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Aging in Thailand: An Overview of Formal and Informal Support

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This series of research reports deals with the status of the elderly in several Asian countries. It presents research that is being conducted under a broad project sponsored by the U.S. National Institute on Aging, the Comparative Study of the Elderly in Four Asian Countries (Grant No. AGO7637). The goal is to measure the social, economic and health characteristics of the older population (age 60 and above), to predict what changes may occur over the next decades, and to suggest implications for public policy. The original countries involved in the study are the Philippines, Singapore, Taiwan and Thailand. Reports on the elderly in other countries in Asia and on methods developed through the project using data from various countries may also be included in this report series.

Organizations collaborating in this research include: Population Studies and Training Center, Brown University; Population Institute, University of the Philippines; Department of Social Work and Psychology, National University of Singapore; Taiwan Provincial Institute of Family Planning; and Institute of Population Studies, Chulalongkorn University.

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Concern about population ageing and the need for policies and programs specifically targeted towards the older age groups is a relatively recent development in Thailand. Recognition of the rapid growth in the numbers of elderly and the inevitable shift towards an older age structure is beginning to increase the saliency of issues related to the health and social and economic welfare of older age groups to governmental officials and agencies. Researchers have been quick to pick up the challenge posed by the need for suitable data on these issues and considerable data collection efforts have been undertaken in Thailand during the last decade and a half. These include national and quasi-national surveys of the elderly as well as qualitative research using ethnographic methods, case studies, and focus groups (Chayovan, Wongsith, and Saengtienchai, 1988; National Statistical Office, 1994; Andrews, undated; Chayovan & Knodel, 1997; Pramualratana 1990, Caffrey 1992a and b; Knodel, Saengtienchai and Sittitrai, 1995; Knodel and Saengtienchai 1996 and forthcoming). The present review draws on this research as well as a variety of other material related to policies and programs affecting the elderly. Generally we use the term elderly to refer to persons aged 60 and older in accordance with the practice followed in most research and as incorporated in most official policies and programs in Thailand.

I. Demographic and Socio-economic Setting

In Thailand, as elsewhere in east and southeast Asia, rapid and substantial demographic, social and economic change has characterized the lifetime of the current generation of elderly. These changes shape and condition their relations with their children, relatives and communities. As such they are important for understanding the past, present, and future situation of the Thai elderly.

Table 1 presents past trends and future projections of key demographic indicators related to population aging in Thailand for the period 1970 to 2030 as estimated by the United Nations (1997 and 1998). Thailand's total population grew by almost 70 percent between 1970 and 2000 increasing from 36 million to just over 60 million making it the 18th most populous country. At the same time the population growth declined substantially from 3 percent around 1970 to under 1 percent currently. Future population growth is expected to slow even further, declining to less than half a percent per year by 2020.

[INSERT TABLE 1 HERE]

The decline in the growth rate is attributable to a rapid and significant fertility decline. The total fertility rate fell from 5.6 around 1970 to below 2 by the later 1990s. Thus total fertility is currently below the replacement level (which is 2.2 at present mortality levels. Fertility is anticipated to remain low for the next few decades, although evidence on family size preferences suggests it is unlikely to continue to fall far below replacement (Knodel et al., 1996; Bongaarts, 1998).

The fertility decline is also the primary demographic force driving population aging in Thailand. The fact that the decline was concentrated within such a relatively short period has important ramifications both the extent and pace of change in the age structure. The median age of the population has steadily risen since the start of fertility decline and by 2010 is expected to have almost doubled since 1970. Moreover, the share of

the population that is aged 60 or older has increased and will continue to do so at an accelerated rate in the coming decades. The pace of population aging in Thailand and other countries with similar rapid fertility declines will by far outpace that experienced historically by Western countries (Jones 1993). The projections indicate that the population aged over age 60 will increase its share of the total from 10 to 20 percent in a matter of only two decades.

Major mortality improvements have also occurred in Thailand over recent decades. Life expectancy at birth increased 10 years between 1970 and 1990 alone. Future improvements will be somewhat dampened by the AIDS epidemic. However, Thailand's recent success in combating the epidemic means that only a slowing and not a reversal of the trend is foreseen (Surasiengsunk et al. 1998). Moreover, since levels at young ages are already quite low, unlike the past much of the future mortality improvement will be concentrated at the older ages. These improvements in mortality translate into increased survival rates to the older ages and thus contribute to the growing numbers of elderly persons. Combined with the past high fertility rates, the result is unprecedented rapid growth of the numbers of Thai elders. During just the three decades between 1970 and 2000, the population aged 60 and older more than tripled and it is anticipated to almost triple again by 2030. Moreover, not only is the elderly's overall share of the population increasing, but the elderly population itself is beginning to age as evidenced by increases in the percent of the elderly who are aged 70 or older.

The changes in age structure that are taking place translate into changes in dependency ratios defined in terms of age groups. The old-age dependency ratio relates the population aged 60 and older to that of ages 15-59 while the total dependency ratio relates both persons below age 15 plus those above age 60 to those in the working ages. The faster growth of the population above 60 relative to population in the working ages results in increases in the old-age dependency ratio. Only a small increase is evident by 2000 but by 2030 there will be less than two working age persons for every person age 60 and over. Changes in the total dependency ratio follow a different path. Because recent fertility trends, the total dependency ratio has fallen substantially during recent decades. It is anticipated to remain low in the coming decades although some increase will occur.

