



## **THE RAPID EXPANSION OF RESIDENTIAL LONG-TERM CARE SERVICES IN BANGKOK: A CHALLENGE FOR REGULATION.**

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## **INTRODUCTION**

As in other middle-income countries, Thailand is experiencing accelerating population ageing, with particularly rapid increases in the numbers of people at very old ages. This creates specific challenges related to meeting health and social care needs associated with later life. Research focussed on other middle-income countries has reported that, though family care for older people remains the dominant form of provision, there has been a notable increase in the number of residential long-term care (LTC) institutions (Camarano et al, 2010; Cheung Wong and Leung, 2012). These can take a variety of forms, in terms of ownership (public sector, for-profit and third sector), scale and the types of services offered (from little more than just shelter to facilities comparable to those in hospitals). One common experience across different middle-income countries is that the regulation of these providers is either absent or very limited (Lloyd-Sherlock, Penhale and Redondo, 2019; Lloyd-Sherlock, 2018). This raises concerns about the quality of care provided to older people in these settings, with growing evidence that this can be very uneven and, in the worst cases, can amount to the abuse of older residents' human rights (Lloyd-Sherlock, Penhale and Redondo, 2018).

Published research about LTC services for older people in middle-income remains very limited, both in relation to the scale of the challenge they are facing and in comparison to high-income countries (Lloyd-Sherlock, 2016). There is evidence that provision varies considerably within countries, in part because government responsibility for these services is usually delegated to

the local level. As such, there is particular value in providing detailed and contextualised of specific local settings and then situating these within wider national experiences.<sup>1</sup>

This paper analyses the nature of residential LTC services in Bangkok and identifies different forms of provision. It also assesses the suitability of current regulatory practices and provides some evidence of service quality. The paper draws on fieldwork focussed specifically on residential service providers. This focus reflected several considerations. First, despite the leading role played by family members in providing long-term care for older relatives, there is evidence that many families struggle to fulfil this role (Knodel and Teerawichitchainan, 2017). There are indications that this is leading to a rapid growth of non-family provision, which mainly consists of either paid carers/nurses or various forms of residential services (Sasat, Choowattanapakorn, Pukdeeprom, Lertrat and Arunsaeng, 2013). State attention has mainly focussed on developing community-based services for older people, such as promoting a national network of care volunteers (Lloyd-Sherlock, Sasat, Morales and Pot, 2017). Residential LTC provision has received less policy priority, both in terms of direct state provision of these services and regulation of other providers.

The paper applies a version of an analytical framework applied in studies of LTC in other middle-income countries in Latin America and Africa (Lloyd-Sherlock, Penhale and Redondo, 2019; Lloyd-Sherlock, 2018). This approach identifies three basic elements of interest: demand for LTC, forms of provision and relevant outcomes. More specifically, the paper compares the Bangkok and, to some extent, Thai experience to other national and local settings. This

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<sup>1</sup> For an example of this approach in Argentina, see Lloyd-Sherlock, Penhale and Redondo (2018).

considers to what extent these experiences are unique to Thailand and to what extent they resemble the nature of LTC observed elsewhere in East and Southeast Asia, as well as in middle-income countries in other regions.<sup>2</sup>

The paper is organised as follows. The next section sets out and explains the study methods. This is followed by a presentation of relevant aspects of local context and how they relate to Thailand as a whole. The main findings of the study are presented in two sections. The first provides an overview and categorisation of different types of residential LTC provision. The second focusses more narrowly on regulation and service quality issues. A discussion section compares these findings to the experiences of other middle-income and Asian countries and considers their wider policy implications.

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<sup>2</sup> Particular reasons for comparing with these Asian sub-regions are observed similarities in wider welfare policies (Walker and Wong, 2005), and claims about similar cultural and social norms towards older people, family duty and elder care (Hayashi, 2013).

## **RESEARCH DESIGN.**

The research design was exploratory, both in terms of its empirical ambition and in terms of the methodological design applied. Using elements of a similar methodological design previously applied in an Argentine city, the study applied a multi-method qualitative approach, with a strong focus on specific local contexts (Lloyd-Sherlock, Penhale and Redondo, 2018).

