

มุมมองผู้มีส่วนได้ส่วนเสียต่อคุณค่าทางเศรษฐศาสตร์และความท้าทายของระบบดูแลระยะยาวผู้สูงอายุในประเทศไทย

Stakeholders' Perspectives on Economic Value and Care Challenges in Long-Term Care for Older Adults in Thailand

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ภูมิหลังและเหตุผล: ประเทศไทยเข้าสู่สังคมสูงวัยอย่างรวดเร็ว ทำให้ความต้องการการดูแลระยะยาว ท่ามกลางข้อจำกัดเชิงโครงสร้างและทรัพยากร จึงจำเป็นต้องใช้มุมมองผู้มีส่วนได้ส่วนเสียในการกำหนดนโยบายการดูแลระยะยาวที่ยั่งยืน

วัตถุประสงค์: เพื่อศึกษามุมมองของผู้มีส่วนได้ส่วนเสียเกี่ยวกับคุณค่าทางเศรษฐศาสตร์ ความต้องการ และอุปสรรคของการดูแลระยะยาวสำหรับผู้สูงอายุ

วิธีการศึกษา: ใช้วิธีการวิจัยเชิงคุณภาพโดยเทคนิคการสนทนากลุ่ม ผู้เข้าร่วมสนทนากลุ่มได้รับการคัดเลือกแบบเฉพาะเจาะจงจากผู้มีส่วนได้ส่วนเสีย 4 กลุ่ม ผู้เข้าร่วมการศึกษา จำนวน 48 คน เก็บรวบรวมข้อมูลโดยการสนทนากลุ่มแบบกึ่งมีโครงสร้าง และจัดบันทึกการสนทนา และนำข้อความที่ได้จากการถอดเทปแบบคำต่อคำ ประโยคต่อประโยควิเคราะห์ข้อมูลด้วยการวิเคราะห์เนื้อหาตามความเป็นจริง และการวิเคราะห์แก่นสาร

ผลการศึกษา: พบประเด็นแก่นสารหลัก 3 ประเด็น ได้แก่ (1) การดูแลระยะยาวเป็นทั้งภาระทางเศรษฐกิจของครัวเรือน และการลงทุนเชิงระบบ (2) ความต้องการการดูแลที่ยังไม่ได้รับการตอบสนอง โดยเฉพาะการสูงวัยในถิ่นที่อยู่เดิม การดูแลผู้มีภาวะสมองเสื่อม และศักยภาพกำลังคน และ (3) อุปสรรคเชิงระบบด้านการเงิน ความเหนียวแน่นของผู้ดูแล การประสานงานข้ามภาคส่วน และบริบททางวัฒนธรรม

สรุปผลและข้อเสนอแนะ: การดูแลระยะยาวสำหรับผู้สูงอายุยังมีช่องว่างด้านการคุ้มครองทางการเงิน การดูแลผู้มีภาวะสมองเสื่อม ศักยภาพกำลังคน และการบูรณาการบริการ จึงควรเร่งพัฒนาระบบการดูแลระยะยาวแบบบูรณาการระดับชาติที่ยั่งยืน เน้นบริการชุมชน การสูงวัยในถิ่นที่อยู่เดิม และความร่วมมือข้ามภาคส่วน

คำสำคัญ: การดูแลระยะยาว, คุณค่าทางเศรษฐศาสตร์, ผู้มีส่วนได้ส่วนเสีย, การสนทนากลุ่ม

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ABSTRACT

Background and rationale: Thailand is rapidly transforming into a super-aged society, resulting in an increased need for long-term care amid structural and resource restrictions. Incorporating stakeholder perspectives is therefore imperative for the development of sustainable long-term care policies.

Objective: This study aimed to investigate stakeholders' perspectives regarding the economic value, care demands, and barriers of long-term care.

Methods: A qualitative research design including focus group discussions was implemented. Participants were purposefully chosen from four stakeholder groups, total 48 individuals. Data was collected by focus group discussions, audio recordings, and field notes, with exact transcripts evaluated by qualitative content evaluation and thematic analysis.

Results: Three main themes were identified: (1) long-term care as both an economic burden on households and a systemic investment; (2) unmet care needs, particularly in the areas of aging in place, dementia care, and workforce capacity; and (3) systemic barriers concerning financing, caregiver burnout, intersectoral coordination, and cultural context.

Conclusions and recommendation: Long-term care for older persons in Thailand continues to encounter deficiencies in financial protection, dementia care, workforce capacity, and service integration. Therefore, it is imperative to establish a sustainable, nationally integrated long-term care system that prioritizes intersectoral collaboration, aging in place, and community-based services.

Keywords: Long-term care, Economic Value, Stakeholder, Focus group

Background and rationale

The global population is ageing rapidly due to prolonged increases in life expectancy and decreasing fertility rates. This demographic shift has led to a significant rise in the demand for long-term care (LTC) services, placing increasing strain on health and social care systems in various contexts.^{1,2} Long-term care involves comprehensive support for those facing functional limits due to chronic illness, disability, or age-related decline, extending beyond services specific to dementia.^{1,2} Neurological disorders, including stroke, substantially lead to physical and cognitive disabilities, often resulting in extended dependency and ongoing care requirements over time.³⁻⁹ The World Health Organization (WHO) defines long-term care (LTC) as a comprehensive array of medical, social, and personal services designed to assist individuals who have diminished intrinsic capacity, are at danger of future decline, and cannot fully restore independent functioning.^{1,2, 10, 11, 12}

Long-term care is structured across various environments, including institutional facilities like nursing homes and adult day-care centers, community-based programs, and home-based care provided by professional caregivers or informal family members.^{2, 13} Worldwide, long-term care recipients are primarily individuals aged 65 and older, with over fifty percent being 80 years or older.¹³ In light of the intricate and enduring aspects of care dependency, modern long-term care (LTC) models increasingly prioritize person-centered care (PCC), which highlights individual preferences, dignity, and autonomy, as well as relationship-centered care (RCC), which emphasizes trust, reciprocity, and enduring interpersonal relationships between care recipients and caregivers.^{10, 14, 15, 16} The economic ramifications of long-term care (LTC) are substantial, with worldwide spending anticipated to exceed trillions of US dollars, indicating a collective and escalating burden shouldered by both formal care systems and informal family networks.^{17, 18}

Thailand exemplifies one of the fastest ageing populations in Asia, making long-term care an immediate issue for public health and social development. Dementia significantly adds to care dependency; nevertheless, a diverse array of chronic diseases and disabilities also plays a considerable role in the increasing demand for long-term care among the elderly.^{17, 19} Historically, caregiving in Thailand has primarily been familial, influenced by entrenched cultural ideals of filial duty and bolstered by community support systems, such as village health volunteers and primary care facilities.^{19, 20} Nonetheless, this dependence on informal caregiving frequently places considerable financial, emotional, and physical strains on households, especially since numerous long-term care expenses are non-medical and insufficiently addressed by public funding systems.^{18, 21, 22, 23} Despite the Universal Coverage Scheme offering some assistance, institutional long-term care services are constrained by exorbitant prices, resulting in families predominantly bearing the burden of care provision, often lacking adequate professional supervision or respite opportunities.²⁰

