
# SENIOR LIVING IN THAILAND

Where the opportunity lies, what slows growth, and what must change.

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# Executive Summary

Thailand's senior living market is real, structurally supported, and selectively investable.

Thailand is on the verge of becoming the first Southeast Asian economy to confront a super-aged population without first achieving high-income status. By 2033 — only seven years from now — more than one in four Thais will be over the age of sixty. Thailand will compress in twelve years what Japan absorbed in twenty-six, and it will do so at roughly a quarter of Japan's income per capita. This is not a slow-moving demographic curve. It is a structural inflection that has already begun to reshape capital allocation, healthcare planning, real estate strategy and consumer demand.

And yet the headline numbers — 14.2 million seniors today, 18.4 million by 2033 — overstate the commercial opportunity. The investable senior living market in Thailand is not the demographic total. It is the affluent layer that can sustain private monthly fees, and that layer is narrow: the commercially monetisable cohort is roughly 2.5-3.5 million seniors, concentrated largely in the top 25-30% of Thai households. Sizing the market from demography downward inflates expectations and produces failed projects. Sizing it from affordability upward yields a smaller but very real category — one that operators with the right model can defend.

This white paper makes that distinction central. Across eight findings, the analysis argues that Thailand's senior living opportunity is a care-operations story for a medically dependent population, not a real-estate or hospitality story dressed in clinical language. Approximately one-third of Thai seniors live with at least one chronic non-communicable disease. Hospital groups with embedded clinical infrastructure hold a structural advantage that hospitality operators cannot easily replicate. The supply base is shallow and fragmented — 944 facilities, 17,349 beds, with 79 percent of nursing homes priced below THB 30,000 per month — and the assisted-living middle is structurally empty. Three business models actually work: premium integrated communities, hospital-linked care chains, and home-care platforms. Each has been validated with listed-company capital and produces distinct unit economics.

The institutionalisation phase has clearly begun. In the fourth quarter of 2023 alone, Thai listed companies deployed more than THB 555 million into operating platforms — Pruksa Holding into Chersery Home, Principal Capital into Baan Lalisa and Health at Home - and, separately, Bangkok Dusit Medical Services into BDMS Silver Wellness & Residence — and Bangkok Dusit Medical Services has since announced a THB 25 billion flagship wellness destination on Crown Property Bureau land in Lumpini. These are not pilot bets. They are platform-level commitments from the largest listed property developers and hospital groups in Thailand.

Two binding constraints remain. The first is workforce: Thailand has 0.7 formal long-term care workers per 100 elderly compared with 4.4 in Australia, a six-fold gap that the International Labour Organization projects will require an additional 250,000 caregivers by 2037. The second is affordability: without long-term care insurance, reverse mortgage instruments or employer-sponsored elder care benefits, the commercial market remains capped at the top quartile. The unlocks are visible — single-window licensing, LTC insurance riders, a senior-living REIT format — but they require coordinated action between regulators, capital markets and operators. Until those unlocks materialise, growth in Thai senior living will be real, but bounded.

**14.2M**

Thai elderly aged 60+ as of 2025 — already outnumbering children under 15.

**2033**

The year Thailand becomes super-aged — the same 12-year transition Japan took 26 years to absorb, at one-quarter the income.

**THB 25BN**

HERCULES – Wellness Project by BDMS, the largest single-project commitment in Thai senior living to date

# The Eight Findings of This Paper

**1**

## Thailand will be super-aged by 2033

14.2 million seniors today, projected at 18.4 million by 2033. Thailand will compress in twelve years what Japan took twenty-six to absorb, at one-quarter the income (USD 7,300 GDP per capita).

**2**

## The real market is the upper-income cohort

Only 25 to 30 percent of Thai households can afford formal care — approximately 2.5 to 3.5 million monetisable seniors. Market sizing must be built from affordability upward, not demography downward.

