with greatest needs such as dementia and other conditions, and contain the cost of the system.

Thailand's approach to social programs has generally been to pilot promising approaches and then scale up the model once it is refined. With respect to health care for the elderly, this has allowed the government to develop the central management capacity, iron out issues relating to financing, and develop first-hand experience that can be used to transfer the model to other locations. It has also allowed the government to develop solutions adapted to local conditions and norms. The challenge is to see whether the promising innovations in social care for the elderly can succeed at scale. Much will depend on the capacity of local authorities to supervise and finance the system and mobilize the community to help. The quality of these programs appears to depend on the resources and ability of local authorities; therefore it will be essential to find ways to build capacity and increase consistency across the country.

Recommendations

Based on these observations, we offer the following recommendations:

Thailand needs to further strengthen government's stewardship function of its aged care system. International experience shows that as countries age, the bulk of care for the elderly is provided at home and in communities, by a combination of familial caregivers and private providers. This process is already taking place in Thailand. The government should play a *stewardship* role in this process. To do this, it would need to progress from being a direct supplier of services, primarily in medical establishments, to being a purchaser and regulator of care services primarily provided at home and in communities by the private sector and NGOs.

To support this shift, the government will need to build its capacity to foster, monitor, and regulate the entire aged care market (public, private, and NGO) and different modalities of care (home-based, community-based, and residential care). This will require capacity building and the establishment of institutional arrangements at all levels and across agencies. While it is encouraging that some building blocks are already in place—such as the presence of a clear needs assessment process, a public health care purchasing model, and reasonably concentrated institutional responsibilities—the following actions are needed:

- **Develop the capacity to gauge and forecast care needs.** Forecasts of care needs can be developed based on the already good data being sourced regularly from surveys like the SOPT. This survey should continue and possibly be expanded to increase representativeness. The information system being managed by the MoPH can also be a source of reliable data. Forecasts should be conducted regularly and shared across government and with the private sector to coordinate and inform investment decisions.
- **Strengthen oversight and monitoring of the private and non-government sectors.** At present, many private care providers remain unregistered and therefore beyond government oversight. The recent introduction of regulations for private sector LTC providers offers the chance to improve standards, in exchange for which the government can facilitate a more

effective linkage between consumers and providers through investment incentives and public-private financing. This is discussed further below.

Develop a fiscally sustainable system for financing LTC. Rapid population aging will result in a larger number of older people with more complex, more expensive, and longer-lasting care needs. This necessitates sustainable financing and delivery models and a sizeable, professionalized workforce. Thailand can transition to this more formalized model of LTC by acting in several areas:

- **Start by broadening the UCS to include a package of LTC to those most in need.** While it would be prohibitively costly to finance the LTC costs of all UCS members, there is a case for covering the cost of accredited services for those with greatest needs and who are poor, whether from private, non-profit, or public providers.
- **Keep costs in check by capping subsidies and prices.** There is a tendency for national health insurance schemes to face ever-rising costs as populations age and suffer from increased morbidity. It is likely that the same will happen to the UCS in coming years, regardless of whether LTC is covered. To contain costs, the scope of support could be limited by introducing a flexible spending account that is graduated according to the beneficiary's need. In Australia's MyAgedCare system, the government's subsidy for care services is a function of beneficiaries' income, so that higher-income elders get a lower subsidy (for a given level of need) and pay the balance of cost out-of-pocket. Only registered providers can compete in the marketplace, with limits on the reimbursements they receive from the scheme.
- **Evaluate the expected costs of LTC subsidies.** A useful first step in determining the appropriate LTC financing model is to evaluate the current and future costs of potential models. This modeling exercise could incorporate a range of care options, taking existing patterns of need and costs and projecting them forward to account for demographic shifts, changes in morbidity, and evolution of industry costs.
- **Consider introducing dedicated LTC insurance** as a means of improving fiscal sustainability of the aged care system in the medium term. This could be done through payroll deduction for the formal sector, and through voluntary contributions for informal workers. Government subsidies or matching grants—financed from general tax revenues, sin taxes, or lottery proceeds—could be introduced to incentivize contributions. Costs can be contained by establishing a national LTC fund with a dedicated agency to manage these moneys and act as purchaser of LTC services.