In line with global trends, Thailand continues to encounter enduring structural issues in the organization and provision of long-term care. Access to services is hindered by ongoing limitations, such as prolonged waiting times, significant out-of-pocket costs in private facilities, transportation difficulties, inadequate understanding of available programs, and an expanding digital divide.²⁴ The viability and quality of long-term

care provision are further jeopardized by worker shortages, considerable caregiver load, and deficiencies in professional training.^{24,25} Simultaneously, there has been an increasing need for specialized long-term care services that cater to disabilities, dementia, and mental health needs, which beyond conventional elder care models.^{29,26,27,28} The issues are exacerbated by enduring policy and financial impediments, such as inadequate public investment, disjointed administrative structures, restricted insurance coverage, and rigid regulatory frameworks, which undermine the long-term viability of long-term care systems.^{29,30,31,32,33,34}

In addition to these structural and financial constraints, apprehensions about perceived service quality and institutional trust remain substantial. Senior individuals frequently convey discontent with institutional care settings, while cultural stigma and negative societal perceptions around dependency and official assistance may postpone or deter the pursuit of support.^{19,20,35,36} Effective communication and interprofessional collaboration are crucial components of integrated long-term care delivery; however, these processes often face challenges due to professional hierarchies, conflicting organizational goals, and persistent communication gaps between health and social care sectors.^{37,38,39,40,41} Collectively, these interrelated problems underscore the necessity for a nuanced, context-sensitive approach to comprehending long-term care, one that incorporates the perspectives of individuals directly involved in its planning, provision, and utilization.

Despite increasing governmental focus on population aging in Thailand, empirical research reflecting the perspectives of many long-term care stakeholders is still limited. There is a paucity of qualitative studies investigating the concurrent experiences and perceptions of economic value, care requirements, and access constraints among administrators, practitioners, supporting organizations, and service consumers. Addressing this research deficiency is crucial for formulating sustainable, equitable, and culturally relevant long-term care changes. To explore stakeholders' perspectives on the economic value, care needs, and structural challenges of long-term care for dependent older adults in Thailand. This study will provide evidence through focus group discussions that will inform policy development, improve service delivery, and aid in the design of integrated long-term care systems that address the intricate and evolving needs of an ageing population.

Method

Study Design

This study employed a qualitative descriptive design to investigate stakeholder experiences and viewpoints regarding long-term care (LTC) for elderly individuals in Thailand. Qualitative description was selected to produce a thorough, low-inference representation of participants' perspectives utilizing colloquial language, while adhering closely to the facts and refraining from imposing a pre-existing theoretical framework.⁴² This methodology is especially appropriate for health services research intended to guide policy and practice. The research was conducted under an interpretivist framework, recognizing that meanings are socially created through interaction and circumstance. To ensure the study quality, we considered parameters of the checklist by the Consolidated Criteria for Reporting Qualitative research (COREQ) in performing interviews, analyzing data and reporting results.⁴³

Research Team and Reflexivity

Focus group discussions (FGDs) were facilitated by a competent qualitative researcher possessing prior competence in community health and gerontology research. The moderator, Wachira Chanabutr, was aided by a note-taker who documented contextual details, group dynamics, and non-verbal communications. None of the facilitators held supervisory or service provision obligations for the participants. Prior to data collection, the research team engaged in reflexive discussions to identify potential assumptions related to long-term care, professional responsibilities, and cultural norms concerning aging and caregiving in Thailand. Reflexive notes were documented during data collection and processing to reduce interpretative bias.

Participants and Setting

Purposive sampling was employed to recruit people possessing direct expertise in long-term care as administrators, planners, service providers, or service recipients. Four stakeholder groups were comprised of: (1) administrators and local government officials ($n = 14$); (2) planners and care practitioners ($n = 12$); (3) representatives of supporting agencies ($n = 10$); and (4) older individuals and family caregivers ($n = 12$). This diversified sample technique aimed to enhance variance and encompass a wide range of opinions regarding policy, service delivery, and lived experience.

Eligibility requirements encompassed being 18 years of age or older, had a minimum of three months of experience with long-term care (as a provider, patient, or caregiver), and proficiency in Thai. Cognitive screening of older persons and family caregivers aged 60 years and above was conducted using the Mini-Mental State Examination (MMSE-Thai 2002); a score of ≥ 24 was required to ensure meaningful participation in group discussions. The MMSE demonstrated a sensitivity of 92%, a specificity of 92.6%, and an efficiency of 92.4%.⁴⁴

The research was carried out in Health Region 7, which includes the provinces of Roi Et, Khon Kaen, Maha Sarakham, and Kalasin in Northeastern Thailand. This region was chosen because of its swiftly aging population and its established combination of community-based and institutional long-term care services. Participants were sourced from public health facilities, encompassing municipalities and subdistrict health-promoting hospitals, in addition to commercial long-term care institutions.

Recruitment

Prior to participant recruitment, administrative consent was secured from provincial and district health authorities. Community health nurses and institutional administrators facilitated the identification of eligible participants. Potential volunteers were approached either in person or over telephone and given comprehensive information about the study's objectives, procedures, confidentiality, and the voluntary nature of their involvement. Informed permission in writing was acquired from all participants before the commencement of data collection. Recruitment persisted until data saturation was attained, characterized by the absence of fresh themes or significant insights during continuous analysis.

Data Collection

Data were collected via semi-structured focus group talks held from February to June 2025. Distinct discussions in focus groups were conducted for each stakeholder group to promote candid dialogue and reduce power disparities. An interview guide was created following a review of the current research regarding the economic benefit of long-term care, care requirements, and access obstacles. The guide underwent evaluation by three specialists in geriatric nursing, public health, and social policy to guarantee content authenticity and clarity.

The primary discussion themes encompassed: (1) perceptions on the economic ramifications of long-term care; (2) perceived care and service requirements of dependent elderly individuals; (3) obstacles to obtaining and providing long-term care services; and (4) recommendations for system enhancement. Focus group discussions were held in private and accessible venues, including subdistrict health-promoting hospitals, community centers, and institutional conference rooms. Each session endured for roughly 60 to 90 minutes.

All discussions were recorded audibly with the consent of the participants. Field notes were recorded to document contextual information and non-verbal exchanges. Audio recordings were transcribed verbatim by an external professional transcription service. Two pilot focus group discussions were held to develop the discussion guide; data from these sessions were excluded from the final study.

Data Analysis

Data were examined via reflexive thematic analysis as outlined by Clarke et al.⁴⁵ The analysis was conducted in four iterative phases: (1) familiarization with the data via repeated reading of transcripts; (2) independent inductive, line-by-line coding by two researchers; (3) organization of codes into candidate themes through constant comparison across transcripts and stakeholder groups; and (4) interpretive refinement and synthesis of themes to identify patterns of shared meaning.

The study team deliberated on analytic inconsistencies until an agreement was achieved. Excel software facilitated systematic data administration, coding, and retrieval. During the analytical process, reflexive talks were conducted to assess how researchers' disciplinary backgrounds and assumptions could influence interpretation.

Trustworthiness

Rigor and trustworthiness were achieved through tactics that addressed credibility, transferability, dependability, and confirmability. Credibility was enhanced through member verification, in which selected individuals assessed and confirmed the accuracy of initial interpretations. Furthermore, data source triangulation (stakeholder/participant triangulation) was utilized by contrasting narratives among stakeholder groups, hence augmenting interpretative validity. Transferability was facilitated by a comprehensive explanation of the study environment, participant attributes, and analytical methodologies. Dependability was improved by preserving an audit trail that records methodological decisions and coding procedures. Confirmability was enhanced via peer debriefing and reflexive journaling, so anchoring findings in participants' narratives rather than researcher biases.