**3**

## This is a care-operations story

Approximately one-third of Thai seniors live with at least one chronic underlying condition, equivalent to 4.6 million people. Hospital groups with embedded clinical infrastructure hold a structural advantage that hospitality operators cannot easily replicate.

**4**

## Supply is fragmented and shallow

REIC 2025 data: 944 licensed facilities, 17,349 beds, 81 percent national occupancy. Seventy-nine percent of nursing homes price below THB 30,000 per month — the premium tier is structurally empty.

**5**

## The middle is absent

Quality assisted living between home care and full nursing barely exists. The 60-to-75 cohort with mild ADL* limitations has no commercial product — the largest format gap in the Thai senior-living value chain.

**6**

## Three business models actually work

Premium integrated communities, hospital-linked care chains, and home-care platforms — each proven with listed-company capital and producing distinct EBITDA profiles of 15 to 25 percent at maturity.

**7**

## The institutionalisation phase has begun

THB 555.6 million committed in Q4 2023 through Pruksa Holding and Principal Capital platform transactions, alongside BDMS's separate THB 25 billion flagship development.

**8**

## Workforce and affordability remain binding

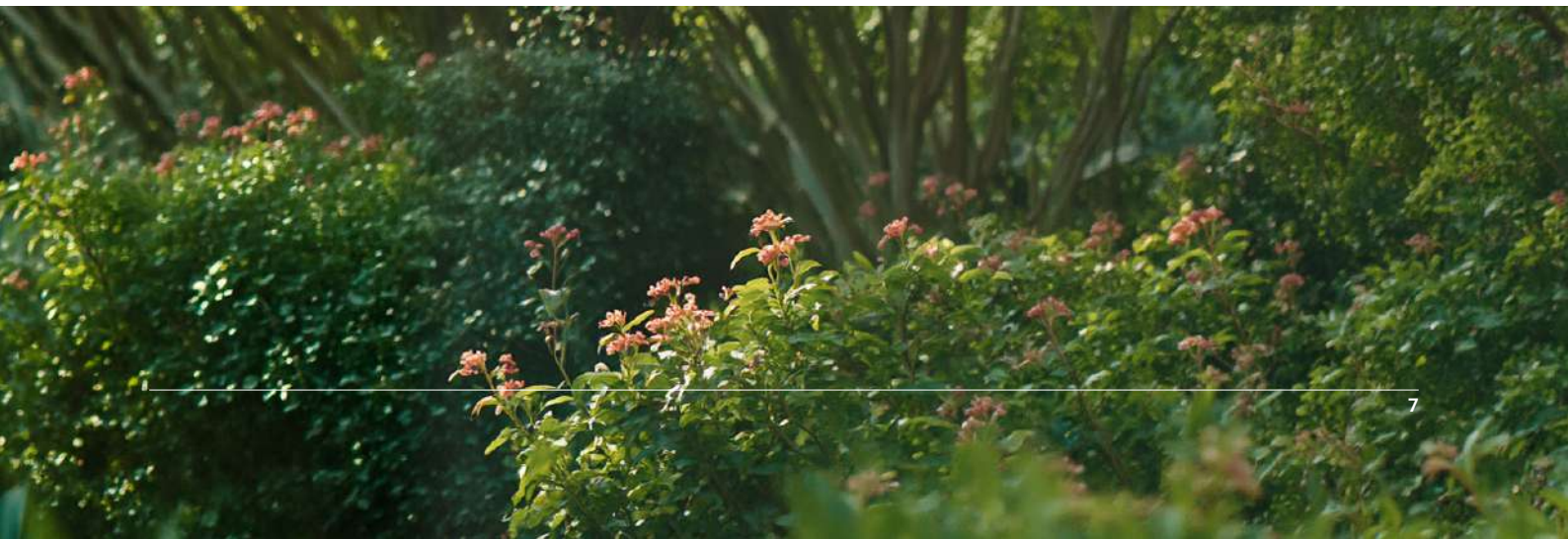
Thailand has 0.7 formal LTC workers per 100 elderly versus Australia's 4.4 — a six-fold gap. The ILO projects roughly 250,000 additional caregivers needed by 2037.