The first element of the study was a review of available, published studies, grey literature and other forms of data on residential LTC in Thailand and Bangkok. All these forms of information were very limited, reflecting the low priority given this issue by the majority of researchers and policy-makers. Although there are some official bodies with which residential providers should register, these are fragmented and serve very different purposes. Private for-profit facilities are required to register with the Department for Business Development in the Ministry of Commerce. Facilities run on a not-for-profit basis should register with the Department for Older Persons, in the Ministry of Social Development and Human Security. Nevertheless, it is difficult to obtain accurate estimates of the number of facilities from either of these agencies, as registration is often incomplete and information out of date. In itself, this lack of official data was a finding of interest, since it indicated (and contributed to) the limited regulatory capacity of state agencies. However, it represented a major challenge for the research design, in terms of identifying eligible facilities for fieldwork.

Several surveys on older people are available for Thailand and more specifically Bangkok (Knodel, Prachuabmoh and Chayovan, 2013). However, most of these are of very limited value to the study, since they only include older people living at home, excluding residents in

institutional settings. The only exception is a survey of 21 residential facilities in Thailand (of which five were in Bangkok), conducted over ten years ago (Sasat, Choowattanapakorn, Pukdeeprom, Lertrat and Aroonsang, 2009). As such, there is a significant gap in knowledge about residential facilities and the older people who live there: a fast-growing and potentially vulnerable group.

The review of available materials demonstrated that terminology about residential LTC was sometimes vague and ambivalent. Some studies develop appropriate categorisations of different forms of provision, ranging in intensity from residential homes for independent older people, to assisted living facilities, nursing homes, LTC hospitals and hospices (Sasat, Choowattanapakorn, Pukdeeprom, Lertrat and Aroonsang, 2009). However, this categorisation is not consistently applied by government agencies or the providers themselves who use terms such as health spas, hospitals and shelters. For the purpose of this study, we use a single term, “residential LTC institution” to describe all forms of provision.

Although the study looks at Bangkok as a whole, it pays particular attention to two separate neighbourhoods located in the district of Bang Khae. Thawi Watthana and Jankawl have similar, middle-class socio-economic profiles, with good access to employment and education. Both contain well-established clubs and community centres for older people, which focus on promoting self-help and independence. The researchers interviewed local key informants working in each of these neighbourhoods, including hospital staff working in geriatric care, primary health care workers in local clinics, local government officials responsible for care services, representatives of local NGOs with interests in LTC, and directors of care homes. The

key informants were asked about what different kinds of residential services were available, the admissions process, quality, regulation and potential problems of abuse or infringement of rights. We also ran focus group discussions (FGDs) with 15 older people in each neighbourhood (Table 1). These people lived in their own homes, rather than in LTC facilities and were recruited through local clubs for older people. All bar one of the participants were between 60 and 69 years old, reflecting the focus of these clubs on more active, less dependent older people. Also, both FGDs were predominantly female, reflecting a higher rate of participation in these clubs for older women than for older men. Information about the research project was sent to representatives of these clubs, as part of an initial phase of preliminary engagement and obtaining informed consent. The FGDs sought to assess participants' general knowledge and perceptions of different local care homes and other LTC services. They also referred to patterns of LTC service use, experiences of these services, reasons for using services, sources of information about services and perceptions of quality. Each FGD ran for between 60 and 90 minutes. Participants gave their permission for the discussions to be recorded, on the understanding that the recordings would be destroyed once the analysis had been conducted.

*Table 1. Selected data for FGD participants.*

Number	Thawi Watthana focus group	Jankawl focus group
Male	-	4
Female	15	11
60-69	14	15
70+	1	-

The research design enabled the collection of some relevant data, but the scope of our enquiry has a number of important limitations. Most importantly, it did not seek to conduct direct data collection at LTC facilities or with the residents of these facilities. This reflected a number of considerations. First, we did not have access to a full register of all care homes, including more informal establishments. Second, we anticipated that care home willingness to participate and provide confidential access to residents would be limited, especially among more informal ones. Together, this would have led to under-representation of such residences. The study in an Argentine city, which served as a model for this study, circumvented this problem to some extent by including an element of clandestine research of facilities (Lloyd-Sherlock, Penhale and Redondo, 2018). However, it was not possible to obtain ethical clearance for applying this controversial approach in this study. A number of FGD participants were in contact with friends or relatives living in residential facilities and were able to share some of these experiences, second-hand, but this only offers limited and potentially unreliable insights. Knowledge of key informants was usually focussed on particular types of providers rather than the overall residential LTC system and a lack of official records limited the extent of their professional knowledge.