Ethical Considerations

Approval was obtained from the Human Research Ethics Committee, Faculty of Medicine, Thammasat University (COA 137/2024). All participants were given detailed verbal and written information regarding the study and granted written informed consent before participation. Participation was optional, and individuals were apprised of their freedom to withdraw at any moment without repercussions. Confidentiality and anonymity were maintained by eliminating identifying details from transcripts and securely archiving audio files, which were subsequently removed after transcription.

Results

Characteristics of the Participants

A total of 48 participants were recruited from four stakeholder groups: administrators and local government officials (n = 14), care planners and practitioners (n = 12), representatives from supporting agencies (n = 10), and older individuals with family caregivers (n = 12). The research was carried out in Health Region 7 of Northeastern Thailand, which includes the provinces of Roi Et, Khon Kaen, Maha Sarakham, and Kalasin, encompassing both community-based and institutional long-term care (LTC) settings.

Table 1 indicates that the predominant demographic of participants was female (70.8%), with the majority aged between 36 and 45 years (37.5%). Registered nurses constituted the predominant professional category at 33.3%, succeeded by administrative personnel at 25.0% and family caregivers at 22.9%. Moreover, half of the participants were involved in institutional long-term care settings (54.2%), and almost half indicated having two to five years of experience connected to long-term care (45.8%). The distribution of participants among the four provinces was equitable, guaranteeing representation from both urban and rural service environments.

Table 1 Demographic Information of Participants.

Characteristic	FCGs 1 (n = 14)	FCGs 2 (n = 12)	FCGs 3 (n = 10)	FCGs 4 (n = 12)	Total (N = 48)
Age (years)					
22-35	4	3	2	2	11(22.9%)
36-45	6	5	4	3	18 (37.5%)
46-59	4	3	3	2	12 (25.0%)
≥ 60	0	1	1	5	7 (14.6%)
Sex					
Female	10	9	7	8	34 (70.8%)
Male	4	3	3	4	14 (29.2%)
Occupational Position¹					
Registered Nurse	4	8	3	1 ²	16 (33.3%)
Administrative Staff	8	1	3	0	12 (25.0%)

Characteristic	FCGs 1 (n = 14)	FCGs 2 (n = 12)	FCGs 3 (n = 10)	FCGs 4 (n = 12)	Total (N = 48)
Social Worker	1	1	4	0	6 (12.5%)
Other Practitioners ³	1	2	0	0	3 (6.3%)
Family Caregiver / Older Adult	0	0	0	11	11 (22.9%)
Years of Experience					
< 2 years	2	1	1	N/A	4 (11.1%)
2-5 years	7	6	5	N/A	18 (50.0%)
6-10 years	3	4	3	N/A	10 (27.8%)
> 10 years	2	1	1	N/A	4 (11.1%)
Work Setting					
Institutional LTC	8	7	5	6 ⁴	26 (54.2%)
Community-based LTC	6	5	5	6 ⁴	22 (45.8%)

¹ Professional positions are classified according to their primary function. Several players assumed various roles.

² Denotes a service user with a prior profession as a nurse.

³ Comprises Physician, Physical Therapist, and Occupational Therapist.

⁴ Service consumers and caregivers were inquired about the principal environment from which they obtain assistance.

Findings

To align with the study objective, results are organized using the investigate stakeholders' perspectives regarding the economic value, care demands, and barriers of long-term care. Accordingly, the findings are presented in three main themes and nine subthemes, reflecting stakeholder viewpoints on Thailand's long-term care (LTC) system. The subjects included (1) the economic significance of long-term care; (2) unaddressed care requirements, and (3) systemic obstacles.

These topics illustrate the concurrent experience of long-term care at the household, service, and systemic levels. Table 2 presents a summary of themes, subthemes, associated codes, and representative quotations.

Theme 1: Economic Value of Long-Term Care

Sub-theme 1.1: Household Burden

Caregivers consistently portrayed long-term care as a significant household burden, encompassing both financial strain and emotional stress. Participants described unpaid caregiving as a central feature of daily life, often requiring family members particularly women to reduce working hours or leave paid employment entirely. This loss of income was frequently accompanied by increased out-of-pocket expenditures, including costs for food supplements, medical equipment, transportation, and home modifications.

Numerous caregivers highlighted the lack of formal financial assistance, indicating that the burden of care-related costs predominantly fell on families. Emotional stress frequently correlated with financial worries,

as caregivers articulated apprehension regarding long-term viability and ambiguity concerning future care requirements.

"I had to completely resign from my job in order to care for my father full-time. Since then, our household income has plummeted drastically, but our expenses have climbed every month medical supplies, transportation, special cuisine, and housing adjustments. The system doesn't help much, so most of the money and emotional stress is on our family. Sometimes it feels like too much." (Female caregiver, 42 years old)

These accounts align with categories pertaining to unpaid caring, diminished household income, out-of-pocket expenses, and absence of institutional support, underscoring the aggregate hardship encountered at the household level.

Sub-theme 1.2: Systematic Investment

Stakeholders described LTC as a mechanism for strengthening health system sustainability, particularly in the context of population ageing. These views were reflected in codes such as community-based LTC, long-term cost savings, and prevention of hospital readmissions.

"Investing in community-based long-term care is not only a social responsibility, but also a cost-effective strategy, from a system perspective. We can prevent repeated hospital admissions, reduce overcrowding, and lower long-term healthcare expenditures by ensuring that older individuals receive appropriate care in the community or at home. Despite the initial appearance of a high investment, it ultimately contributes to the system's stability and the conservation of resources." (Male administrator, 51 years old.)

Theme 2: Unmet Healthcare Needs

Sub-theme 2.1: Autonomy and Dignity (Aging in Place)

Stakeholder participants articulated a pronounced preference for aging in place, highlighting the significance of autonomy, dignity, and familiarity with home and community settings. Senior individuals and their caregivers articulated that being at home is fundamental to emotional well-being and personal identity.

Participants also emphasized the scarcity of community resources, such as insufficient home-care services, inadequate assistive devices, and a deficiency in environmental adaptations. These limitations impeded older persons' capacity to reside autonomously, notwithstanding their desires. Codes related to this subtheme encompassed the preservation of autonomy, dignity, aging in situ, and inadequate community resources.

"The majority of the elderly individuals with whom I interact are eager to remain in their own residences. That is the location where they feel at ease and maintain control over their lives. Residing at home affords them dignity. However, in all honesty, the system fails to provide sufficient support for them there is insufficient home care, safety support, or follow-up resulting in a significant number of individuals being compelled to vacate their residences, despite their wishes." (Female planner, 39 years old)

Sub-theme 2.2: Inequalities in Dementia Care

Families and practitioners uniformly characterized dementia care as a significant unmet necessity. Participants indicated restricted availability of early screening, diagnostic services, and dementia-focused day-

care programs. Caregivers often articulated ambiguity regarding the management of behavioral symptoms, safety issues, and the development of the disease.

A lot of families reported experiencing isolation and a lack of assistance, especially in rural or resource-constrained regions. Codes related to this subtheme encompassed insufficient screening, restricted dementia services, and inadequate caregiver support systems.

"We were genuinely unsure of where to go or what to do when my mother began experiencing memory problems. There were no explicit guidelines, no appropriate screening, and no one to provide an explanation of the disease's progression. We experienced a sense of complete helplessness and overwhelm, as if we were left to manage everything independently, particularly given the scarcity of dementia services in our region." (Female family caregiver, 55 years old)

Sub-theme 2.3: Deficiency in Workforce Training

Healthcare practitioners saw deficiencies in formal training as an impediment to delivering high-quality long-term care. Participants said that a significant portion of their knowledge was obtained through informal, experiential learning rather than formal education or certification programs. This was especially apparent in the care of dementia and the management of intricate chronic illnesses.