*Activities of Daily Living

# Table of Contents

This white paper is organised in six chapters that build a sequential argument. Chapter A establishes why Thailand's ageing transition matters now. Chapter B defines the market structure and the missing continuum-of-care pathway. Chapter C maps demand against supply at the provincial level. Chapter D introduces the three business models that work and the value-chain decomposition behind them. Chapter E presents nine Thai case studies and the institutional capital signals that prove the thesis. Chapter F sets out the geographical priorities, the 2026-to-2030 supply pipeline, three auditable scenarios, and the four constraints that must be unlocked.





Chapter A

# Why This Matters Now

An ageing certainty meets a fragile family safety net — formal senior care moves from social issue to investable category.

# The Demographic Shift

Thailand will age faster than major advanced-economy precedents and will do so with just a quarter of the income.

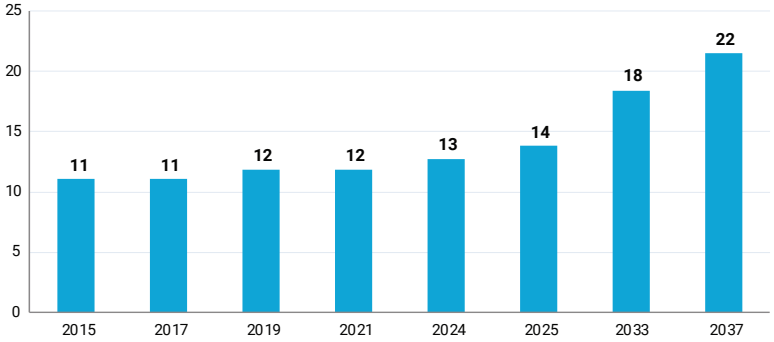
Thailand's senior population reached 14.2 million in 2025 — the year in which, for the first time in Thailand modern history, citizens aged sixty and over outnumbered children under fifteen. This is a structural reversal, not a cyclical fluctuation. The cohort already includes 2.3 million Thais aged eighty and above, the highest-care segment of the population and the fastest-growing band of the pyramid. By 2033, projections from the National Statistical Office and the National Economic and Social Development Council place the 60-plus population at approximately 18.4 million, the threshold at which Thailand formally crosses into super-aged status.

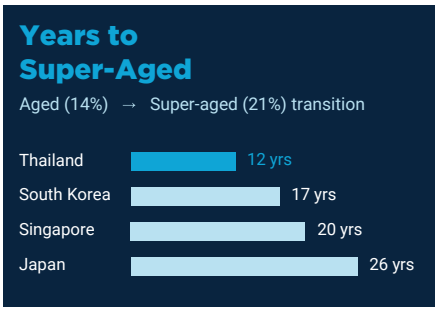
What distinguishes Thailand from comparable Asian transitions is the pace and the income context. Japan took twenty-six years to move from aged to super-aged status. South Korea took seventeen, Singapore twenty. Thailand will compress the same transition into twelve years, and it will do so with a GDP per capita of roughly USD 7,300 — about a quarter of Japan's income at the equivalent demographic milestone. Thailand is ageing before it gets rich, and that single fact dictates almost every strategic implication explored in this paper. The old-age dependency ratio is rising from 14.4 per hundred working-age adults in 2015 to a projected 56.2 by 2040 — a near-quadrupling that will reshape household economics, fiscal planning and labour markets simultaneously.