Rapid social and economic changes that have potentially profound and complex implications for the circumstances under which the future elderly will live have accompanied the demographic change. Until the onset of the recent economic crisis that swept much of the region since mid-1997, Thailand experienced a prolonged period of rapid economic growth averaging 5 percent annual increases in the gross national product during the quarter century between 1970 and 1995 (World Bank, 1997). Nevertheless, Thailand has remained in the mid-range of developing economies in Asia in terms of the average GNP per capita. Although the majority of Thais still live in rural areas and are engaged in agriculture, between 1970 and 1990, the agricultural share of the labor force dropped from 80 to 64 percent and the proportion of the population in municipalities increased from 13 to 20 percent (World Bank, 1997). Formal education has also expanded. Especially striking are increases evident in the percentage of young persons who are continuing to secondary school which recently has been made mandatory. Although economic growth has come abruptly to halt with the recent economic crisis and turned negative in 1997 and 1998, it is still too soon to know just how extensive or prolonged the impact will be (Thai Farmers Bank, 1999). Even if recent predictions of renewed positive growth in 1999 prove too optimistic , it is

unlikely that major reversals in trends that are shaping the social context of the elderly will occur.

The elderly themselves have changed in important ways as a result of the demographic, social and economic change that has taken place. The elderly are living longer, a fact that contributes to the aging of the elderly themselves. According to the Surveys of Population Change conducted by the National Statistical Office, between 1974-76 and 1995-96, life expectancy at age 60 increased from 18.9 to 23.9 for women and 16.1 to 20.3 for men. The rapid expansion of education when the elderly of the last few decades were in their childhood and youth is resulting in pronounced compositional in the percent literate in recent decades. Gender differences in schooling in the past also leave their mark on the elderly of today. Thus in 1970, close to half of men and over 90 percent of women aged 60 and over were unable to read or write. By 2000, only modestly more than a tenth of elderly men and a quarter of elderly women will be illiterate (Christenson and Hermalin, 1991). Moreover, the average educational level of the elderly population will continue to improve over the coming decades as the better educated cohorts succeed those less educated ones in as time passes.

II. Formal Policies and Organized Programs

A. General Government Policies

Governmental concern about the elderly can be judged from policy statements from several sources: published formal statements presented to the parliament at the time a new government assumes office outline the policies they wish to pursue; national five-year plans for social and economic development are routinely formulated by the National Economic and Social Development Board (NESDB) to serve as guidelines for development activities; and a long-term plan for the elderly was formulated and subsequently revised by special committees formed for this purpose. Moreover, several laws as well as articles in the new constitution adopted in 1997 refer to the elderly.

The general policy statements presented to the parliament by recent governments have all contained some references to the elderly. However, these statements typically group the elderly together with other segments of the population such as children, the indigent, and the disabled whom are all seen as having special welfare needs. Among the five governments to take office during the period 1991 to 1997, several references were made to the need for ensuring health care to the elderly, including free medical insurance at government facilities. Other references have been made to establishing legislation to protect the elderly from exploitation, looking after their livelihood, developing their potential, and promoting their support and care. The concern with health aspects of elderly (and other groups) is related to the development of the free medical care program for elderly described below.

Elderly issues do not appear to be of high priority in most of Thailand's Five-Year Plans that guide national development (Chongvatana, Wongboonsin and Kowantanakul, 1998). As with statements to the parliament, they are usually included together with the broader set of disadvantaged groups mentioned above. The current Eighth Five-Year Plan (1997-2001), however, includes a section dealing with "isolated indigent elderly". The plan mentions providing social welfare benefits to elderly, including an increased living allowance to indigent elderly, universal free health

services for elderly, and discounted fares for transportation, both in urban and rural areas. Other goals mentioned are to encourage and assist families to understand and care for elderly members; to encourage private hospitals, NGOs, religious institutions and communities to share in caring for the aged; and to apply legislative measures to regulate private enterprises involved with providing services to the elderly (NESDB, undated).

The first Long Term Plan for the Elderly in Thailand (1986-2001) was developed by a special committee in compliance with recommendations of the 1982 World Assembly on Aging in Vienna sponsored by the United Nations. The Plan outlined policies and strategies in five aspects: health, education, income and employment, social and cultural issues, and social welfare (Sub-Committee of Research and Long-Term Planning for the Elderly, undated). It emphasizes efforts to enable elderly to be self-reliant and for the family to provide care and support. In 1992, at the request of the National Senior Citizen Council of Thailand for the government to be more explicit regarding policies on welfare, the long term plan was revised (Working Group on Policies and Main Strategies for Support of Elderly 1992). The policies advocated include providing welfare, educating the elderly on matters of relevance to them, supporting appropriate work, encouraging the community, religious institutions and the private sector to assist elderly, training personnel, and collecting basic data on elderly issues.

The elderly are explicitly mentioned in the 1997 Constitution of Thailand. Article 54 states that "persons who are 60 years old and over and who have insufficient income to maintain their living are entitled to receive assistance from the state." Article 80 further states that "The state must provide welfare for elderly, the poor, the handicapped or disabled, and destitute persons so they can have a good quality of life and be self reliant." A draft of an organic law specifying the type of welfare and benefits to elderly are entitled is being submitted to parliament. Moreover, existing legislation in the civil and commercial law specifies the reciprocal responsibilities of parents and children. One article specifically stipulates that children have the duty to support parents (section 2, article 1563). The criminal law also specifies penalties for persons who abuse the elderly (article 398) and for persons who dessert elderly (as well as children and ill persons) who can not help themselves leaving them prone to dangerous risk.

B. Health Policy and Programs

Not only does the likelihood of chronic conditions increases greatly with old age but injuries and their complications can have serious consequences requiring medical attention and hospitalization. In recognition of the special health care needs of the elderly, the MOPH officially established the Institute of Geriatric Medicine in 1994. The government has initiated a program of free medical care for persons aged 60 and over. In addition, some Thai elderly are also covered by other government schemes, in particular voluntary government health insurance (through the Health Card Scheme) and the Civil Servant Medical Benefits Scheme. Thus, some elderly have multiple health insurance coverage from the government since they may qualify for more than one scheme.