Practitioners indicated a necessity for structured training, supervision, and ongoing professional development to enhance confidence and competence. This subtheme was substantiated by codes including informal learning, inadequate training, and the necessity for structured education.

"On-the-job experience is the primary source of the majority of our talents, as opposed to structured training. In the long-term care system, formal training is frequently neglected due to chronic staff shortages and limited budgets, which complicates the effective management of complex cases among older individuals." (Female nurse, 34 years old)

Theme 3: Systemic Obstacles

Sub-theme 3.1: Funding Deficiencies

Participants identified fragmented and short-term funding channels as a significant systemic obstacle. Numerous LTC programs were found to depend on project-based budgeting, resulting in discontinuity with the conclusion of funding cycles. Administrators voiced apprehension regarding the lack of long-term financial strategy and consistent resource distribution.

Codes related to this subtheme encompassed fragmented funding, short-term budgets, and unsustainable planning.

"Long-term care is funded by the Long-Term Care Fund, and local committees make decisions on a case-by-case basis. Nevertheless, service continuity is disrupted, and innovation and long-term system planning are constrained by limited budgets, complex governance structures, and delayed disbursement in decentralized fiscal arrangements." (Female administrator, 47 years old)

Sub-theme 3.2: Caregiver Burnout

Family caregivers often reported physical fatigue, emotional turmoil, and deteriorating personal health due to extended caring duties. Participants highlighted the shortage of respite services and psychosocial support, observing that caring responsibilities were frequently incessant and unyielding.

This subtheme was evident in codes including fatigue, deteriorating health, and insufficient respite services.

"There are days when I am completely drained, both physically and emotionally. It is a full-time obligation to provide him with care; however, there is no designated area for me to recuperate, and no one to assume my responsibilities when I require a break. at times, caregivers may experience a sense of invisibility within the system, as they are expected to manage independently without any genuine assistance." (Female caregiver, 60 years old)

Sub-theme 3.3: Inadequate Intersectoral Coordination

Stakeholders emphasized inadequate cooperation between the health and social care sectors. Participants reported inadequate communication, ambiguous role definition, and disjointed service provision, frequently leading to interruptions in care for elderly individuals.

Codes pertaining to this subtheme encompassed inadequate cross-sector communication and insufficient continuity of care.

"Healthcare and social service providers seldom communicate or exchange information, even when they are providing care for the same elderly individual." Consequently, older individuals are displaced between systems, and care becomes fragmented. The integration and linking of long-term care data should be more systematic to guarantee the continuity of care." (Female social worker, 44 years old)

Sub-theme 3.4: Cultural Stigmatization

Institutional long-term care was largely regarded as socially stigmatized. Participants articulated significant cultural expectations on filial duty, resulting in families eschewing formal care providers despite caregiving demands above their capabilities.

This subtheme was underpinned by rules including social judgment, standards of filial piety, and restricted acceptance of institutional care.

"Our society frequently perceives the act of placing parents in a nursing home as a breach of filial obligation or abandonment. Individuals converse, and families perceive scrutiny from the community. Despite the fact that the physical, emotional, and financial burden of caring for our parents becomes overwhelming and there are moments when we plainly require professional support, many of us continue to do so at home due to this stigma." (Male family caretaker, 48 years old)

Table 2 Summary of themes and sub-themes

Main themes	Subthemes	Key descriptions	Example quotes
Theme 1: Economic value	1.1 Household burden	Long-term care was regarded as a significant financial and emotional strain for families. Uncompensated caring duties frequently compelled family members, especially women, to diminish or forgo paid employment, resulting in income reduction and heightened household expenditures.	<i>"I had to terminate my career to care for my father, which led to a substantial decrease in our household income. Consequently, the complete financial responsibility falls upon us, with minimal to no external assistance."</i>

Main themes	Subthemes	Key descriptions	Example quotes
	1.2 Systematic Investment at the Macro Level	Long-term care was regarded as a strategic public investment. Stakeholders highlighted that preventive and community-oriented long-term care services could diminish hospital admissions and yield long-term financial savings for the healthcare system.	<i>"Investing in community-based long-term care programs can reduce costs for the system relative to recurrent hospital admissions."</i>
Theme 2: Unmet Healthcare Needs	2.1 Autonomy and Dignity (Aging in Place)	Older adults and their caregivers demonstrated a pronounced inclination to stay in their residences and localities. Nevertheless, inadequate community resources and support services constrained the capacity to uphold autonomy and dignity while aging in place.	<i>"Elderly individuals desire to remain in their residences; however, the current system fails to provide the necessary support for their safe continuation."</i>
	2.2 Inequalities in Dementia Care	Dementia care was identified as a significant unmet requirement. Participants indicated restricted access to screening, dementia-specific services, and caregiver support, resulting in families feeling unprepared and inundated.	<i>"We lack strategies to address memory issues; families experience a sense of disorientation and helplessness, as though abandoned to navigate this challenge independently."</i>
	2.3 Deficiency in Workforce Training	Healthcare practitioners emphasized insufficient formal education in geriatric and dementia care. Predominantly depended on informal, experiential learning, which constrained confidence in addressing intricate care requirements.	<i>"The majority of us acquired knowledge through practical experience; we require adequate training to manage intricate cases involving older adults."</i>
Theme 3: Systemic Obstacles	3.1 Funding Deficiencies	Disjointed and ephemeral funding sources were recognized as obstacles to sustained long-term care delivery,	<i>"The Long-Term Care Fund is the foundation of long-term care, with local case-based decisions. However, continuity, innovation, and long-term</i>

Main themes	Subthemes	Key descriptions	Example quotes
		leading to the interruption of programs and services.	<i>planning are undermined by fiscal decentralization, limited budgets, and delayed disbursement.</i>
	3.2 Caregiver burnout	Extended caregiving without sufficient break or assistance resulted in physical fatigue, emotional strain, and deteriorating health among family caregivers.	<i>"At times, I feel unable to continue; there is no refuge or assistance available for caregivers like us."</i>
	3.3 Inadequate Intersectoral	Inadequate communication and coordination across health and social care sectors led to disjointed services and a deficiency in continuity of care for elderly individuals.	<i>"Healthcare personnel and social service staff do not communicate with one another." Older individuals find themselves in a state of stagnation, lacking genuine continuity of care.</i>
	3.4 Cultural Stigmatization	Institutional long-term care continued to be socially stigmatized. Cultural norms around filial obligation deterred families from utilizing formal long-term care services, despite care requirements surpassing home capabilities.	<i>"It is often asserted that placing one's parents in a nursing home constitutes abandonment, prompting many families to cope, even when the burden becomes excessive."</i>

Challenging Factors

Participants identified several interconnected problems that hindered the efficacy and sustainability of Thailand's long-term care (LTC) system. These issues arose at the household, service delivery, and systemic levels, illustrating the aggregate effects of caregiver burden, unfulfilled care requirements, and institutional limitations.

Restricted Support Frameworks

Stakeholders regularly indicated insufficient support systems for family caregivers and frontline care professionals. Caregivers emphasized the lack of organized instruction on caregiving methods, stress alleviation, and communication abilities, which resulted in ambiguity and emotional distress. Practitioners observed that insufficient interdisciplinary teamwork frequently led to fragmented care and service disruption.