**Thailand will age faster than major advanced-economy precedents — and at one-quarter the income**

| 14.2m | 2.3m | USD7,300 | 22.0 |
|---|---|---|---|
| Thai elderly aged 60+ (2025) | Thais already aged 80+ (2024) | GDP per capita (2024) | old-age dependents per 100 working-age |
| Outnumbers children under 15 for the first time | Highest-care cohort, growing fastest | Thailand will age before it gets rich | Up from 14.4 in 2015 → 56.2 by 2040 |

**Thailand population aged 60+ (millions, actual & projected)**




Thailand will compress in 12 years what Japan absorbed in 26.

Source: NSO Survey of Older Persons 2024; NESDC long-range projections; World Bank; UN Population Division; OECD.

The implication for senior living operators is direct. Demand is not a long-dated thesis dependent on cultural change or policy reform. Demand is being produced today, by Thais already born, and the cohort with the highest care intensity — the 80-plus segment — is growing faster than the cohort behind it. Operators building capacity now will be running into a rising occupancy curve for at least the next fifteen years. Operators that delay will be entering a market in which the structural advantages have already been claimed.

# Social and Economic Pressure

Social and economic pressure the traditional family safety net is unwinding while financial fragility deepens

The demographic curve alone would be a manageable challenge if Thailand's traditional family-based care system remained intact. It is not. Two structural forces are dismantling the informal safety net that has historically absorbed elder care in Thai households: family structure is fragmenting, and household finances are deteriorating.

## Family structure is changing

Between 2005 and 2019, the share of Thai elderly women living alone rose from 5.9 percent to 13.7 percent — a more than doubling in fourteen years. Average household size fell from 3.1 to 2.9 between 2017 and 2020, and continues to compress. The fertility rate has collapsed to 1.0, among the lowest in Asia, which means the next generation of potential family caregivers will be both smaller and more geographically dispersed than any in modern Thai history. The cultural assumption that an adult child — typically a daughter — will be available to provide informal care for an ageing parent is increasingly an assumption, not a reality.

## Financial fragility is deepening

Roughly 34 percent of Thai seniors live below the poverty line, according to NESDC 2024 data. The minimum Old Age Allowance tier pays THB 600 per month, which covers about three percent of the average cost of a private nursing home. The OECD-equivalent pension replacement rate stands at 37.5 percent, well below the OECD average of 52 percent. Most Thai retirees enter old age with neither the savings nor the pension flows to fund private formal care, and many also lack adult children with the capacity to subsidise it.

**The traditional family safety net is unwinding while financial fragility deepens**

### Family Structure Is Changing

| | |
|---|---|
| **5.9% → 13.7%** | Thai elderly women living alone (2005 → 2019)<br>NSO; WHO |
| **3.1 → 2.9** | Average Thai household size (2017 → 2020) fewer co-residents available for elder care<br>NSO |
| **1.0** | Fertility rate — among the lowest in Asia, shrinking the future caregiver pool<br>World Bank |

### Financial Fragility Is Deepening

| | |
|---|---|
| **34%** | Thai seniors live below the poverty line<br>NESDC 2024 |
| **THB 600** | Monthly Old Age Allowance covers ~3% of average nursing-home cost<br>DOP |
| **37.5%** | OECD-equivalent pension replacement rate (vs 52% OECD average)<br>OECD |

**So What**

Two structural forces collide: families that can no longer absorb care, and households that struggle to pay for it. The market that emerges is bifurcated — a thin affluent layer that can pay private rates, and a vast underserved middle that needs subsidised or hybrid solutions. Operators must pick a side; trying to serve both with one product fails on both.