Free Medical Care Program. Starting in 1989, the Ministry of Public Health initiated a free medical care program for disadvantaged elderly that has been subsequently extended to cover all elderly. Under this program, all government hospitals and health centers provide free services nationwide to

persons 60 years and older with an “elderly card”. The program operates through a “gatekeeper” and referral system. The first contact in the rural area is the sub-district (tambol) health center while in urban areas initial contact should be through local community health facilities. Complicated cases will be referred to higher-level facilities such as district, provincial or general hospitals. The program has been operating on a non-means tested and thus all Thai elderly are potentially covered by this form of government health insurance. Given the scale of the program, it has been a major payer for health costs for the elderly. During the years 1995-97, this program accounted for about 5 percent of the MOPH total budget (personal communication from the Institute of Geriatric Medicine). The program is currently being modified and will be integrated with the Medical Welfare Card program. Under this modified program, it is unclear if means testing will eventually be applied.

Health Card Scheme. The government subsidized prepaid voluntary health insurance scheme known as the Health Card Scheme started as a pilot project in 1983 and was subsequently extended to all provinces. The current cost of a card is 500 Baht a year.[1] The target groups are farmers in rural areas, workers in small firms (with less than 10 workers), seasonal workers, and self-employed persons. As of 1997, about 2 million health cards were issued. A card costs 500 Baht per household and covers up to 5 members including the elderly. The government has been subsidizing this project, initially spending 500 Baht for each card sold. This amount was doubled starting fiscal year 1998. The benefits to those covered by a health card are similar to those of the free elderly medical care program. It is also based on a referral system from lower to higher level facilities.

Civil Servant Medical Benefits Scheme. Health benefits have been included as one of the fringe benefits offered by the Thai government to all government and state enterprise employees. The health benefits also extend to employees' spouses, parents, and up to three children. This benefit scheme has been in existence for many decades. Under the scheme, outpatient bills from public outlets are refunded to the patient. The costs of inpatient care may be directly paid to the hospitals or reimbursed to the patient depending on circumstances. Retirees, active employees and their dependents can freely seek inpatient care at public or private facilities with some ceiling applied to private outlets on the reimbursement. Both as a result of the economic crisis that started in 1997 and the rapid increase of expenditure from 4.3 billion Baht in 1990 to 13.6 billion Baht in 1996, the Ministry of Finance has instituted new regulations to contain costs by means of co-payment and reimbursement ceilings.

Private Health Insurance. Private health insurance does not play a major role in financing health care for Thai elderly. Generally private insurance is uncommon (Ron, Abel-Smith and Tamburi 1990). To the extent it exists, it is offered on a group or individual basis. Medical care coverage can be offered either as an attachment to a life insurance policy or as an independent insurance policy. In either case, health services are normally provided at private facilities on a fee-for-service basis. The extent of coverage depends on the insurance company and amount of premium. Unfortunately, most insurance companies do not offer policies to people aged 60 years and older because of the high health risks of older persons and potentially large amount of expenditures that could be involved. Once an insured person reaches 60 years old, the insurance policy will be terminated (based on informal discussions with insurance companies by Chutima Suraratdecha).

C. Pensions and Retirement Benefits

There are two major government sponsored plans for retirement benefits in Thailand: one for civil servants and state enterprise employees and one to cover general workers under the Social Security Act (Phananiramai and Ingpornprasit, 1994). The latter program, however, only takes effect since the end of 1998. Government employees constitute approximately 6-7 per cent of the Thai labor force. The new Social Security Scheme will increase the number of persons under a government retirement benefit system to 18 per cent of the labor force.

Retirement Benefits for Government Employees. Although work as a government employee in Thailand has been associated with low pay, it has also been considered to provide a high level of security because of the wide range of welfare benefits it provides, including retirement schemes. At present there are two systems of retirement benefits for government employees: the pension system and the pension fund scheme. The government pension system has been in existence for a long time. In this system, civil servants with continuous employment for 25 years may choose to receive either a lump sum payment or a monthly pension upon retirement. Those who work with the government for 10 years or more but less than 25 years will receive only a lump sum payment. State enterprises' employees generally receive a lump sum payment upon their retirement.

The projection of the increase in the amount of pension the government must pay for future retirees has prompted the government to initiate the so-called 'Pension Fund for Civil Servants' in 1996. Those employed prior to the initiation of this scheme had to choose between the new and the old system. New employees, however, must join the new Pension Fund Scheme. The conditions to receive a pension or lump sum payment upon retirement are similar in both systems. However, retirees under the new system receive a lower monthly pension but also receive a lump sum of their contribution at retirement. Based on the August 1998 round of the labor force survey, there were about 2.4 million government employees, accounting for about 7 percent of the total labor force.

Old age benefits for private employees. A public social security system was established in Thailand in 1990 for workers of private enterprises with 10 or more employees. The initiation of coverage for old age benefits, however, was delayed until year end 1998. Contributions to the pension fund are made by three sides: employees, employers, and the government. The exact contribution of each side and the benefits to be paid for old age are still under discussion but may not be equal and are not to exceed 3 percent for any one party. The Social Security Office, however, has started to collect an amount equivalent to one percent of the employee's salary from the employees and employers. Pension benefits are not to be paid for at least another 15 years. In order to collect old age benefits, members must be 55 years old and have contributed at least 15 years. The benefits will be based on the number of years of participation and the average monthly salary during the last five years. Members who have made the contribution less than 15 years and retire at the age of 55 will receive a lump sum equal to their contribution plus interest. As of 1997, about 6.1 million workers, or 18 percent of the total labor force, are insured by the public social security system. It is projected that this number will increase in the future as more and more businesses are enrolled in the program.

D. Welfare Programs

The DPW (DPW) is the main government provider of social welfare for elderly Thais.[2] Several types of services are have been offered including residential services, monthly allowances for indigent elderly, and service centers for elderly. In addition, various ministries and agencies have cooperated in an attempt to foster elderly clubs.