Participants underscored the necessity for enhanced cooperation among nurses, social workers, village health volunteers, and local administrative entities to effectively meet intricate care requirements and alleviate the stress on individual caregivers.

Regulatory and Structural Limitations

Participants identified insufficient policy coherence and fragmented governance as significant issues at the system level. Long-term care policies were regarded as inadequately coordinated across sectors, exhibiting minimal coherence between national plans and local execution. Insufficient and temporary finance also limited the continuity and scalability of LTC services.

Infrastructure constraints were emphasized, notably the absence of age-friendly environments. Participants observed that inadequate housing, restricted public transit, and insufficient community amenities hindered older individuals' capacity for independent living, hence augmenting their need on familial care or institutional services.

Deficiencies in Person-Centered and Responsive Services

Participants recognized deficiencies in service transparency and responsiveness as other issues. Numerous caregivers and elderly individuals indicated challenges in obtaining clear and thorough information regarding available long-term care services, eligibility requirements, and referral processes. The absence of information hindered informed decision-making and postponed service utilization.

Moreover, stakeholders highlighted that older persons and families were infrequently engaged in care planning or service assessment, diminishing the services' responsiveness to individual preferences and cultural contexts. Inadequate chances for ongoing professional development were seen, hindering the provision of compassionate and culturally responsive care.

These problematic aspects collectively demonstrate the intricate interaction between household burdens, unmet care requirements, and structural limitations within Thailand's long-term care system. Ongoing discrepancies between service demand and availability, coupled with financial and governance constraints, highlight the necessity for coordinated and integrated strategies in the development of long-term care.

Discussions

This study offers a comprehensive, multi-faceted analysis of long-term care (LTC) for dependent elderly individuals in Thailand, highlighting the interplay of economic factors, unmet care requirements, and systemic obstacles that influence the existing LTC environment. By incorporating the perspectives of administrators, practitioners, supporting agencies, and service users, the findings enhance current evidence by illustrating that issues in long-term care are interconnected and mutually reinforcing, functioning at home, community, and systemic levels.

Economic Value of Long-Term Care

Stakeholders generally characterized long-term care as being a dual economic reality: a significant household burden and a strategic state investment. Female family caregivers reported substantial financial burdens due to decreased workforce engagement, loss of income, and rising out-of-pocket costs associated with daily care and home modifications. These findings correspond with global literature highlighting the

unequal economic and psychosocial burdens experienced by informal caregivers, especially women, in both high-income and low- and middle-income countries (LMICs).^{46,47,48,49,50,51}

In contrast, administrators and planners underscored the enduring economic benefits of investing in community-based and preventative long-term care services, emphasizing their capacity to decrease unnecessary hospital admissions and postpone institutionalization. This viewpoint aligns with findings from nations like Japan and South Korea, where publicly funded long-term care insurance programs have facilitated better service accessibility and bolstered health system sustainability.^{52,53,54} Thailand's anticipated long-term care expense, forecast to approach 500 billion baht by 2040, highlights the imperative for establishing sustainable finance methods that reconcile governmental investment, social insurance systems, and household contributions.^{55,56,57} The confluence of different viewpoints illustrates a structural tension between immediate household expenses and long-term systemic benefits, indicating that policy interventions must explicitly consider both aspects to attain equity and sustainability.

Unmet Healthcare Needs

The research revealed ongoing unmet care requirements that hinder the efficacy and responsiveness of Thailand's long-term care system. A significant discovery was the pronounced preference among older persons and families for aging in place, indicating a need to preserve autonomy, dignity, and social connectivity within familiar surroundings. Although this desire corresponds with person-centered care concepts and research connecting community-based care to enhanced quality of life,^{58,59,60} participants identified insufficient local resources, inadequate house renovations, and restricted transportation services as significant limitations.

Dementia care has arisen as a significant service deficiency. Families regarded dementia as a "silent crisis," marked by restricted access to early screening, insufficient specialist day-care facilities, and inadequate caregiver education. These findings reflect global evidence showing that dementia services in low- and middle-income countries frequently fall short of the swiftly increasing incidence rates, leading to postponed diagnoses and increased caregiver strain.^{61,62} In the absence of focused dementia-specific interventions, informal caregivers are likely to continue as the principal and frequently unsupported providers of care. The capacity of the workforce was another significant issue. Practitioners in various environments indicated a dependence on experiential learning instead of formal geriatric or dementia-specific training, which raises issues regarding care quality and staff readiness. This finding aligns with international studies highlighting that systematic workforce development, encompassing certification pathways, ongoing professional education, and mentorship, is crucial for enhancing long-term care systems.^{63,64} Addressing workforce deficiencies is thus not merely a question of skill augmentation but also a need for providing safe, person-centered, and culturally competent care.

Systemic Obstacles to Efficient Long-Term Care Provision

The findings underscore structural impediments that impede the operation of the long-term care system, in addition to human and service-level deficiencies. Disjointed and short-term finance mechanisms were generally regarded as detrimental to program continuity and long-term planning, an issue frequently noted in low- and middle-income country contexts where long-term care is consistently deprioritized in comparison to acute care.^{65,66,67} This financing uncertainty constrains the scalability of effective pilot efforts and undermines institutional responsibility.

Caregiver burnout has become a widespread and inadequately handled concern. Family caregivers reported physical fatigue, emotional turmoil, and deteriorating health, corroborating global research that associates extended informal caring with depression, musculoskeletal ailments, and diminished quality of life.^{68,69,70,71} The lack of structured respite services and psychosocial support intensifies caregiver vulnerability, highlighting the necessity for policies that acknowledge caregivers as secondary users of care rather as overlooked resources.

Participants highlighted inadequate coordination across health and social care sectors, leading to fragmented service delivery and interrupted care continuity. These findings correspond with international research that identifies intersectoral collaboration as a continual problem in integrated care models.^{72,73,74} In the absence of shared governance frameworks, interoperable information systems, and explicit role delineation, older persons and their families frequently find themselves navigating intricate systems autonomously.

The cultural stigma associated with institutional long-term care constitutes an additional obstacle. Ingrained values of filial piety and moral obligation deter families from pursuing formal care, even when caregiving demands surpass household capabilities. This stigma, observed in Thailand and other Asian cultures,^{75,76,77,78} fosters dependence on informal care and postpones prompt service utilization. perpetuates reliance on informal care and delays timely service utilization.

Overcoming cultural hurdles necessitates not just the development of services but also public dialogue and community involvement that reconceptualizes long-term care as a supplementary, rather than a replacement, form of familial support.

Implications for Policy and Importance

The findings indicate four interconnected priorities for long-term care reform in Thailand: (1) fortifying financial protection via sustainable and pooled financing mechanisms; (2) broadening dementia-specific and community-based services to facilitate aging in place; (3) investing in workforce development across both formal and informal care sectors; and (4) improving coordination between health and social services. Although worldwide long-term care models provide significant insights, direct policy implementation is improbable to work without meticulous cultural and institutional adjustments.^{79,80,81}

In Thailand, where familial caregiving is paramount, effective long-term care reform must be community-oriented, culturally attuned, and participatory, actively involving older individuals and caregivers in

the design and assessment of services. The conclusions derived from this study transcend the Thai context. Numerous low- and middle-income countries encounter analogous demographic shifts, little public investment, and robust familial caregiving norms. The findings enhance the global dialogue on reconciling traditional care practices with the requirements of contemporary, equitable long-term care systems.

