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ORIGINAL ARTICLE

The rapid expansion of residential long-term care services in Bangkok: a challenge for regulation

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ABSTRACT

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. This paper analyses the nature of residential long-term care (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 study applies a multi-method qualitative approach, using the key informant interviews including HSW, PHCW, LGO, NGOs, and DCH, focus groups and documentary evidence to piece together a "map" of available services. Content analysis was carried out for qualitative data. It provides important insights including a very limited supply of residential LTC in Bangkok relative to the rapidly growing demand, scarce financial support to service providers, largely absent or in the early stage of state regulation, and a continued stigmatisation of residential LTC. Future research should focus more on quality of care and encourage family members to provide support and care for older persons in residential facilities, and should consider including a larger sample size and larger areas.

Key words: long-term care, older people, Bangkok, regulatory practice, residential service

INTRODUCTION

As in other middle-income countries, Thailand is experiencing accelerating population ageing. Particularly, the rapid increasing in the numbers of people at very old ages. In 2019, the number of Thais in the "oldest old" age group (age 80 years) was 1.9 million persons, in the next 20 years, the number of this aged group will be 3 million persons.[1] This creates specific challenges related to meeting health and social care needs associated with later life,

for example, support caring system for frail and dependent older person, including specific public policy, community-based and institutional-based long-term care, health and social services, quality of care, and innovation and technology.

Research focused 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.[2,3] 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 shelter to facilities).

One common experience across different middle-income countries is that the regulation of these providers is very limited.[4,5] In Bangkok and the metropolitan areas had a higher prevalence of dependents older persons and had a higher number of long-term care facilities than other parts of Thailand. In addition, residential care home provided services for all level of care needs due to the majority of residents had chronic health problems and needed moderate to high level of care.[6] Although, the quality of care has already well monitored in acute care settings, but evaluating the quality of services in residential care home for older people is a new initiative. The study's literature review earlier found very limited standards or regulations for agencies that provide services, both home-care services and institutional long-term care.

The Ministerial regulations has just prescribed the care of the elderly or people with dependence to be other businesses in health establishments on 31 July 2020. It was included the standard for day care, residential and rehabilitation, and palliative care.[7]

However, it more emphasis on the registration for care provider, care workers and facilities safety and environment 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[5]. More recently, this has had specific implications for the capacity to respond to Covid-19 in the care settings.[8] 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.[9]

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 focused specifically on residential service providers. Despite the leading role played by family members in providing long-term care for older relatives, there is evidence that many families struggle to fulfill this role.[10]

The paper applies a version of an analytical framework applied in studies of LTC in other middle-income countries in Latin America and Africa.[4,5] 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 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.[3]

METHODS

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.[11]

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. 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. Several surveys of older people are available for Thailand and more specifically Bangkok.[12] However, most of these only include older people living at home, excluding residents in institutional settings. The only descriptive study of 21 residential facilities in Thailand (of which five were in Bangkok), conducted over ten years ago.[6]

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.[6] However, this categorisation is not consistently applied by government agencies who use terms such as day care, residential and rehabilitation, and palliative care. For the purpose of this study, we use a single term, "residential LTC institutions" to describe all forms of provision.

Data collection

This study was approved by the Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University (Certificate of Approval No. 144/2018). The data collection was conducted during June-September 2018.

The two distinctive neighborhood, Thawi Watthana and Jankaew, located in the district of Bang Khae of Bangkok, were selected with the inclusion criteria, included socio-economic profile (we selected one middle-class and one less affluent neighbourhood), well-established clubs and community centres for older people and there was all type of residential LTC institutions available in these areas.

The researchers conducted in-dept interviewed to 5 local key informants working in each neighbourhood, with a total of 10 participants from two neighbourhoods. The key informant included hospital staff worker (HSW) in geriatric care, primary health care workers (PHCW) in local health centres, local government officers (LGO) responsible for care services, representatives of local non-government organizations (NGOs) with interests in LTC, and directors of care homes (DCH). They must have at least one year working experience in these fields and willing to participate in this study. The interview questions included, what different kinds of residential services were available, the admissions process, quality, regulation and potential problems of abuse or infringement of rights. The researchers asked for permission before tape recordings and they would be destroyed once the analysis had been done.