## LOCAL CONTEXT: THAILAND AND BANGKOK.

Table 2 presents data on the size and functional status of older populations for Thailand and more specifically for Bangkok.<sup>3</sup> Older age is associated with increased difficulties in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which enable an individual to carry on with life independently. It is projected that the number of Thais aged 80 or older will increase between 2000 and 2050 when they will account for 10 per cent of the total population. Consequently, demand for LTC services is set to accelerate rapidly.

Table 2. Data on older populations and functional status.

	Thailand 2015	Bangkok 2017
Population 60+ (1000 people)	10,732	1,089
Population 70+ (% of total)	6.9%	4.9%
% of population 60+ with at least 1 ADL	8.2%	8.6%
Number of people aged 60+ with at least one ADL	928,400	93,228

Sources: NSO. 2017 Survey of Older Persons in Thailand; UN. World Populations Prospects: the 2017 Revision.

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<sup>3</sup> Throughout this section, data for Thailand also include those for Bangkok. It was not possible to obtain more disaggregated data, which would have demonstrated greater differences between Bangkok and other parts of the country.

Table 3. Older people who reported they need someone to help with daily activities (%).

	Total	Bangkok	60-69	70-79	80+
Yes	8.2%	8.6%	4.2%	8.3%	25.2%
No	91.6%	91.4%	95.7%	91.6%	74.8%
Unknown	0.1%	0.0%	0.2%	0.1%	0.1%
Non-family caregiver (Out of Yes)	2.2%	6.3%	0.4%	1.5%	3.8%
Volunteer carer	17.9%	1.8%	16.1%	24.5%	28.0%
Older people's club	31.4%	7.5%	29.4%	35.4%	31.4%
Trained carer	7.4%	5.7%	5.3%	6.3%	10.0%

Source: NSO. 2017 Survey of Older Persons in Thailand.

In 2017, 93,228 people aged 60 and over living outside residential LTC facilities in Bangkok claimed they needed someone to help with daily activities (Table 3). Over a quarter of people aged 80 or more reported they needed help. Use of non-family caregivers (such as paid carers) was very infrequent, albeit somewhat higher in Bangkok (where 6.3 per cent of people aged 60 or more in need of care used them). By contrast, older people in need of care in Bangkok were less likely to be visited by voluntary carers linked to government programmes (1.8 per cent) than in the country as a whole (17.9 per cent), and were less likely to be members of older people's clubs (7.5 per cent versus 31.4 per cent). For both Bangkok and Thailand, the large majority of carers, paid and unpaid, reported that they had never received caregiver training (94.3 per cent in Bangkok; 92.6 per cent in Thailand). Overall, these data indicate that services to provide or support LTC for dependent older people living at home were very limited, and

that this demand was mainly met by untrained family carers, usually women. Increasing demands on these female relatives, including higher rates of paid employment, reduce their capacity to perform this role effectively. Most families in Bangkok are therefore faced with an “all or nothing” choice between care provision by family members with limited external support (such as training, respite care or day centres) or full-time admission into a residential facility.

In contrast to the limited provision of LTC services for dependent older people, government funding for health care services is relatively embracing (Table 4). A dedicated health insurance scheme for current and retired civil servants and a social security health fund for employees of larger private sector firms include around 17 per cent of the labour force. Most of the remaining population are included in Thailand’s Universal Coverage scheme (UCS) (Sasat, 2018). The broad extent of these schemes explains why only a small proportion of Thais have purchased additional private insurance.

Table 4. Coverage of older people by different health insurance schemes (%).

	Total	Bangkok	60-69	70-79	80+
Civil Servant Medical Benefit Scheme	12.9%	18.1%	12.6%	13.3%	13.5%
Social Security Scheme	1.6%	5.3%	2.4%	0.6%	0.3%
Universal Coverage Scheme	82.4%	68.1%	82.1%	83.0%	82.6%
Private insurance	0.3%	2.1%	0.3%	0.3%	0.4%

Source: NSO. 2017 Survey of Older Persons in Thailand.

The UCS provides a wide range of health services free of charge. These include some hospital outpatient, inpatient and accident and emergency services, as well as dental services, diagnostics, essential medicines and some medical supplies. The UCS also includes preventive and health-promotion services, such as immunisations, annual physical check-ups and primary and secondary prevention for non-communicable diseases. These wider services also include some forms of rehabilitation conducted within formal healthcare settings. However, only mainstream healthcare facilities can be reimbursed by the UCS or the other social insurance funds, which largely excludes services provided at home or in residential LTC facilities.