Limitations

This qualitative study emphasized the depth of stakeholder perspectives rather than generalizability. Data were gathered from a singular health region, perhaps constraining applicability to alternative scenarios. Cultural norms and social desirability may have limited critical expression, notwithstanding the use of stratified focus groups. The experiences of older persons with significant cognitive impairment were indirectly obtained via caregivers.

Conclusions

This study illustrates that long-term care (LTC) in Thailand is perceived as both (i) a substantial household burden driven by income loss, out-of-pocket costs, and caregiver strain and (ii) a strategic public investment that can reduce avoidable hospital use and strengthen system sustainability when delivered through community-based, preventive models, as evidenced by focus group discussions with administrators and local government officials, care planners and practitioners, supporting agencies, and older adults with family caregivers. The priority care demands of all stakeholder groups were to enable aging in place with dignity, expand dementia-specific pathways (screening, day care, and caregiver guidance), and enhance workforce capacity through structured training and supervision. Stakeholders also identified systemic obstacles that currently impede the attainment of these objectives: fragmented and short-term financing, inadequate respite and psychosocial support for caregivers, weak coordination and information continuity between health and social care, and persistent cultural stigma associated with formal/institutional care. Ultimately, the results substantiate the necessity of a nationally integrated, person and relationship-centered long-term care (LTC) system that is in accordance with the experienced priorities of older individuals and their families in terms of financing, workforce development, and cross-sector governance.

Recommendations

Reforms should prioritize the following: the expansion of community-based and dementia-specific services, systematic workforce development, strengthened health–social care integration, and public strategies to reduce stigma and reposition formal long-term care as a complementary service to family care. Sustainability pooled financing should also be a priority.

Body of knowledge

This study provides concise multi-stakeholder evidence from a middle-income, increasingly aging context, conceptualizing long-term care (LTC) as an interconnected care ecosystem that is influenced by

culture, gender, and informal caregiving. The results bolster person- and relationship-centered care frameworks and provide transferable insights for the development of long-term care in comparable environments.

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References

1. World Health Organization. **Rebuilding for sustainability and resilience: strengthening the integrated delivery of long-term care in the European Region** [Internet]. 2022 [Cited 2025 Oct 26] Available From: <https://www.who.int/europe/publications/i/item/WHO-EURO-2022-5330-45095-64318>
2. World Health Organization. **Long-term care for older people: package for universal health coverage**. [Internet]. 2024 [Cited 2025 Oct 26] Available From: <https://www.who.int/publications/i/item/9789240086555>
3. Uddin KN. Non-communicable disease (NCDs). *Birdem Med J* 2021; 12(1):1-5. DOI: 10.3329/birdem.v12i1.57217
4. World Health Organization. **World Stroke Day 2022** [Internet]. 2022 [cited 2025 Apr 2] Available from: <https://www.who.int/srilanka/news/detail/29-10-2022-world-stroke-day-2022>
5. CareerStaff Unlimited. **Healthcare Staffing Blog: The biggest challenges of long-term care in 2023** [Internet]. 2022 [Cited 2022 Dec 29] Available from: <https://www.careerstaff.com/healthcare-staffing-blog/biggest-challenges-of-long-term-care/>
6. Sidek NN, Kamalakannan S, Tengku Ismail TA, Musa KI, Ibrahim KA, Abdul Aziz Z, et al. Experiences and needs of the caregivers of stroke survivors in Malaysia-A phenomenological exploration. *Front Neurol* 2022; 13: 996620. DOI: 10.3389/fneur.2022.996620
7. Fong JH. Disability incidence and functional decline among older adults with major chronic diseases. *BMC Geriatr* 2019; 19(1): 323. DOI: 10.1186/s12877-019-1348-z
8. Van Dyke,K. The Incredible Costs of Chronic Diseases: Why they Occur and Possible Preventions and/or Treatments. *J Health Edu Res Dev* 2016; 4(3): 182. DOI: 10.4172/2380-5439.1000182
9. World Health Organization. **WHO European Centre for Primary Health Care: annual report of activities 2017** [Internet] 2018 [Cited 2025 Oct 26] Available from: <https://iris.who.int/items/1fc995ae-6b91-4476-adbf-7c7285ecc193>
10. World Health Organization. **Ageing and health** [Internet]. 2025 [cited 2025 Apr 2] Available from: <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>

11. Perracini MR, Arias-Casais N, Thiagarajan JA, Rapson C, Isaac V, Ullah S, et al. A Recommended Package of Long-Term Care Services to Promote Healthy Ageing Based on a WHO Global Expert Consensus Study. *J Am Med Dir Assoc*. 2022; 23(2): 297-303.e14. DOI: 10.1016/j.jamda.2021.12.019
12. World Health Organization. **Integrated continuum of long-term care** [Internet]. 2024 [cited 2025 Apr 2] Available from: <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/ageing-and-health/integrated-continuum-of-long-term-care>
13. OECD. **Health at a glance 2019: OECD indicators**. Paris: OECD Publishing; 2019 [Internet]. 2024 [cited 2025 Apr 2] Available from: <https://doi.org/10.1787/4dd50c09-en>
14. Cornelison L. The culture change movement in long-term care: Is person-centered care a possibility for the looming age wave?. *NAELA J* 2016; 12(2): 203–20.
15. Hirschmann K, Schlair S. Relationship-centered care. In: Sreeramoju P, Weber S, Snyder A, Kirk L, Reed W, Hardy-Decuir B, editors. *The patient and health care system: Perspectives on high-quality care*. Cham: Springer; 2020. 143–56.
16. Nolan MR, Davies S, Brown J, Keady J, Nolan J. Beyond person-centred care: A new vision for gerontological nursing. *J Clin Nurs* 2004; 13(s1): 45–53. DOI: 10.1111/j.1365-2702.2004.00926.x
17. World Health Organization. **World failing to address dementia challenge** [Internet]. 2021 [cited 2025 Apr 2] Available from: <https://www.who.int/news/item/02-09-2021-world-failing-to-address-dementia-challenge>
18. Hfocus(เจาะลึกระบบสุขภาพ). **กรมการแพทย์ห่วง "สังคมสูงวัย" พบ! ผู้สูงอายุป่วยสมองเสื่อมเพิ่มขึ้นทุกปี** [อินเทอร์เน็ต]. 2566 [อ้างเมื่อ 2 เมษายน 2568]. จาก: <https://www.hfocus.org/content/2023/12/29302>
19. Mongklam P, Kraithaworn P, Piyatrakul S. Exploring dementia care for community-dwelling older adults in Thailand: A qualitative descriptive study. *Belitung Nurs J* 2025; 11(4): 459–67. DOI:10.33546/bnj.3835.
20. World Bank Group. **Caring for Thailand's aging population**. Bangkok: World Bank; 2021 [Internet]. 2021 [cited 2025 Apr 2] Available from: <https://www.worldbank.org/en/country/thailand/publication/caring-for-thailand-s-aging-population>
21. Nalinee Nakittipha Chuakhamfoo, Pudtan Phantunane, Sirintorn Chansirikan, Thaworn Sakunphanit, Supasit Pannarunothai. Cost of dementia care in rural Thai households. *J Med Assoc Thai* 2020; 103(11): 1138. DOI: 10.35755/jmedassothai.2020.11.11212
22. Lindeza P, Rodrigues M, Costa J, Guerreiro M, Rosa MM. Impact of dementia on informal care: A systematic review of family caregivers' perceptions. *BMJ Support Palliat Care* 2020; 14(e1): e38–e49. DOI: 10.1136/bmjspcare-2020-002242
23. Hu Y, Guo X, You H, Liu L, Wang Y. Mediating effect of social support on the relationships between caregiver burden and quality of life in family caregivers of people with dementia: A cross-sectional study in Rural China. *BMC Nurs* 2025; 24(1): 37. DOI: 10.1186/s12912-024-02671-9.