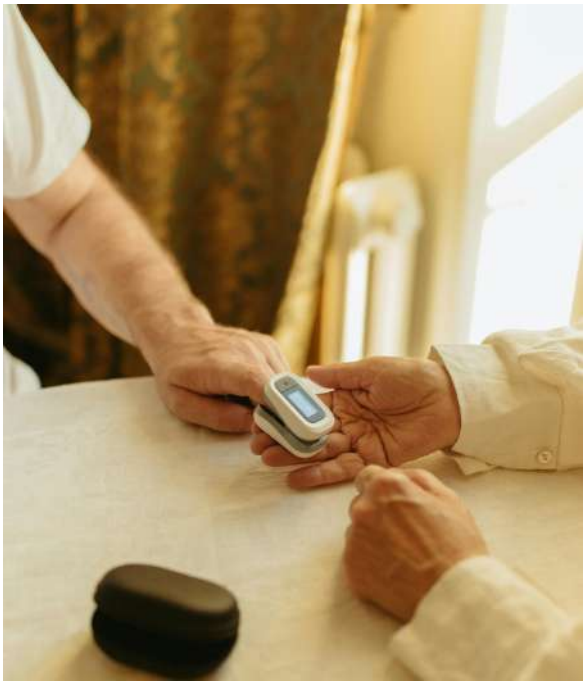
Source: NSO Survey of Older Persons 2024; NESDC; OECD Pensions at a Glance ; UTCC Centre for Economic Forecasting 2025.

The strategic consequence is a bifurcated market. A thin affluent layer can pay private rates and is already supporting the premium operators profiled later in this paper. A vast underserved middle needs subsidised, hybrid or insurance-backed solutions that do not yet exist at scale. Operators must pick a side. Trying to serve both with a single product — a recurring temptation for entrants from hospitality or general real estate — fails on both. The premium tenant will not accept a downmarket aesthetic; the middle-market family cannot meet premium pricing. The two segments require different cost structures, different brand identities and different distribution channels.

# The Care-Need Pyramid

## The care-need pyramid senior living in Thailand is a care-operations story for a medically dependent population

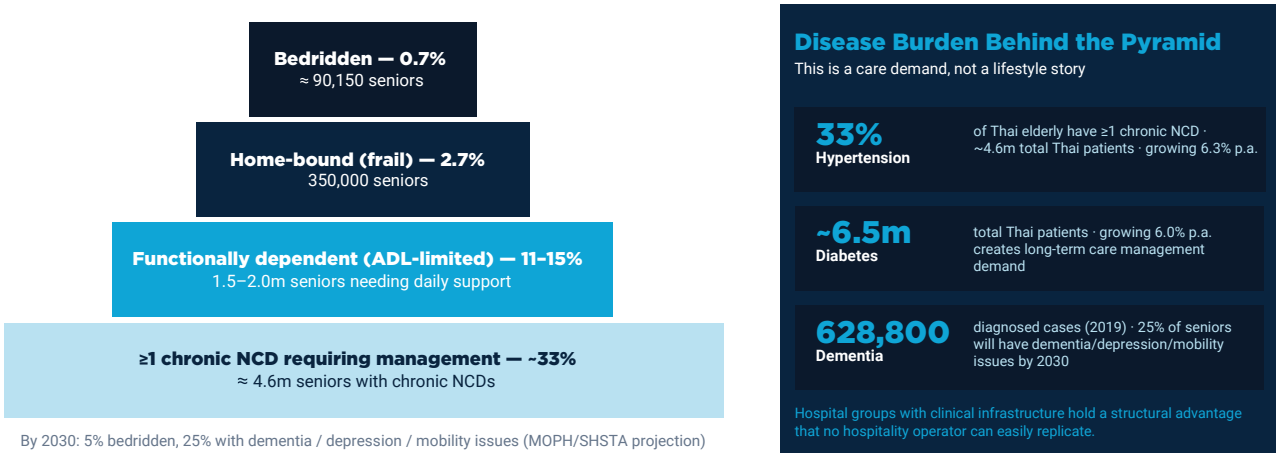
The single most important framing decision in this market is whether to treat senior living as a lifestyle category or a care category. Thai demographic and disease data make the answer unambiguous: this is a care market. Approximately seventy-five percent of Thai elderly live with at least one chronic non-communicable disease — roughly 4.6 million people. Eleven to fifteen percent are functionally dependent with activities-of-daily-living limitations, representing 1.5 to 2.0 million seniors who require daily support. About 2.7 percent are home-bound and frail; 0.7 percent are bedridden. By 2030, MoPH and SHSTA projections indicate that five percent of the 60-plus cohort will be bedridden and twenty-five percent will live with dementia, depression or mobility issues.