Current estimates of the number of people living in long-term care facilities are not available, either for Bangkok or for Thailand as a whole. A survey of residential facilities for older people in Thailand by Sasat et al. (2009) identified 138 institutions, of which 60 were private nursing homes, 44 were public and not-for-profit residential homes, 25 were long-term care hospitals, and six were assisted living facilities. Around half of these institutions, 68, were located in Bangkok.

Taken together, these data show that the wider context of LTC for older people in Bangkok was distinct from that pertaining to the country as a whole. Older people in Bangkok had higher rates of participation in insurance schemes offering more generous entitlements than the UCS. They were less likely to engage with charitable and social assistance interventions, such as care volunteers and older people's clubs. In part, this reflected wealth differentials: 20 per cent of older people in Bangkok reported annual incomes below 30,000 baht, compared to 39 per

cent for the country as a whole. The apparent concentration of residential LTC facilities in Bangkok may have reflected a range of factors: the relative affluence of these families, more limited availability of family or voluntary carers and more rapidly evolving social norms towards acceptance of residential care.

## **MAPPING RESIDENTIAL SERVICES FOR OLDER PEOPLE IN BANGKOK.**

Given the lack of systematic information about residential facilities in Bangkok, this section draws on the key informant interviews, focus groups and documentary evidence to piece together a “map” of available services. This approach is not comprehensive, and should be taken as broadly indicative of characteristics of the various types of service provided in the city. Rather than apply a categorisation based on the form of care, as developed by Sasat et al (2009), we apply a categorisation relating to the type of provider organisation.

### *Government residential care homes.*

Two government-run care homes operate in Bangkok: Bangkae1 and Bangkae 2, part of a national network of 25 government facilities. These two care homes have a combined capacity of around 350 residents. A third government-run facility, the Pathumthani Centre (Thanyaburi District, Pathum Thani Province) has a capacity of around 100 places. It is located 43 kilometres outside Bangkok, and has a notional role to take “overspill” from the city. Similarly, Bangkae 1 sometimes admits people from other provinces when local capacity is unavailable.

Residents in these government facilities fall into three categories. The large majority are people entitled to free care on a means-tested basis. Applicants must be able to demonstrate that they fit at least one of the following criteria: coming from households experiencing financial distress or where they are exposed to abuse, being entirely homeless, or lacking access to care from either a relative or non-relative. A second category of residents are not means-tested and are required to pay a monthly rate of 1,500 Baht (around US\$50). This is greater than the

maximum pension paid to older people by the Universal Old Age Allowance Programme.<sup>4</sup> Both these categories live in either single or shared rooms typically containing between three and five people. A third category of residents pay around 300,000 baht for the construction or refurbishment private bungalows within the care facility, and then pay a monthly rental of between 1,500 and 2,000 baht. Ownership of these properties reverts to the facility when the resident passes away.

Critically, for all categories it is stipulated applicants must not suffer from communicable diseases, such as Tuberculosis and Leprosy, any psychiatric problem, or serious functional impairments (although residents will not be forced to leave if any of these develop at a later date). These government facilities are viewed as residential homes rather than nursing homes, since they do not offer specific health services for residents and provide only limited skilled nursing care due to under staffing (only full-time registered nurse in each). For example, the bungalows were only equipped with warning bells very recently. If residents go on to become highly care dependent or to develop conditions like dementia, they are placed in separate buildings within the same facility and will be offered more personal assistance from a helper with basic training under the registered nurse's supervision.

Key informants from both neighbourhoods referred to the scarcity of places in government facilities relative to local needs. With reference to means-tested applicants, one commented:

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<sup>4</sup> Thailand provides a Universal Old Age Allowance of between 600-1000 Baht (20-33 US\$) per month, depending on age. Under the monthly allowance, effective from October 2011, older persons of 60 to 69 years of age, 70 to 79 years of age, 80 to 89 years of age and 90 years old and older receive monthly allowances of 600, 700, 800, and 1,000 Thai Baht respectively.