Foster the participation of private providers. While the private market for aged care services is still limited outside of the health sector, it is expected to grow rapidly in the next few years given the growing elderly population. To encourage this growth, government policy and regulation will need to provide an economic environment conducive to investment, while also guaranteeing standards of care and safety. It must also balance the need to offer adequate incentive to private providers with the need to ensure equitable access to essential services for those with limited means. With this in mind, it would be useful to:

- **Explore how expatriate demand for care services can be leveraged to benefit local consumers.** There are potential synergies between foreign and local clients in terms of service provision. This could involve, for example, offering incentives to firms targeting the overseas market, on the proviso that they also offer a proportion of places to Thai citizens at a discounted rate. Strengthening infrastructure like public transport and health services in areas with a high expatriate population could be justified based on the increased tax revenues they bring. This would attract more foreigners and have indirect benefits for the local community. Businesses serving the foreign market may also have greater capacity to trial complex technologies and develop advanced skills that can then be transferred to the local market. This may even prompt growth of intermediate suppliers to the elder care market (for example, of assistive technologies), reducing the cost of goods and services for other consumers.
- **Improve the linkage between providers and consumers.** To do this, an industry-led accreditation or quality rating system could be introduced to help consumers choose between care options and nudge providers towards higher standards of customer service. An online information portal could also be established to provide information on registered care providers in each locality.
- **Facilitate the development and adoption of assistive technology.** The role of technology in aged care seems to be an underexplored area in Thailand to date. Even basic assistive technologies (such as elevated toilet seats and walking frames) could be made more affordable. Advanced technologies, such as smart phone-based applications, video meetings, and personal care robots could help reduce difficulty with daily tasks and improve socialization. While some of this technology is likely years away in terms of feasibility, affordability, and adoption, it is an area where government could begin exploring how policy can support its development. Again, the expatriate market may be an early adopter, which could help build experience and local capacity.

Strengthen community support systems. With close linkages to the primary health care system, the government has laudably developed community support systems for LTC by employing volunteer workers. This has capitalized on Thailand’s longstanding VHV program. While it is certainly desirable as a solution to the problem of aged care affordability, reliance on volunteers is unlikely to have the required capacity going forward. Volunteers may not wish to continue working for more than a short time, and finding sufficient volunteers to cater to growing needs may not be feasible in all locations. The time bank model is a promising solution, because the flow of ‘young old’ who can provide a few years of support will grow alongside the population needing care. However, the young old may not have the time or energy to meet all the care needs of the target population, and this program would need to be complemented by professional care services where needed.

- Innovative approaches will need be considered to **encourage people to sign up for volunteering.** These might include offering more flexible working arrangements (such as lower caseloads and fewer workdays per week), coverage of incidental costs like transport, and better incentives (such as public recognition, or privileged access to services).

- Some programs that work in high-capacity LAOs appear to be less successful in those with lower capacity. To address this, the government could **develop strategies to build local government implementation capacity**. Community and non-government stakeholders should also be closely involved. It is promising that Thailand has already established a track record of partnership between local hospitals, social services, and community-based organizations, which would serve as a solid basis on which to develop the system further.
- LAOs also need **adequate resources**, including staffing and funding for transport services and day centers. The funding of LAOs should therefore be reviewed and enhanced as required, and LAOs should be trained and held accountable for the equitable and effective use of these funds. The NHSO's capacity to regulate the use of funds also needs to be strengthened.

Build a skilled elder care workforce. While Thailand appears well equipped to meet acute health care needs of its population, the availability of home care and LTC is already limited relative to demand. Recruiting care workers is complicated by the physically and emotionally difficult working conditions, low pay and low job status. Turnover rates tend to be high, as workers burn out or find more attractive opportunities. This can be a challenge for the private sector, given the high cost of worker turnover and risks to service quality or business viability from remaining understaffed. In order to address these challenges, the government could:

- **Promote enhanced training for care workers.** While there is currently a minimum requirement for formal care workers to receive 70 hours of training, the government could further professionalize the workforce by offering higher levels of education for care workers. These courses should be offered part-time, in order to make it possible for workers to refresh or enhance their skills while continuing to work. On-the-job training opportunities could also be developed in partnership with employers.
- **Open career pathways for migrants.** Finally, in-migration of care workers could be facilitated to meet growing demand for certain types of work that cannot be filled domestically. This may require changing regulations that make it difficult for overseas care workers to work in Thailand, such as the requirement for nurses to have proficiency in the Thai language (Natali et al. 2014).

Tackle elderly poverty. Despite the presence of universal health care and a universal old-age safety net, elderly poverty remains widespread. The financial vulnerability of the elderly, and hence their access to care, is likely to worsen as rising dependency ratios diminish the capacity of families to care for their elders. The cost of accessing health and social care services (for example, the need for public transport, food, and accommodation) is also still prohibitive for some. This necessitates a **review of the Old Age Allowance benefit amount**. While the devotion of some of the sin tax budget to raising the Old Age Allowance is a start, the increment does not make up for the erosion of this benefit through inflation.

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