The disease profile behind these care states is dominated by conditions that compound with age. Hypertension affects approximately fourteen million Thai patients and is growing at 6.3 percent per year. Diabetes affects roughly 6.5 million and is growing at six percent. Diagnosed dementia

cases reached 628,800 in 2019 and are projected to multiply as the 80-plus cohort expands. These are not conditions that lifestyle programming addresses. They are conditions that require medication management, supervised mobility, post-acute rehabilitation and end-of-life palliative pathways — the operating capabilities of a clinical institution, not a hospitality brand.

**The care-need pyramid shows that senior living in Thailand is a care-operations story**




Source: REIC 2024; MoPH; SHSTA; Department of Disease Control; Eurogroup Consulting analysis.

This is why hospital groups have a structural advantage in Thai senior living that hospitality operators cannot replicate. A clinical license, an established referral network, twenty-four-hour medical staffing and post-discharge pathways are not amenities. They are the substrate on which any premium Thai senior living product must be built. The cases profiled in Chapter E — Bangkok Dusit Medical Services, Thonburi Healthcare Group, Principal Capital and Pruksa's ViMUT partnership — all leverage exactly this advantage. Hospitality-only operators face a structural pricing discount of twenty to forty percent for an equivalent physical product, because Thai families will not pay premium rates for a residence that cannot manage their parent's chronic disease.

# The Affordability Pyramid

## Eighty percent of Thai households cannot afford formal care, so the real market is limited to the top quintile.

Demographic and clinical demand define the size of the population that needs care. Affordability defines the size of the population that can pay for it commercially. These are very different numbers, and conflating them is the single most common error made by entrants into the Thai senior-living market.

Eurogroup Consulting analysis of household income data, operator pricing and OAA coverage produces four affordability bands. The top five to eight percent of Thai households can afford premium integrated communities priced at THB 80,000 to 200,000-plus per month — the segment served by Aspen Tree, HERCULES – Wellness Project by BDMS and Otium Phuket. The next ten to twelve percent (taking the top to fifteen-to-twenty percent) can sustain hospital-linked nursing at THB 40,000 to 80,000 per month — the band in which Jin Wellbeing County and Chersery Home operate. A further band stretching to the top twenty-five-to-thirty-five percent can pay mid-market nursing rates of THB 20,000 to 40,000 per month,

## The Core Thesis

The commercial market is the top 25–30% of Thai households (~2.5–3.5m seniors). Market sizing must be built from affordability upward, not from demographic totals downward.

| | |
|---|---|
| **~2.5–3.5m** | commercially monetizable seniors today |
| **Top 25%** | of households define the investable universe |
| **5–8%** | of households can afford the premium tier |

Source: DOP (OAA); NSO Socio-Economic Survey 2021; NESDC 2024; operator pricing benchmarks 2024–2025; Eurogroup Consulting analysis.

but only where operating costs have been carefully managed and scale is achieved. The remaining sixty-five to seventy-five percent of households cannot afford private care at all and depend on government provision, NGO-led facilities such as Sawangkanives, or informal family arrangements.

The commercial implication is that the addressable senior-living market in Thailand is the top twenty-five-to-thirty percent of households — approximately 2.5 to 3.5 million seniors today. Within that, the genuinely premium tier is the top five-to-eight percent, or approximately 700,000 to 1.1 million seniors. Every credible market sizing in this paper builds from this base upward. Any sizing that starts from the full 14.2 million 60-plus population and applies a generic conversion rate will produce numbers that no Thai operator has ever achieved.