24. Toprak DK, Şahin B. Evaluation of long-term care services in Turkey from the perspectives of primary stakeholders. **Geriatr Nurs** 2025; 64: 103437. DOI: 10.1016/j.gerinurse.2025.103437
25. Brown Wilson C. Developing community in care homes through a relationship-centred approach. **Health Soc Care Community** 2009; 17(2): 177-186. DOI: 10.1111/j.1365-2524.2008.00815.x
26. OECD. Care Needed: Improving the Lives of People with Dementia. Paris: **OECD Publishing**. 2018. DOI: 10.1787/9789264085107-en.
27. Navia RO, Constantine LA. Palliative care for patients with advanced dementia. **Nursing** 2022; 52(3): 19-26. DOI: 10.1097/01.NURSE.0000820024.83629.ee
28. Haque A, Soonthornchaiya R, Othaganont P, Chen Y-J. **Perceptions of Caregivers about Long-term Care Services in Bangladesh: A Qualitative Descriptive Study**. 2023; 27(3): 472-84. DOI: 10.60099/prijnr.2023.261494
29. von der Warth R, Kaiser V, Reese C, Brühmann BA, Farin-Glattacker E. Barriers and facilitators for implementation of a complex health services intervention in long-term care homes: a qualitative study using focus groups. **BMC Geriatr** 2021; 21(1): 632. DOI: 10.1186/s12877-021-02579-y
30. Ling T, Brereton L, Conklin A, Newbould J, Roland M. Barriers and facilitators to integrating care: experiences from the English Integrated Care Pilots. **Int J Integr Care** 2012; 12: e129. DOI:10.5334/IJIC.982
31. Threapleton DE, Chung RY, Wong SYS, Wong E, Chau P, Woo J, et al. Integrated care for older populations and its implementation facilitators and barriers: A rapid scoping review. **Int J Qual Health Care** 2017; 29(3): 327-334. DOI: 10.1093/intqhc/mzx041
32. Ikegami, N. Financing Long-Term Care: Lessons From Japan. **International Journal of Health Policy and Management** 2019; 8(8): 462-466. DOI: 10.15171/ijhpm.2019.35
33. Chen S, Li L, Jiao L, Gong S, Wang Z, Liu H, et al. Long-term care insurance in China: Current challenges and recommendations. **J Glob Health** 2024; 14: 03015. DOI: 10.7189/jogh.14.03015
34. Nazaripanah NS, Nadrian H, Bahrevar V, Lotfalinezhad E, Hashemiparast M. Barriers to participation in Iran's Integrated Geriatric Care Program: A qualitative study. **PLoS One** 2025; 20(2): e0315034. DOI: 10.1371/journal.pone.0315034
35. Sidek NN, Kamalakannan S, Tengku Ismail TA, Musa KI, Ibrahim KA, Abdul Aziz Z, et al. Experiences and needs of the caregivers of stroke survivors in Malaysia-a phenomenological exploration. **Front Neurol** 2022; 13:996620. DOI: 10.3389/fneur.2022.996620
36. Mohiuddin AK. An extensive review of patient satisfaction with healthcare services in Bangladesh. **Patient Experience Journal** 2020; 7(2): 59-71. DOI: 10.35680/2372-0247.1415
37. Tan AJQ, Chua WL, McKenna L, Tan LLC, Lim YJ, Liaw SY. Interprofessional collaboration in telemedicine for long-term care: An exploratory qualitative study. **J Nurs Scholarsh** 2023; 55(6): 1227-1237. DOI: 10.1111/jnu.12925

38. Meleis AI. Interprofessional Education: A Summary of Reports and Barriers to Recommendations. *J Nurs Scholarsh* 2016; 48(1): 106-112. DOI: 10.1111/jnu.12184
39. Pecukonis E. Professional centrism and its role in shaping interprofessional education: Implications for social work education. *J Teach Soc Work* 2020; 40(3): 211–20. DOI:10.1080/08841233.2020.1751776.
40. Curtis K, Tzannes A, Rudge T. How to talk to doctors--a guide for effective communication. *International Nursing Review* 2011; 58(1): 13-20. DOI: 10.1111/j.1466-7657.2010.00847.x.
41. Barbosa IA, Silva MJP. Nursing care by telehealth: What is the influence of distance on communication? *Rev Bras Enferm* 2017; 70: 928–34. DOI: 10.1590/0034-7167-2016-0142.
42. Sandelowski M. What's in a name? Qualitative description revisited. *Res Nurs Health* 2010; 33(1): 77–84. DOI: 10.1002/nur.20362.
43. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19(6): 349–57. DOI: 10.1093/intqhc/mzm042.
44. สถาบันเวชศาสตร์ผู้สูงอายุ. การประเมินเทคโนโลยีทางการแพทย์ เรื่องการเปรียบเทียบความสัมพันธ์แบบทดสอบสภาพสมองเสื่อมเบื้องต้น ฉบับภาษาไทย (MMSE-Thai) 2002 และแบบทดสอบสมรรถภาพสมองไทย (Thai Mini-Mental State Examination; TMSE) ในการคัดกรองผู้สูงอายุภาวะสมองเสื่อม. กรุงเทพฯ: ซีจีทู; 2551.
45. Clarke V, Braun V, Hayfield N. **Thematic analysis**. In: Smith JA, editor. *Qualitative psychology: A practical guide to research methods*. Los Angeles: Sage Publications; 2015. 222–48.
46. Arno PS, Levine C, Memmott MM. The economic value of informal caregiving. *Health Aff (Millwood)* 1999; 18(2): 182-188. DOI: 10.1377/hlthaff.18.2.182
47. Navaie-Waliser M, Feldman PH, Gould DA, Levine C, Kuerbis AN, Donelan K. When the caregiver needs care: the plight of vulnerable caregivers. *Am J Public Health* 2002; 92(3): 409-413. DOI: 10.2105/ajph.92.3.409
48. Gumas ED, Gunja MZ, Williams RD. **The Unequal Weight of Caregiving: Women Shoulder the Responsibility in 10 Countries: Findings from the Commonwealth Fund 2023 International Health Policy Survey** [Internet] 2024 [Cited 2025 Oct 26]. Available From: <https://www.commonwealthfund.org/blog/2024/unequal-weight-caregiving-women-shoulder-responsibility-10-countries>
49. Brady S. New Role, New Paycheck: The Impact on Women's Wages When Becoming a Caregiver for an Aging Parent. *Res Aging* 2024; 46(3-4): 197–209. DOI: 10.1177/01640275231217297
50. Cascella Carbó GF, García-Orellán R. Burden and Gender inequalities around Informal Care. *Invest Educ Enferm* 2020; 38(1): e10. DOI: 10.17533/udea.iee.v38n1e10
51. MetLife Mature Market Group. **The MetLife Study of Caregiving Costs to Working Caregivers** [Internet]. 2011 [Cited 2025 Oct 26]. Available From: <https://www.homecaregenerations.com/wp-content/uploads/2012/02/study.pdf>