Residential Services. Thai government policy has generally tried to foster familial care of the elderly and has not emphasized institutional care. Nevertheless the DPW has established a small number of government residences intended mainly for poor, homeless and deserted elderly. The first such home for the aged was established in 1953. The number has increased to 16 by 1997. The total number of residents is slightly more than 2000, including a small number who are not welfare cases but able to pay for their housing and services on the premises. Several charity organizations, especially ones associated with ethnic Chinese, also operate homes for the aged. In addition, there are private for-profit nursing homes. Systematic data on the non-governmental homes are unavailable. So far private homes can be managed free of government regulations.

As a primarily Buddhist country, some elderly live in temples as monks and nuns. According to the 1990 census, about 3 percent of men aged 60 and live in temples 98 percent of whom are monks. Only about 0.2 percent of elderly women lived in temples. Of these, it is likely that most are nuns although the percentage is unknown since nuns are not specifically identified as such in the census. Thus the census figures suggest that only a small number of homeless elderly stay in temples. A national unpublished study carried out in 1994-95 by the DPW in the 32 provinces that reported back there were 1115 elderly staying in 362 temples (personal communication from the DPW). As a result of this study, the department started a program to promote the use of temples as residences and service centers for needy elderly. As of mid-1998, almost 200 temples located in two-thirds of the provinces have agreed to participate and activities had already started in some.

Monthly allowance for indigent elderly. In 1993 the DPW started a program to provide monthly subsistence allowances of 200 Baht for indigent elderly in rural areas. Eligible elderly for monthly allowance are selected by local village welfare assistance centers, set up throughout the country through the DPW and must be approved by the provincial welfare office. The initial budget covered 20,000 elderly in over 5000 villages. This program subsequently expanded to cover 318,000 rural elderly in almost all villages by 1997. The 1998 number is expected to remain at this level.

The DPW also initiated a project in 1993 to solicit donations from the private sector to fund monthly subsistence allowance of 200 Baht for indigent urban elderly. However, only several hundred elderly have received allowances though this program and almost all are in Bangkok.

E. Other Organized Programs

Social Services Centers for Elderly. The DPW operates centers designed to provide a variety of social services for elderly. The first center was opened in 1979; by 1998 there were 13 centers spread throughout the country and found in every region. Health care, physical and occupational therapy, exercise, income generating activities, education, religious activities, and

social work services are provided at the center itself. The centers also arrange home visits by mobile units to provide counseling, medical services and information to elderly in need. In addition, emergency shelter for short term stays of up to 15 days are available for elderly in difficulties.

Elderly clubs. Elderly clubs or senior citizen associations in Thailand were formally promoted by the government during 1980s based on the idea that informal group gatherings among older persons has long been common in Thailand. The goal was to facilitate the formation of self-help organizations of elderly that can provide as well as receive assistance or services (Siripanich et al. 1996). The government through the Ministry of Public Health and the DPW thus encouraged and supported elderly to form club in every community. In 1995, 14 percent of elderly nationwide reported themselves as a member of an elderly group (Chayovan and Knodel 1997).

The number of elderly clubs grew rapidly in Thailand during 1980s. Although some clubs were formed out of genuine local initiatives, most were the result of government prompting with the support of either the Ministry of Public Health or the DPW. Club offices tended to be located either at a government health outlet or a temple. A 1994 study found that there were about 3,487 senior citizen clubs all over Thailand (Siripanich et al. 1996). The clubs varied considerably in size and activities. In the absence of continuing follow-up and support by the governmental agencies involved, substantial numbers of clubs were either dissolved or became inactive. The main reasons for the failure of so many clubs included a lack of clear initial aims at the time of formation, inadequate sizes and inconvenient locations for members.

In their effort to promote the importance of elderly clubs and strengthen networking among them, the DPW organized a series of annual national conferences of club representatives starting in 1983. One outcome was an agreement to set up an autonomous organization to coordinate activities of elderly clubs all over the country. The Senior Citizen Council of Thailand was officially registered as a legal entity in 1989 and is a recognized organization in voicing the rights and demands of elderly. At present, there are about 300 senior citizen clubs registered as members of the Council. To qualify, for membership, the club must have at least 50 members, be in existence for not less than a year, and have continuous activities. Since many of the clubs initiated by the government promotion effort had less than 50 members did not have continuous or organized activities, the number of member clubs is far below the number that had been formed in the height of the campaign to promote elderly clubs.

Other Activities. In addition to the above mentioned programs, there are numerous small scale efforts to support and assist the elderly made by governmental and non-governmental organizations, sometimes in collaboration with each other. For example, the Ministry of Transportation has reduced fares on state railways. The DPW has an explicit policy to encourage partnerships in various programs with the private sector. One example is the program to provide funds for cataract operations for poor elderly and donated eyeglasses (for elderly and children) in rural areas. As of 1997, the program had distributed almost 15,000 eye glasses, frames or lens to their target population. HelpAge International (HAI) has its Asia regional office in Thailand through which they also run a Thailand country program. They work through local NGOs, including religious organizations, with HAI serving a coordinating and fund raising function. The activities sponsored by HAI include training seminars, promotion of income generation activities among

elderly, eye care and cataract operations, and an “Adopt a Granny” program whereby several hundred needy elderly cases in several provinces receive financial assistance. The program is currently being expanded and modified (personal communication from Sawang Kaewkantha, HAI).

III. Informal Sources of Support

A. Cultural and Religious Underpinnings

The Thai population is relatively homogeneous population in major cultural aspects. The vast majority are ethnic Thais and speak some form of the Thai language; about 95 per cent profess Buddhism, typically of the Theravada branch. Still, numerous minorities can be defined in terms of ethnicity, language or religion. Muslims constitute approximately 4 percent of the population and make up the largest and most notable religious minority. According to the 1990 census, most Muslims (81 per cent) live in the southern region, about half of whom are Malay-speaking. The remaining Muslims are mainly in Bangkok and the central region (Knodel et al. 1999).