# Chapter A Synthesis

Chapter a synthesis five forces converge to make formal senior living strategically relevant in Thailand

Five structural forces, examined across the preceding sections, now converge to elevate senior living from a social-policy issue to a commercial investment category in Thailand.

**Five forces converge to make formal senior living strategically relevant in Thailand**

| 01 | 02 | 03 | 04 | 05 |
|---|---|---|---|---|
| **Demographic certainty** | **Family-decoupling** | **Health complexity** | **Affluent silver pool** | **Policy & capital tailwinds** |
| 20% → 31% in 16 years. The wave is locked in by people already born. | Living-alone seniors and shrinking households make informal care unsustainable. | NCDs, dementia and falls drive sustained demand for medicalised housing and rehab. | A growing minority — Thai HNWIs, returning expats, foreign retirees — can pay private rates. | BOI incentives, LTR visa, hospital diversification and developer pivots are activating supply. |

**The question is no longer whether a formal senior living market will exist in Thailand — it is who will own the profitable layers of it.**

Chapter B

# How the Market Is Structured

A Thailand-specific taxonomy of senior living categories, highlighting the missing continuum-of-care pathway that represents the largest format gap.

# The Thailand Senior-Living Taxonomy

Five commercial opportunity spaces define the perimeter, while adjacent and policy-led models sit outside it.

Senior living in Thailand cannot be analysed through Western category taxonomies. American CCRC structures, European nursing-home regulations and Singaporean public-private models all rest on assumptions about insurance pooling, ownership norms and licensing pathways that do not apply in Thailand. A Thailand-specific taxonomy is required, and it must distinguish two layers: the commercial opportunity spaces in which capital can be deployed at scale, and the regulatory and operating overlays that determine which models sit inside or outside that commercial perimeter.

Eurogroup Consulting's analysis, synthesised from KPMG Thailand, BOI incentive guidelines, MoPH care-facility licensing and REIC 2025 supply data, identifies five core commercial opportunity spaces in Thai senior living. The first, OS1, is active-age communities — urban independent-living developments led by real-estate logic and serving the Thai 55-to-70 self-pay cohort and foreign retirees. The second, OS2, is destination wellness retirement — resort-style villages with a hospitality service layer, oriented to high-net-worth Thais and inbound foreign retirees, found principally in Phuket, Chiang Mai and Hua Hin. The third, OS3, is care-integrated residences — assisted living and memory care with on-site clinical staffing, paid for primarily by adult children and operating as a clinical-hospitality hybrid. The fourth, OS4, is hospital-linked post-acute and step-down long-term care — rehabilitation and recovery beds adjacent to or within hospitals, funded by insurance, family payments and medical-tourism flows. The fifth, OS5, is aging-in-place through home care and digital coordination platforms — operationally led, capital-light and the only model that can credibly serve provincial demand at scale.

**Five opportunity spaces define the commercial perimeter — adjacent and policy-led models sit outside it**

**LAYER 1 — COMMERCIAL OPPORTUNITY SPACES**

| Opportunity space | What it is | Care intensity | Primary payer | Operating logic | Status |
|---|---|---|---|---|---|
| OS1 Active-age communities | Urban independent living, wellness-led, no on-site nursing | Low | Self-pay (Thai 55–70, foreign retirees) | Real-estate-led | Core market |
| OS2 Destination wellness retirement | Resort-style retirement villages, hospitality service layer | Low–Medium | Self-pay HNW + foreign retirees | Hospitality-led | Core market |
| OS3 Care-integrated residences | Assisted living + memory care; on-site clinical staff | Medium–High | Adult children (urban professional) | Clinical + hospitality hybrid | Core market |
| OS4 Hospital-linked post-acute / step-down LTC | Rehab and recovery beds adjacent to or within hospitals | High | Insurance + family + medical-tourism | Hospital-led | Core market |
| OS5 Aging-in-place (home care + digital) | Home-based caregiving, digital coordination, family portal | Variable | Family (adult children) + insurers | Operations / platform-led | Core market |