52. Rhee JC, Done N, Anderson GF. Considering long-term care insurance for middle-income countries: comparing South Korea with Japan and Germany. **Health Policy** 2015; 119(10): 1319–29. DOI: 10.1016/j.healthpol.2015.06.001
53. Kim H, Jeon B, Frisina Doetter L, Tamiya N, Hashimoto H. Same same but different? Comparing institutional performance in the long-term care systems of Japan and South Korea. **Soc Policy Adm** 2022; 56(1): 148–62. DOI: 10.1111/spol.12761.
54. Kim H, Yoon NH, Hahn Y, Hashimoto H. Explaining Variations in Long-term Care Use and Expenditures Under the Public Long-term Care Insurance Systems: A Case Study Comparison of Korea and Japan. **Int J Health Policy Manag** 2023; 12: 6640. DOI: 10.34172/ijhpm.2022.6640
55. Chen L, Zhang L, Xu X. Review of evolution of the public long-term care insurance (LTCI) system in different countries: influence and challenge. **BMC Health Serv Res** 2020; 20(1): 1057. DOI: 10.1186/s12913-020-05878-z
56. Yiengprugsawan VS, Piggott J, editors. Shaping long-term care in emerging Asia: policy and country experiences. 1st ed. **Abingdon: Routledge**; 2022. doi:10.4324/9781003131373
57. Pattaraporn Khongboon, Sathirakorn Pongpanich. Estimating Long-Term Care Costs among Thai Elderly: A Phichit Province Case Study. **J Aging Res** 2018; 2018: 4180565. DOI: 10.1155/2018/4180565
58. Vanleerberghe P, De Witte N, Claes C, Schalock RL, Verté D. The quality of life of older people aging in place: a literature review. **Qual Life Res** 2017; 26(11): 2899–907. DOI: 10.1007/s11136-017-1651-0
59. Owusu B, Bivins B, Marseille BR, Baptiste DL. Aging in place: Programs, challenges and opportunities for promoting healthy aging for older adults. **Nurs Open** 2023; 10(9): 5784–6. DOI :10.1002/nop2.1872.
60. Miller KEM, Mulholland Green C, Fassinger A, Wolff JL. Long-Term Care Services and Supports Needed for Successful Aging-in-Place: A Critical Review. **Annu Rev Public Health** 2025; 46: 487–505. DOI: 10.1146/annurev-publhealth-071823-113604.
61. Ferri CP, Jacob KS. Dementia in low-income and middle-income countries: Different realities mandate tailored solutions. **PLoS Med** 2017; 14(3): e1002271. DOI: 10.1371/journal.pmed.1002271.
62. Fam J, Mahendran R, Kua EH. Dementia care in low and middle-income countries. **Curr Opin Psychiatry** 2019; 32(5): 461–4. DOI: 10.1097/YCO.0000000000000523.
63. Mattap SM, Mohan D, McGrattan AM, Allotey P, Stephan BC, Reidpath D, et al. The economic burden of dementia in low- and middle-income countries (LMICs): a systematic review. **BMJ Glob Health** 2022; 7(4): e007409. DOI: 10.1136/bmjgh-2021-007409.
64. Tran TA, Mattap SM, Warren N, Teng JHJ, Duong MD, Hoang VM, et al. Caregiver burden among dementia caregivers in low-and middle-income countries in Asia: a systematic review. **Aging Ment Health** 2025; 29(4): 578–90. DOI: 10.1080/13607863.2025.2462110.

65. Siqueira M, Coube M, Millett C, Rocha R, Hone T. The impacts of health systems financing fragmentation in low- and middle-income countries: a systematic review protocol. **Syst Rev** 2021; 10(1): 164. DOI: 10.1186/s13643-021-01714-5.
66. World Health Organization. **Long-term care financing: lessons for low- and middle-income settings.** Brief 6. Ensuring financial protection in long-term care. Geneva: World Health Organization; 2024.
67. Gatome-Munyua A, Sparkes S, Mtei G, Sabignoso M, Soewondo P, Yameogo P, et al. Reducing fragmentation of primary healthcare financing for more equitable, people-centred primary healthcare. **BMJ Glob Health** 2025; 10(1): e015088. DOI: 10.1136/bmjgh-2024-015088
68. Schulz R, Sherwood PR. Physical and mental health effects of family caregiving. **Am J Nurs.** 2008; 108(9): 23–7. DOI: 10.1097/01.NAJ.0000336406.45248.4c.
69. Gérain P, Zech E. Informal Caregiver Burnout? Development of a Theoretical Framework to Understand the Impact of Caregiving. **Front Psychol** 2019; 10: 1748. DOI: 10.3389/fpsyg.2019.01748.
70. Gérain P, Zech E. A Harmful Care: The Association of Informal Caregiver Burnout With Depression, Subjective Health, and Violence. **J Interpers Violence** 2022; 37(11-12): NP9738–NP9762. DOI: 10.1177/0886260520983259.
71. Soh XC, Hartanto A, Ling N, Reyes M, Sim L, Nadyanna M. Prevalence of depression, anxiety, burden, burnout, and stress in informal caregivers: An umbrella review of meta-analyses. **Arch Gerontol Geriatr Plus** 2025; 100197. DOI: 10.1016/j.aggp.2025.100197
72. Schulz R, Sherwood PR. Physical and mental health effects of family caregiving. **Am J Nurs** 2008; 108(9): 23–7. DOI: 10.1097/01.NAJ.0000336406.45248.4c.
73. Newbould L, Samsi K, Wilberforce M. Developing effective workforce training to support the long-term care of older adults: A review of reviews. **Health Soc Care Community** 2022; 30(6): 2202–17. DOI: 10.1111/hsc.13897.
74. Hajji O, El Abbadi B, Akhnif EH. Systematic Review of Financing Functions for Universal Health Coverage in Low- and Middle-Income Countries: Reforms, Challenges, and Lessons Learned. **Public Health Rev** 2025; 46: 1607745. DOI: 10.3389/phrs.2025.1607745.
75. Wu X. Negotiating filial care in transitions: an ethnographic study of family involvement in China's nursing homes. **J Chin Sociol** 2023; 10(1): 9. DOI: 10.1186/s40711-023-00187-4.
76. Zhan HJ, Feng Z, Chen Z, Feng X. The role of the family in institutional long-term care: cultural management of filial piety in China. **Int J Soc Welf** 2011; 20: S121–34. DOI: 10.1111/j.1468-2397.2011.00808.x.
77. Xiao C, Patrician PA, Montgomery AP, Wang Y, Jablonski R, Markaki A. Filial piety and older adult caregiving among Chinese and Chinese-American families in the United States: a concept analysis. **BMC Nurs** 2024; 23(1): 115. DOI: 10.1186/s12912-024-01789-0.

78. Woo J. The Myth of Filial Piety as a Pillar for Care of Older Adults among Chinese Populations. **Adv Geriatr Med Res** 2020; 2(2): e200012. DOI: 10.20900/agmr20200012.
79. Fischer J, Hongsoo K, Doetter LF, Rothgang H. Social Long-Term Care Insurance: An Idea Travelling Between Countries?. **International Impacts on Social Policy: Short Histories in Global Perspective**. Cham: Springer International Publishing, 2022. 435-447. DOI: 10.1007/978-3-030-86645-7_34
80. Chow N. The practice of filial piety and its impact on long-term care policies for elderly people in Asian Chinese communities. **Asian J Gerontol Geriatr** 2006;1(1):31–5.
81. Jeon B, Kwon S. Health and Long-Term Care Systems for Older People in the Republic of Korea: Policy Challenges and Lessons. **Health Syst Reform** 2017; 3(3): 214–23. DOI: 10.1080/23288604.2017.1345052.