There are such a lot of complicated steps when you refer someone to Bangkhae. Cases come to us either by referral from health centres or because they are identified by volunteer carers. We then need to make a home visit with nurses and social workers, to evaluate what assistance they need. We have to check whether they really don't have families, or whether their families are unable to provide care, perhaps because the children need to work and have no alternative to leaving the older person on their own all day.

Likewise, key informants added that waiting lists for bungalows in the facilities were several thousand long, so that many people were likely to die before being eligible to purchase one.

In effect, the main form of residential LTC provided by government agencies in Bangkok comes in the form of acute hospital care. Older people in need of rehabilitation or lacking access to family support are sometimes permitted to stay in these settings for protracted periods, as a form of *de facto* long-term care facilities as a result of protracted inpatient stays. The Hospital Accreditation Act of 1999 (HA, 2018), sought to tackle bed-blocking by accelerating inpatient discharge protocols. There is evidence that this led to higher rates of readmission and drove the expansion of formal and more organised forms of private provision, including residential care and 24 hours in-home care service by care assistants. Additionally, Bangkok has a 300 bed government Neurological Institute which contains inpatients with a range of conditions, including dementia.

*NGOs and religious organisations.*



Bangkok also contains LTC facilities run by NGOs, including Swangkaniveji Retirement Home, run by the Thai Red Cross, with a capacity of around 468 people. To be entitled to a place, older people must reserve it in advance and make payments before they retire. The current level of required payment is 850,000 baht (about US\$28,000). Once a place becomes available they are theoretically permitted to stay until their death, when the place is returned to the Thai Red Cross. The home provides a number of services related to health promotion, disease prevention and recreation. However, it does not cater for older people with high levels of dependency. If residents become highly dependent over time most relocate to private sector nursing homes if they can afford them. Residents are required to pay a monthly service charge of 2,500 baht (around US\$80).

A local NGO runs a small residential facility exclusively for 63 older women, Bann Sutthawas, which provides services free of charge, including personal care. However, as with Swangkaniveji Retirement Home, residents who become seriously ill are referred to hospitals. Eligibility criteria include being destitute, aged over 60, being physically independent, and having no communicable disease, psychiatric problems or other serious illness.

Some Buddhist temples in Nonthaburi, which is located next to Bangkok, offer free shelter for small numbers of older people identified as highly vulnerable by local communities. There are some examples of temples working with local health and care agencies to coordinate support for more dependent residents, but this is unusual. One key informant reported that their sub-district office had worked with a local temple to equip a room for LTC provision. In this case, care was provided jointly by volunteers, temple monks and the local authorities. This form of

collaboration is very limited in extent, but may represent a model that could be significantly scaled up in future years

*Private sector facilities.*

There has been a rapid growth in the numbers of private residential care homes in Bangkok, most of which provide some health services and are therefore best categorised as nursing homes. However, rather than use this term, many prefer to describe themselves as hospitals or even health spas. In part, this reflects the Thai registration and regulation systems, which do not apply categories such as nursing home or assisted living facility. It also reflects cultural preferences and a continued stigmatisation of residential LTC.

A typical example is the Chersery Geriatric Hospital, established in 2017. The facility provides a wide range of post-acute care and services for chronic health conditions associated with later life and for older people with moderate to high levels of dependency. Unlike government and NGO facilities, it offers private accommodation, including in-house specialist doctors, round-the-clock nursing and rehabilitation. Rates vary between 90,000 baht (around US\$3,000) per month for a private room to 45,000 baht (around US\$1,500) per month for a shared one. This cost does not cover specific medical services, such as emergency care.

Less intensive care is provided by around 12 private hospitals which were initially established to provide a range of services to people of all ages, but which increasingly offer specialist care for older people expected to remain there on a long-term basis. After the introduction of the UCS some private hospitals saw substantial falls in acute care inpatients and so they converted acute care wards into chronic care. According to local informants, these hospitals offer around 600

LTC beds, at a monthly rate ranging from 20,000 to 50,000 baht (around US\$650 to US\$1,600).

A third form of private residential provision consists of small-scale, informal providers. It is thought that this is a rapidly growing sector, but official data on the number of facilities and the kind of services they provide are unavailable, as there is no law enforcement for registration.

Comments from local key informants included:

There are thousands of them. You can find them on every corner of Bangkok.

I know about hundreds of these informal old age homes, both registered and unregistered ones. They advertise all over the place.

They just want to make money. They rent houses that were not well-designed in the first place and try to convert them into nursing homes.