As in other southeast Asian countries, the primary responsibility for the elderly in Thailand has traditionally been with the family. A strong sense of moral obligation that adult children should support and care for elderly parents is a pervasive aspect of Thai cultural values and provides a strong normative basis for the prevailing pattern of familial support. As noted above, this responsibility is reflected in both the laws of the land and in the formulation of social policy. Focus group research indicates that both elderly parents and their adult children share similar view regarding this sense of responsibility and that it is found in all regions, transcending economic status or rural-urban residence (Knodel, Saengtienchai and Sittitrai 1995).

Repaying parents is generally viewed by Thais as a continual obligation that starts when the children are old enough to provide meaningful help and commonly begins long before parents reach old age. However, the care and support provided by children when their parents are too old to take care of themselves is viewed as the culmination of this process. Underlying the obligation to repay parents are the concepts of ‘*katanyu katawethi*’ and ‘*bunkun*’, both of which are firmly ingrained in Thai Buddhist culture but have no simple English equivalents (Rabibhadana, 1984; Podhisita, 1985). Both terms relate to reciprocation of actions that incur a sense of gratitude and debt. *Katanyu* refers to a constant sense of awareness on the part of someone for benefits which another person has bestowed upon him. *Katawethi* refers to doing something in return for them. *Bunkun* characterizes the person who bestows favors which incur a sense of gratitude and debt on the beneficiary.

The concept of *katanyu katawethi* usually refers specifically to parent-child relationships while *bunkun* extends to many realms of life. Both concepts, however, characterize the essence of the relationship between parents and children. Giving life to and raising a child provides parents with the epitome *of bunkun* and instills a sense of gratitude and debt in the child that is virtually impossible to repay completely. This *bunkun* parents have in relation to children directly leads to the sense of obligation adult children have to provide support and care to them when the parents are in their elderly years. Although Thai Muslims do not describe filial piety in these same terms they also have a strong sense of obligation to parents that is deeply rooted in their religion. Indeed through out much of east and

southeast Asia, there are similar cultural prescriptions related to the obligation to repay parents especially when they reach older ages and can no longer support and take full care of themselves (Asis et al. 1995).

B. Living Arrangements

A central feature of family support in Thailand for elderly members is coresidence (or a functionally equivalent arrangement) with one or more adult children. Table 2 provides several indicators relevant to describing the living arrangements of Thai elderly in relation to their children. The surveys included information on adopted and step children as well as the respondent's own biological children. Approximately 4 percent of elderly are without any biological, adopted or step children.

[INSERT TABLE 2 HERE]

A common, if narrow, measure of such coresidence is the percentage of elderly who coreside with one or more of their children in the same household.[3] Among elderly with at least one living child, a modest decline in literal coresidence, from 80 percent in 1986 to 74 percent in 1995. The lower levels of coresidence found in the more recent data possibly signifies the start of a trend away from coresidence. However, differences in sampling techniques and survey methodology between the sources could also account for all or part of the differences. Table 2 also indicates that very few Thai elderly live alone and that this has not changed over the period covered. In contrast, the percent of elderly living with only a spouse has increased. This might reflect an increased tendency for adult children to establish separate, but nearby households, as long as elderly parents have each other to live with. The finding that living alone has not increased, however, suggests that once one of the parents die, coresidence may be initiated.

Measures of literal co-residence ignore situations in which elderly parents and children live in separate dwellings very nearby, an arrangement that can also meet many of the same needs of the elderly as sharing a dwelling. Such situations are not unusual in Thailand, especially in rural settings (Cowgill, 1972; Knodel and Saengtienchai, 1996). A more encompassing estimate of the extent to which living arrangements facilitate daily interaction between elderly parents and their children can be obtained by combining information on coresidence with that on the frequency of contact elderly have with non-coresident children. As Table 2 indicates, 91 percent of elderly parents in 1986 and 90 percent in 1995 either coreside in the same household or have daily contact with at least one child. This means that over half of elderly parents (54% in 1986 and 60% in 1995) who do not coreside in the same dwelling with a child nevertheless see a non-coresident child every day.

The fact that there is little change in this more comprehensive measure between the 1986 and 1995 surveys suggests that the apparent decline between the two surveys in literal coresidence in the same household does not reflect a trend away from a family system of support and care of elderly. Instead a limited modification of living arrangements may be occurring that retains frequent interactions and essential exchanges between parents and children but provides greater privacy for both parties. In focus group discussions, some elderly indicated a preference for this type of arrangement, especially as long as they are in good health (Knodel, Saengtienchai, and Sittitrai, 1995).

Comparisons between the younger and older, rural and urban, and Buddhist and Muslim elderly with respect to living arrangements are shown in Table 3 based on the 1995 survey.[4] Since minor coresident children are likely to be largely dependent on parents, we focus on adult children only.[5] The vast majority of elderly have at least one adult child. Among those who do, there is little difference between younger and older elderly or between Buddhists and Muslims is the percentage of elderly who live with children. However, it is more common for those in urban than rural areas to share the same dwelling with an adult child. This is more than compensated for, however, by the higher percentage of rural elderly who have daily contact with their children. Thus the combined measure of coresidence and/or daily contact is slightly higher for rural than urban elderly. These findings probably reflect differences in land availability and housing styles between urban and rural areas. Having separate dwelling units either within the same compound or nearby is undoubtedly more feasible in rural villages than in towns or cities where land and housing prices make such arrangements prohibitive for many.

[INSERT TABLE 3 HERE]

Also shown in table 3 are the percentages of elderly who coreside with an ever married son and with an ever-married daughter. Living with married children reflect the 'mature' stage of living arrangements which eventually evolve once dependent single children leave the household. Far more Thai elderly parents live with an ever-married daughter than an ever-married son. This tendency, however, it largely a rural phenomenon. Among urban elderly, there is little difference in the proportion who live with an ever-married son or daughter. The rural-urban differences in this respect undoubtedly reflect the far greater influence of Chinese ethnicity (and the associated preference for residing with a married son) among urban Thais compared to their rural counterparts. At the same time, there is little difference between younger and older elderly or between Buddhists and Muslims in the tendency to live with a married daughter rather than a married son.