We also ran a focus group discussion (FGDs) in each separated neighbourhood. Each group contained 15 participants with a total of 30 participants from two neighbourhoods. The participants were

recruited through local clubs for older people with the inclusion criteria, include aged 60 years and over, both male and female and were living in these areas at least 3 months, and willing to participate in the FGD.

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. One group found that all FGD participants were female due to there were fewer male members in that senior club. 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.

Data analysis

Descriptive analyses were carried out for quantitative data, such as demographic data of participants. Quantitative data from the in-dept interview from the key informants and from the focus groups were collected by the researchers in the form of field noted and audio-tapes recoding, which were later transcribed for content analyses. 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 (Table 1).

Table 1 Selected data for focus group discussion's participants.

	Focus group discussion (FGD)		
	Thawi Watthana	**Jankaew**	**Total**
Sex			
Male	-	4	4
Female	15	11	26
Age groups			
60-69	14	15	29
70+	1	-	1

RESULTS

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.[13] Old 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 from 2 to 4.4 per cent of the total population between 2019 and 2037.[1] 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 one 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.

Table 3 Characteristic of older people and carers (%)

	Total	Bangkok	60-69	70-79	80+
Older People					
Need someone to help with ADL					
Yes	8.2%	8.6%	4.2%	8.3%	25.2%
No	91.6%	91.4%	95.7%	91.6%	74.8%
Unknown	0.2%	0.0%	0.1%	0.1%	0.0%
Member of Senior club	31.4%	7.5%	29.4%	35.4%	31.4%
Carers					
Type of carers					
Non-family caregiver	2.2%	6.3%	0.4%	1.5%	3.8%
Volunteer carer	17.9%	1.8%	16.1%	24.5%	28.0%
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 the senior 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).[14].

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).[14] 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+
Universal Coverage Scheme	82.4%	68.1%	82.1%	83.0%	82.6%
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%
Private insurance	0.3%	2.1%	0.3%	0.3%	0.4%
Unknown	2.8%	6.4%	2.6%	2.8%	3.2%

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

The UCS provides a wide range of health services free of charge. 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[10]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.

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 by type of provider organisation.

Government residential care homes

Two government-run care homes operate in Bangkok: *Public care home 1* and *public care home 2,* part of a network of 25 government facilities. These two facilities have a combined capacity of around 350 residents. A third government-run facility, the *public care home 3* has a capacity of around 100 places. It is located 43 kilometers outside Bangkok, and has a notional role to take "overspill" from the city. Similarly, the *public care home 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 to 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 those who have less affluent or a middle-class and have no carer or prefer not living at home, are required to pay a monthly rate of 1,500 Baht (around US$50). This is greater than the maximum of the Universal Old Age Allowance Programme. 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. 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.

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:

"There are such a lot of complicated steps when you refer someone to Public care home. 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, including nurses and social workers, and 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." (PHCW2)

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.

NGOs and religious organisations

Bangkok also contains LTC facilities run by an international NGOs, 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. However, it does not cater for older people with high levels of dependency.

A local NGO runs a small residential facility exclusively for 63 older women, *not-for-profit care home*, which provides services free of charge, including personal care. Eligibility criteria include being destitute, aged over 60, being physically independent, and having no communicable disease, psychiatric problems or other serious illness. However, as with another not-for-profit retirement home, residents who become seriously ill are referred to hospitals.

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. 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 categorized 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 nor assisted living facility.

A typical example is *hospital 1* 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.