And

These days, nursing homes are not legally certified by any laws, so it's a kind of unofficial. If it is established by doctors or nurses themselves, maybe there will be fewer problems. There are places set up by non-experts who lack professional knowledge... It's unclear who is responsible for registration or control. So it's a kind of freestyle opportunity for any entrepreneur if they have a budget. It's not important whether these services are good or not [DCH 2].

## **QUALITY AND REGULATION.**

Historically, no regulatory or specific legal provisions existed for residential LTC institutions in Thailand. In 2012 the Ministry of Social Development and Human Security (MSDHS) published a set of standards for homes run by either both or public and private agencies. These refer to building standards, space per resident, environmental health, and general service standards (MSDHS, 2012). However, there was no available information to assess how much these standards were applied in practice. One official commented:

I never intervene in their work at all. I ask residents what they think and they say it is OK.

No-one complains.

Private LTC facilities are not officially required to register with the Department of Business Development (DBD) in the Ministry of Commerce unless they are registered as a company for tax purposes. In 2018, there were 181 facilities registered with the DBD, of which 84 were located in Bangkok (MoC, 2018). The majority of private nursing homes are also members of the Thai Elderly Promotion and Health Care Association, which contained 131 members in 2018 (Thai Elderly Promotion & Health Care Association, 2018). This organisation also promotes care standards by seeking academic support and collaborating with related organisations. However, it does not apply specific guidelines or protocols.

The DBD promotes Business Quality Standards (BQS), both as a tool and a strategy for business development. BQs aim to help Thai businesses meet their commercial potential and bring service delivery up to international standards. They cover 12 business development areas, including “Care Service Standards for Older People” (DBD, 2013). In theory, these standards

are monitored by inspection teams making annual pre-arranged visits. Although, inspections mainly focus on business development, they also cover staff development plans, job descriptions, the cleanliness of the facilities, and resident records. They do not, however, have a specific focus on the quality of clinical or non-clinical care.

The Health Establishment Act of 2016 required the Ministry of Public Health (MoPH) to oversee quality across a range of services. These did not initially include residential LTC facilities, but they are shortly to be brought within its scope. A single set of standards is applied to a very wide set of providers, ranging from health promotion for those older people who can live independently to residential services for highly dependent older people. These general standards do not include specific elements relating to LTC nursing home services.

Consequently, the prospects that these standards will provide a rigorous regulatory mechanism for nursing homes appear to be remote.

All the key informants in this study agreed that regulation is largely non-existent, with no official registers or information on service quality. One local informant, a primary health care professional mentioned that they were not permitted to visit providers, even if they had concerns about particular residents. A care home director observed:

Yes, a [MoPH] official comes, but not more than once a year. Usually, we just need to submit some documents to show that we comply with their standards. The documents are mainly about the services we offer and the design of the building. They don't go into any detail. (H-FS2)

On the rare occasions that MoPH inspections take place and facilities are found to be sub-standard, the usual practice is for these facilities to be given a period of time to improve. They are not fined or closed down. In the worst cases, providers are no longer permitted to advertise that they are certified as compliant with official care quality standards.

Another care home director noted that some providers are registered as “health care facilities”, rather than as hospitals or nursing homes, as this means they are not overseen by the MoPH. In some cases, these providers are registered with the DBD, as commercial enterprises. The key informants reported that among smaller, more informal residential LTC facilities, registration with any official agency was the exception, not the norm.

Since 2017 a more specific national set of standards for LTC facilities has been developed by the Department of Health Services Support at the Ministry of Public Health. This has been done in consultation with technical experts, the Thai Older People’s Promotion and Health Care Association and other stakeholders. The draft categorises LTC facilities into day care providers, residential facilities and nursing homes without health professionals. It sets out a standardised set of curricula and training programmes for paid and unpaid carers, with three levels of training qualification (based on 18, 70 and 420 hours of training respectively). Additionally, it seeks to develop accreditation and registration systems for care workers who have completed formal training. In theory, these standards will be applied to all residential facilities, including those run by private firms, NGO and religious organisations. As of July 2019, the draft bill had passed the public hearing stage, but the cabinet had yet to approve it.