C. Material and Social Support from Non-Coresident Children

Non-coresident children can be important sources of economic and social support to elderly parents through providing money or gifts of food and useful items as well as though frequent visitation. Results in Table 4 indicate the vast majority of Thai elderly (over 90 percent) have at least one child living outside the household. According to the 1995 survey, among elderly who have a non-coresident child, almost 90 percent received gifts of food or clothes during the prior year and about the same proportion received some money from their children. Moreover, almost 70 percent received at least a 1000 Baht from children. Although younger and older elderly as well as rural and urban elderly are similarly likely to receive gifts or money, younger and urban elderly who receive money are more likely to receive at least 1000 Baht. In the case of urban elderly this probably reflects higher incomes of their children and the higher costs of living in urban areas. Muslim elderly are somewhat less likely than Buddhists to receive material support from children although most Muslims still receive each of the kind of supports shown.

[INSERT TABLE 4 HERE]

Table 4 also shows the percentage of non-coresident sons and daughters of elderly who provide different types of social and economic support to their parents. Except for giving at least 1000 Baht, the majority of both

sons and daughters provide each of the other types of support to parents, i.e. giving food or clothes, giving any money, and visiting at least monthly. Nevertheless, daughters are modestly more likely than sons to provide each type of support. This gender difference generally holds true regardless of age or place of residence of the parents. It also holds true for Buddhists. For Muslims, however, gender differences are largely absent except that daughters are more likely to give food or clothes than are sons.

The likelihood a child to give different types of support seems lar gely unrelated to the age or place of residence of the elderly parent. The main exceptions are that children of younger and urban elderly are considerably more likely than those of urban parents to give at least 1000 Baht. Religious differences are also modest or absent except in than Muslim children, especially daughters are less likely than Buddhists to provide any money. Nevertheless Muslim children of both sexes are as likely as Buddhists to provide at least 1000 Baht to their parents in a year. Thus in terms of significant money support the two religious groups are very similar.

D. Main sources of support

In each of the national surveys of the elderly in 1986, 1994 and 1995, approximately half of all persons aged 60 and over report that children are their most important source of income. There is little evidence of any change in reliance on children for support.[6] Table 5 shows detailed distribution of main sources of support based on the 1995 survey. There is little difference in the percentage relying on children as the main source of income between rural and urban elderly or between Buddhists and Muslims. Virtually no elderly in any category shown report relying on welfare as their main source of income.

[INSERT TABLE 5 HERE]

Although the overall pattern of main sources of income differs little by religion, some contrasts are associated with age and to a lesser extent with place of residence. Reliance on one’s own or spouse’s work is the most important main source of support for younger elderly, ahead of even children, but is far less common than depending on children for older elderly. Rural elderly are more likely to be supporting themselves though own work or their spouse work than are urban elderly. In contrast, urban elderly are more than twice as likely as rural elderly to rely mainly on pensions and savings .

Assistance from relatives other than children as a main source of income is rare in Thailand, with only 6 percent reporting this as the case. However, relatives are very important for the small minority of childless elderly, almost half (47 percent) of whom indicate that their main source of income are relatives (not shown in table). It is also common for childless elderly to reside with other relatives. Analysis of data from the 1995 survey shows that over 60 percent live with at least one other adult relative other than a spouse (Knodel and Chayovan, 1997).

IV. Discussion and Conclusions

The last decade or so has witnessed a significant expansion of government programs in Thailand designed to provide health, welfare and retirement benefit to significant numbers of elderly. Particularly noteworthy is the establishment of free government medical care for the elderly, monthly welfare allowances to indigent elderly, and the Old Age

Benefits Plan established under the Social Security Act. At the same time, there are important limitations and qualifications to this expansion of government assistance. Economic pressure is leading to modifications to the free elderly medical care program, the consequences of which are not yet clear; full scale old age benefits from social security will not start for another decade and a half and will cover only the minority of the labor force who are employed in large firms in the formal sector; and the amount of the welfare allowance to indigent elderly is very modest and unlikely to cover even subsistence needs.

Despite the expansion of government assistance, budgetary considerations as well as traditional values continue to direct government policy towards an emphasis on the family as the primary institution for assistance and support. This stress on the family's responsibility for elderly members is evident in the original and revised Long Term Plan for the Elderly as well as the National Five Year Plans, including the current 8th plan. It is also evident in the very modest scope of the program to provide residential services for homeless or deserted elderly. Nevertheless, the elderly appear to be receiving increasing recognition as their numbers and share of the population expand. The current constitution, adopted in 1997, explicitly identifies elderly as one of the disadvantaged groups in society for which the state must provide.

Since private health insurance remains unaffordable or unattainable for most elderly people, the government can be expected to remain the most important provider of health services for the population in older ages. The rapid projected growth of the Thai elderly population means that the number of people eligible for free government medical care and the amount of government spending on the program can be expected to rise rapidly unless restrictive eligibility criteria are imposed. Regardless of the share that the state will pay for elderly health care, population aging is likely to exert considerable strain on the use of health facilities and personnel. This is virtually inevitable given the rapid growth in the size of the population that underlies the population aging process and the fact that elderly make disproportionate use of health services, especially hospitalization (Knodel, Chayovan and Siriboon 1992a). Moreover, the demand for health services is likely to be further exacerbated by the improving educational composition of the elderly age group, since better educated elderly are likely to demand more and better services.