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 a new law enforcement for registration in January 2021. 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." (PHCW2)

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. 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." (LGO1)

Private LTC facilities are not officially required to register with the Department of Business Development (DBD) in the Ministry of Commerce (MoC) unless they registered as a company for tax purposes. In 2018, there were 181 facilities registered with the DBD, of which 84 were located in Bangkok.[15]. The majority of private nursing homes are also members of the Thai Elderly Promotion and Health Care Association, which contained 131 members in 2018.[16] 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 Health Establishment Act of 2016 required the Department of Health

Service Support, Ministry of Public Health (MoPH) to oversee the 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 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, yes 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." (HSW2)

Since 2017 a more specific national set of standards for LTC facilities has been developed. It was drafted with the initiative of the Department of Health Service Support, Ministry of Public Health, in the consultation with technical experts and other stakeholders. The standard for day care, residential and rehabilitation, and palliative care has just been released on 31 July 2020.[7] These regulations would effectively after prescribing 180 days for service providers to prepare and improve their facilities according to the standard. That means this regulation would come into forced from 27 January 2021. In theory, these standards will be applied to all residential facilities, including those run by public, private firms, NGO and religious organisations. Additionally, it seeks to develop accreditation and registration systems for care workers who have completed formal training based on 18, 70 and 420 hours of training from basic, medium and high level respectively.

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.[17] 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.[18,19] 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 a private home. He saw the female care assistant cleaned his father's testicles, then pat her hand on his father's head and kiss him. His father cried afterwards. When my friend told the care assistant that his father did not like being treated that way, she replied that his father did not say anything and he even smiled. My friend didn't know what to do. His father used to be a headmaster in school. He ordered the people around and now he has to accept this sort of treatment… Older people not 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 staffs 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 poor quality of more informal private facilities.

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." [PHCW2].

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. More generally, in the past, 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 the scope of this study has some of important limitations. Nonetheless, it draws on what may be incomplete and imperfect information from local key informants and 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[17], 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, 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 from the private sector is unaffordable to the majority of older people.

A particularly distinctive feature of residential care in Thailand is that states rarely provide financial support to

providers. This contrasts with countries such as Japan and South Korea, where social insurance systems are the dominant form of financing. 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 has recently put into law and experience to date indicates that it will take some time to get effect and considerable effort is put into ensuring compliance.

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.[4,5] In most high-income countries, the certification of LTC providers can link assessed quality to permission to operate and eligibility for funding.[14] However, the available evidence from Latin American countries indicates that this is rarely put into practice and that regulation in no more effective than in Thailand. [4,5] 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.[20,21]

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 dementia and without dementia were cared for in the same way, and that access to appropriate medication, psychological support and rehabilitation was minimal.[22] Another study in China reported frequent verbal and physical abuse of care home residents.[23] In South Korea, journalists published a review of 114 cases of criminal behaviour by care homes including elder abuse.[24] The lack of research or data on these issues in Bangkok or elsewhere in Thailand is therefore a cause for concern. 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.

The fieldwork, analysis and drafting of this paper were completed before the onset of the Covid-19 pandemic. Independently of the fieldwork conducted for this paper, in late April 2020 informal discussions were held with a small number of staff and directors in public and private residential facilities. In all facilities, interviewees commented that no government guidance or advice for care homes had been made available to them. In the absence of guidance in Thai, several had resorted to translating guidance provided in English from the World Health Organisation and other sources.[25]. At the time of these interviews, private care home respondents reported there had no specific contact with government agencies about the pandemic. Although the spread of the pandemic in Thailand was relatively limited at the time of writing, the policy neglect of residential LTC providers leaves their residents and staff in an acutely vulnerable position.

CONCLUSION AND RECOMMENDATION

Qualitative study aimed to analyze the nature of residential LTC services in Bangkok and identifies different forms of provision. The finding showed the limited supply of residential LTC in Bangkok, scarce financial support to service providers, largely absent or in the early

stage of state regulation and a continued stigmatisation of residential. Therefore, the quality of care in residential facilities should be studied more in the future to improve the quality of life among older people. Finally, a larger sample size and larger areas should be used conducted in order to develop a more high-profile response to the rapid expansion of residential long-term care.

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