The extent to which the joint MSDHS and MoPH regulations, if made into law, will be implemented is open to question. First, it will be necessary develop a much more complete coverage of information and registration of service providers. Also, even in high-income countries, there is an evident tension between these ideal roles and the political realities of LTC regulation. One dilemma is the need to maintain standards without undermining profitability for private providers, which might hence reduce supply (Mor, 2014). As one key informant in this study observed:

I've been reading for a while about the requirements of the government. I feel surprised because I cannot do it, nobody will do it. It's too perfect. As it is said Thailand's law is good on paper, but not in practice. (NGO1)

Some private service providers have expressed strong opposition to the proposed standards, claiming that they will lead to a large increase in their costs and that this will be passed onto service users. This is likely to lead to further market segmentation between providers that apply legal standards, but which are only affordable for the richest Thais, and informal providers which are more affordable but for which there are no quality guarantees.

This study was not able to collect systematic data about the quality of care provided by residential LTC facilities in Bangkok. However, two separate studies report that older people face an increased the risk of developing depression after they were admitted into LTC institutions in North East Thailand (Tosangwarn et al., 2018; Wongpakaran et al., 2012). A number of key informants raised concerns about the treatment of older people they knew. One commented:

A friend of mine visited his father at private home. He saw the female care assistant rub his testicles, then pat his head and kiss him. His father cried afterwards. But when my friend told the care assistant his father did not like being treated that way, she replied that his father did not say anything and he even smiled. My friend doesn't know what to do. His father used to be headmaster in school. He ordered the people around and now he has to accept this sort of treatment... Older people don't say anything, but that doesn't mean they are not thinking and perhaps they are afraid to speak up. [NGO1]

It is unlikely that this was an isolated experience. A local health worker observed that the majority of residents in LTC facilities had no idea about what their rights were. More generally, most staff in private care homes did not have adequate training and most were paid at a very low rate typically between 70,000 and 10,000 baht a month. Not surprisingly, informants expressed particular concerns about the quality of more informal private facilities. It was observed that many were established by “non-medical entrepreneurs”, and were primarily concerned about minimising operating costs and maximising profits.

Linked to these quality concerns, there were indications that residents were sometimes kept in or were admitted into facilities against their will. This is not surprising, given the highly stigmatised nature of these facilities. One informant noted:

People in this community told us that some older people are just brought along by their children to this place or that place. It seems like the older person has no choice. The children don't have time to look after them, so that's the way it has to be. [PHC2].

One local informant working at a government run facility added:



Some residents really don't want to stay here. They want to go home, but their relatives don't want to look after them anymore so they've no choice. (H-FS2).

Another added that:

Children (the adult children) seldom come here, because they will be asked negatively why they don't take care of their parents. They will put older person in a taxi and tell the driver to take older person here. They wouldn't appear themselves. (DCH1)

As well as increasing the isolation of older people in residential LTC, the lack of family engagement limits opportunities for families to be aware of problems and to hold providers to account, as well as for older residents to report any concerns to a trusted family member. As such, the high level of societal stigma and denial about the growing use of residential LTC may permit many problems to go undetected and unchallenged. More generally, there were indications that the public were not in a strong position to assess the quality of services in LTC facilities as "informed consumers". Key informants claimed that it was usually assumed that care quality was closely linked to the cost of different care homes and that, in the absence of more reliable sources of information such as official registers, families were left to rely on the internet or word of mouth.

## **COMPARATIVE DISCUSSION.**

As discussed in the methods section, the scope of this study has a number of important limitations. First, it mainly relates to specific geographical settings that are unlikely to be representative of the wider national experience. Second, the paper does not provide comprehensive data about the numbers and types of residential LTC providers outside the state sector. Instead, it draws on what may be incomplete and imperfect information from local key informants. Data on the quality of service provision are especially limited, since systematic information is not collected by regulators, and it was not feasible to conduct direct fieldwork in care homes or with their residents. In the light of these limitations, the research findings should be interpreted with caution. Nonetheless, it is possible to identify with some confidence a number of important insights.