The impact of population aging on public welfare funding is harder to predict as it depends on uncertain trends in the existing family system, the future course of economic trends affecting both the state and families, and the extent of political commitment for the state to take on a greater role in societal welfare measures. The Asian economic crisis that started in mid-1997 has undoubtedly created greater need for assistance on the part of families but also has posed difficulties for government funding of programs. For example, the DPW recently requested the increase of the monthly substance allowance to 300 Baht, but the request was turned down ostensibly due to the current financial crisis. The current economic situation may also be partially behind the move from a policy of universal free government health services to elderly to a means-based program. The full impact of the crisis on the well-being of elderly through effects on public programs and the family support system is unknown. Systematic research into this issue would be useful.

The family and particularly adult children continue to be the backbone of the system of support and care provided to Thais once they reach older ages and are no longer able to depend fully on their own resources. This is equally true for the majority Buddhist and the minority Muslim populations. Despite the major social, economic and demographic changes that have occurred in Thailand over recent decades, the evidence points to little if any significant erosion of this familial system of care and support. Although literal coresidence appears to have declined modestly, the large majority of elderly still coreside with children and many who do not, live or nearby enough to an adult child to have daily contact. There has also been little apparent change over the last decade in the proportion of elderly Thais who depend on children as their main source of income.

The relative stability in the aspects of the family support system noted above does not mean that the current family system of support will remain unmodified in the foreseeable future. Many forces have been cited that have potentially profound and complex implications for intergenerational relations and the familial support system. These include smaller family sizes, increased economic activity outside the home by women (the predominant caretakers), physical separation of parents and adult children associated with urbanization and increased migration, and ideational change (Mason, 1991; Martin, 1989 and 1990; Caldwell, 1982).

While these forces may cause some erosion in family support, the values that underlie familial support appear to be deeply ingrained in Thai culture and thus may be resistant to radical alteration or rapid change. A recent analyses suggests that, even though fertility decline means that the elderly of the future will have fewer living children, this alone will not lead to a major reduction in key aspects of support from them (Knodel, Chayovan and Siriboon 1992b). Arrangements may also evolve that leave both generations of elderly parents and adult children better off. For example, higher incomes could permit a shift from literal coresidence to living in separate but nearby dwellings, an arrangements that could continue to meet the needs of both generations but enhance their privacy as well.

A common perception underlying some government policy statements regarding the elderly in Thailand and perpetuated by the media and by some non-empirically based social science commentary is that socio-economic change is leading to widespread desertion of rural elderly as their children move away to urban areas and leave them behind (e.g. Chanswangpuwana 1997; Charasdamrong 1992; Phananiramai 1997: 24). Although there certainly are some such cases and they deserve priority for welfare assistance, evidence suggests the phenomenon is far less than typically assumed. For example, one newspaper feature focused on cases of deserted elderly in an impoverished community which it claimed exemplified the phenomenon (Charasdamrong 1992). A subsequent systematic study of that same community yielded a very different picture. There were indeed two cases who were truly deserted by their family and lived off begging or offerings from their neighbors. However, overall among the 102 elderly in the community no-one else appeared to be deserted. Even among the few cases who lived alone or as a solitary couple, most received assistance from their children or relatives (Knodel and Saengtienchai 1996). Many elderly in the village were, however, very impoverished and, although not deserted, in need of economic assistance together with their families.

On a national scale, the desertion of elderly does not seem wide spread. The small minority of elderly who are in institutional dwellings are

almost all in temples as monks or nuns. Among the large majority who live in private dwellings and have children, a 1995 national survey of older persons found 90 percent either live with or very nearby children. Moreover among the remaining elderly parents a large majority receive substantial financial assistance from a child. Even among childless elderly, over 60 percent live with an adult relative and most of the remainder with a spouse (Knodel and Chayovan 1997). The fact that abandonment of the Thai elderly by their children or kin is uncommon, however, does not mean that Thai elderly do not face serious economic problems. Nor does it mean that they necessarily have access to the extra-familial services that are necessary for their well-being (Knodel, Amornsirisomboon and Khiewyoo, 1997). It does mean, however, that programs intended for assisting elderly Thais should in many cases consider aid to needy families with elderly members rather than focus only on the tiny minority who are truly deserted by their children and kin.

The interaction between the state's and family's role in ensuring the well-being of the elderly is complex. Changes in family support may themselves lead to changes in state services as well as vice versa. Given the pressures social change is exerting on family care and the sensitivity of state measures to the uncertain course of the economy, it will be important to continue to monitor the situation. A good start in conducting careful empirical research on the older population using both surveys and qualitative research approaches has already been made in Thailand and should continue.

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Table 1: Demographic trends and projections: Thailand 1970-2030

Indicator	1970	1980	1990	2000	2010	2020	2030
Total population (in 1000)	35,745	46,718	55,839	60,495	64,568	67,798	70,735
Growth rate (%)	3.0	2.1	1.3	0.7	0.6	0.4	0.4
Total Fertility Rate	5.6	3.6	2.3	1.7	1.9	2.0	2.1
Life-expectancy at birth	58.2	63.1	68.3	69.7	72.1	74.9	76.3
Median age	16.8	19.4	23.3	28.1	32.5	36.4	39.7
# persons age 60+ (1,000s)	1,715	2,527	3,719	5,245	6,957	10,208	14,897
% of population age 60+	4.8	5.4	6.7	8.7	10.8	15.1	21.1
% of elderly age 70+	35.9	38.3	39.7	41.0	44.5	40.6	43.5
Old-age dependency ratio	0.10	0.10	0.11	0.13	0.16	0.23	0.35
Total dependency ratio	1.04	0.83	0.63	0.51	0.48	0.54	0.67

Notes: All projections are based on medium-variant assumptions. Growth rates, total fertility rates, and life-expectancies represent averaged values from the two adjacent 5-year time periods (e.g., for 1960, the value is the average of 1955-60 and 1960-65) except for 2030, in which case the value is interpolated between the mid-points of the 2025-30 and 2030-40 periods.
Dependency ratios are defined as follows:
Old-age dependency ratio = population age 60 and over/population age 15-59
Total dependency ratio = (population age 0-14 + population age 60 and over)/ population age 15-59

Data Sources: United Nations, 1997 and 1998.

Table 2. Selected indicators of living arrangements among persons 60+

	1986	1994	1995
Among all elderly			
% childless	3.5	3.5	4.4
% living alone	4.3	3.6	4.3
% living only with a spouse	6.7	11.6	11.9
Among elderly with at least one child			
% living with a child	79.7	75.4	74.2
% Living with a child or seeing a child daily	90.7	n.a.	89.8

Notes: All results are based on national representative surveys; 1986 results are from the Socio-economic Consequences of the Aging Population in Thailand survey (SECAPT); 1994 results are from the National Statistical Office Survey of Elderly in Thailand; 1995 results are from the Survey of the Welfare of Elderly in Thailand (SWET).
Children include own, adopted and step children.
Source: Knodel and Chayovan, 1997.

Table 3. Living arrangements in relation to adult children, by place of residence and religion, Thailand 1995

	Total	60-69	70+	Rural	Urban	Buddhists	Muslims
Among all elderly							
% having an adult child	95.5	95.3	95.7	95.5	95.4	95.4	98.4
Among elderly with at least one adult child							
% living with adult child	72.5	71.8	73.7	71.0	79.6	72.6	72.4
% living with adult child or seeing a child daily	89.0	88.3	90.2	89.2	88.4	89.1	86.9
% living with an ever married son	20.5	18.8	23.3	18.4	30.1	20.3	25.7
% living with an ever married daughter	35.4	33.7	38.2	36.2	32.0	35.5	34.7

Source: the 1995 Survey of the Welfare of Elderly in Thailand (SWET).

Table 4. Intergenerational support from non-coresident children to elderly parents, by place of residence and religion, Thailand 1995

	Total	60-69	70+	Rural	Urban	Buddhists	Muslims
Among all elderly							
% having a child living outside household	90.9	90.3	92.0	92.4	84.2	90.9	93.1
Among elderly with at least one non-coresident child							
% receiving food or clothes	89.2	89.8	88.2	89.8	86.2	89.4	82.8
% receiving any money	88.1	87.9	88.4	88.3	86.9	88.7	70.6
% receiving 1000+ Baht	69.1	71.4	65.4	66.8	80.8	69.5	58.8
Among non-coresident children of elderly							
% of sons who give food or clothes	67.9	67.4	68.7	67.8	68.8	67.9	69.2
% of daughters who give food or clothes	76.5	77.5	74.9	76.9	74.5	76.6	74.7
% of sons who give any money	58.5	57.4	60.3	57.8	63.6	58.6	52.7
% of daughters who give any money	63.7	63.4	64.1	63.5	65.0	64.1	52.6
% of sons who give 1000+ Baht	31.9	33.6	29.3	29.2	49.5	31.8	33.2
% of daughters who give 1000+ Baht	34.4	37.9	28.9	31.5	52.5	34.5	33.5
% of sons who visit at least monthly	56.6	55.4	58.5	56.6	56.6	56.6	57.1
% of daughters visit at least monthly	61.2	60.3	62.5	61.6	58.5	61.4	55.3

Source: the 1995 Survey of the Welfare of Elderly in Thailand (SWET).

Table 5. Main source of income of persons aged 60+, by place of residence and religion, Thailand 1995

	Total	60-69	70+	Rural	Urban	Buddhists	Muslims
Own work or spouse	36.2	47.6	17.1	37.4	30.6	36.1	40.4
Children	48.6	39.4	63.6	48.2	50.1	48.6	48.6
Children and other sources	2.5	2.6	2.2	2.4	2.5	2.5	0.0
savings/interest	4.4	4.0	5.0	3.9	6.4	4.3	6.8
Pension (or retirement pay)	2.3	2.5	2.0	1.8	4.8	2.4	0.0
Other relatives	5.9	3.8	9.4	6.1	5.3	5.9	4.1
Other (including welfare)	0.1	0.1	0.1	0.1	0.2	0.1	0.0
Total percent	100	100	100	100	100	100	100

Source: the 1995 Survey of the Welfare of Elderly in Thailand (SWET).

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[1] The Thai Baht was worth approximately US $0.04 (25-26 Baht=$1) during much of the last decade when many of the various programs described in this chapter were initiated. Since mid 1997, the rate was 'floated' and as of early 1999 is worth slightly less than US $0.03 (35-36 Baht=$1).

[2] Much of the information relating to the DPW come from their annual reports; some information was solicited through interviews.

[3]. In a small proportion of cases coresiding elderly live with a minor child. In the 1995 survey, for example, 3 percent of households of respondents age 60 or over with a coresident child had no child at least 18 years old.

[4] For the purpose of this presentation, urban is defined as officially designated municipalities and Bangkok. Given that the sample is nationally representative, the number of Muslims on which the results are based is relatively modest, thus some caution is called for when considering the results relating to religious differentials. For example, the total unweighted number of Muslim elderly in the sample is 229 compared to 4223 Buddhists.

[5] Adult children includes those who are age 18 or over or are ever married. No age limit is imposed on results relating to non-coresident children.

[6] The percentage citing children as their main source of support was 47 percent in 1986, 54 percent in 1994 and 49 percent in 1995. Differences in the coding schemes detract somewhat from precise comparisons. For example, 7 percent of elderly are coded as receiving no income in 1986 while only 1 percent are coded as such in 1994 and no-one is coded as such in 1995. If these persons are excluded from the 1986 figures the percent reporting children as the main source of support rises to 51 percent. The 1995 survey included separate codes for persons who cited two sources equally as their main source. If those who only cite children are combined with those who cite children plus another source, the percent for whom children are the main source rises to 53 percent. Thus the three surveys seem to reflect very similar percentages of elderly for whom children are the key source of support.