It is evident that the supply of residential LTC in Bangkok is very limited relative to the rapidly-growing demand. Although supply shortfalls have been observed in high-income countries (OECD, 2011), the degree of unmet need in Thailand is especially large. This is more comparable to South Africa and countries in Latin America than to Asian countries such as Japan and South Korea, where government subsidies for residential provision spurred rapid increases in provision. With a capacity of just 350 people (excluding social hospitalisation), state provision of residential LTC in the city of Bangkok is very limited relative to demand. As a result, the large majority of residential LTC is unaffordable to the majority of older people. At around 20,000 baht a month, the cost of cheaper private provision is still above the reported income of more than 80 per cent of older people in Bangkok (NSO, 2017). Outside of the private sector, residential LTC facilities rarely admit older people with high levels of dependency or serious

health conditions. This has also been observed in South Africa and Latin America (Lloyd-Sherlock, 2018; Lloyd-Sherlock, et al, 2018). Studies in Chinese cities report access to residential LTC is very limited for less affluent older people, or those with conditions such as moderate or severe dementia (Yu et al., 2015).

A particularly distinctive feature of residential care in Thailand is that states rarely provide financial support to providers. This contrasts with countries like Japan and South Korea, where social insurance systems are the dominant form of financing. In South Africa and Latin America substantial amounts of public funds are allocated to paying for or subsidising residential LTC offered by non-state providers. To date, there are no proposals or political pressures to extend state support for residential providers in Thailand with policy continuing to heavily emphasise family care supported by community volunteers.

Second, the available data indicate that state regulation is largely absent or ineffectual. This is due to the fragmentation of responsibilities across different agencies, some of which are primarily concerned with business development. The new joint MSDHS and MoPH regulatory framework is yet to be put into law and experience to date indicates that it will have little effect unless considerable effort is put into ensuring compliance. As a result, reliable data about care quality are unavailable for researchers and service users. In the absence of external scrutiny, there are grounds for concern about the quality of care in some residential facilities, especially the large numbers of informal private providers.

These different issues, particularly the rapid expansion of weakly regulated private provision, bear considerable resemblance to those reported for other middle-income countries, such as

Argentina and South Africa (Lloyd-Sherlock, 2018; Lloyd-Sherlock et al, 2019). It might be expected that in countries where states offer financial support for residential providers, government agencies would be in a stronger position to regulate and impose quality standards. In most high-income countries, the certification of LTC providers can link assessed quality to permission to operate and eligibility for funding (Mor, 2014). However, the available evidence from Latin American countries indicates that this is rarely put into practice and that regulation is no more effective than in Thailand (Lloyd-Sherlock, Penhale and Redondo, 2019; Lloyd-Sherlock, 2018). Similarly, in South Korea there are no official quality standards for residential providers, care homes are warned about inspections several days in advance and many state-funded homes have yet to be inspected (Republic of Korea, Ministry of Health and Welfare, 2017; Lee and Kim, 2012).

The limited data presented in this paper suggest that residential care for older people remains to some extent stigmatised. This has wide-ranging consequences, including on how service providers present and describe themselves to the outside world. Similar findings have been reported for other Asian countries (Huang et al, 2018; Ma, Shi and Li, 2019). For example, it has been reported that in South Korea admitting older people into residential care is usually justified in terms of incurable chronic health conditions rather than care needs (Park et al, 2015). This in turn can affect the treatment of older people in residential facilities, encouraging them to conform to a passive “sick-role” within a context of total institutional control (Manning, 1992). More generally, societal stigma may explain the reluctance of policy-makers to develop a more high-profile response to the rapid expansion of residential long-term care:

acknowledging a change that contradicts supposed norms of family solidarity may be politically unpopular.

The limited data presented in this paper are unable to do more than hint at the effects of Bangkok's long-term care providers on the quality of life of their residents. A combination of stigmatisation and ineffective regulation creates a context that is unlikely to promote good practice. The limited research on the quality of residential provision in other countries with stigma and weak regulation demonstrates this consequence. A study of care homes in China reported that residents with and without dementia were cared for in the same way, and that access to appropriate medication, psychological support and rehabilitation was minimal (Wu, Gao, Chen, & Dong, 2016). Another study in China reported frequent verbal and physical abuse of care home residents (Wang et al, 2018). In South Korea journalists published a review of 114 cases of criminal behaviour by care homes, including elder abuse (Korea Centre for Investigative Journalism, 2019). A separate study reported a wide range of prosecutions in South Korea related to different forms of elder abuse (Hyok, 2017). The lack of research or data on these issues in Bangkok or elsewhere in Thailand is therefore a cause for concern, both reflecting and contributing to denial among policy-makers and society in general. Without academic scrutiny, robust state regulation and informed public debate about the realities of long-term care, large numbers of vulnerable older Thais will face the risk of poor quality care, including neglect, abuse and the deprivation of fundamental human rights.

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