**LAYER 2 — REGULATORY & OPERATING OVERLAY — WHAT SITS OUTSIDE THE CORE COMMERCIAL PERIMETER**

**Non-licensed residential / hospitality-led**
No on-site nursing licence; revenue from real estate or hospitality services
Adjacent

**Licensed residential care facility**
MoPH-licensed; minimum staffing ratios; quality liability rests with operator
Core

**Hospital-linked care unit**
Operates under hospital licence; clinical governance via parent group
Core

**Public / subsidised housing**
NHA, Thai Red Cross, Sawangkanives — mission-led, not investable
Policy-led

Source: Eurogroup Consulting taxonomy synthesised from KPMG Thailand 2024, BOI guidelines, MoPH Care Facility licensing, REIC 2025, and the deep research opportunity-spaces framework.

Sitting outside the commercial perimeter — but still important to map — are three categories that shape competitive dynamics without being directly investable. Non-licensed residential developments lack on-site nursing licenses and monetise through real-estate or hospitality service fees only; they are adjacent rather than core. Licensed residential care facilities under MoPH supervision sit firmly within the commercial perimeter but carry quality liability that operators must underwrite. Hospital-linked care units operate under the parent hospital's license, with clinical governance flowing from

the medical group. Finally, public and subsidised housing — National Housing Authority projects, Thai Red Cross Sawangkanives, government Sawangkanives sites — is mission-led, not investable, and serves a different societal function entirely.

This taxonomy matters because it forces investors to identify which opportunity space they are entering before debating which physical product to build. Many failed Thai senior-living ventures conflated OS1 with OS3 — building independent-living units, marketing them as senior friendly, but failing to install the clinical capabilities required when residents inevitably moved into ADL dependence. The cases that succeed, profiled in Chapter E, anchor in a single opportunity space and partner outward.

# The Care Continuum and the Assisted-Living Gap

Five stages of need, with one structural gap: assisted living is too light for hospitals yet too complex for hospitality.

Beyond the static taxonomy, senior care also exists on a continuum of dependency that residents move through over time. A Thai senior at sixty-five may enter the system as an active-age resident in a wellness community; over the following ten to twenty years that same resident will progress through supported independence, into assisted living, on into skilled nursing and dementia care, and ultimately to hospice or palliative care. The economic value of senior-living platforms accrues to those operators who can hold a customer across that continuum, capturing the recurring revenue at every stage rather than losing the customer at each transition point.

The Thai market has supply at the two ends of the continuum and a critical gap in the middle. Active-age communities and wellness retirement (OS1 and OS2) are supplied by developers and hotel groups, with low operational complexity.

Skilled nursing and dementia care exist as fragmented SME provision — REIC counts 944 facilities — and hospitals dominate post-acute and palliative care. The structural gap sits at the assisted-living and care-integrated residences stage (OS3). This is the segment that requires daily ADL support, supervised medication management and dementia programming, all delivered in a residential rather than a hospital setting. It is too light for hospital licensing to be a natural fit, too clinically complex for hospitality operators to staff confidently, and too regulated for casual entrants to navigate quickly. The result is that almost no Thai operator currently spans the full continuum: Aspen Tree spans early stages but stops at high acuity; Thonburi Healthcare Group and Jin Wellbeing partially span mid-to-high acuity but cluster around their hospital anchor; BDMS is strong on high acuity but has not yet templated assisted living at scale; Health at Home covers home delivery only.

The strategic implication is direct. The first operator to credibly bridge the assisted-living stage at scale — through branded mid-tier rollouts with embedded clinical governance — captures the largest format gap in Thai senior living, and the largest pool of monetisable demand from the urban professional cohort paying for elderly parents. The capital signals tracked in Chapter E indicate that this race is already underway: Prinsiri's investment in Chersery Home, Principal Capital's stake in Baan Lalisa, and Pruksa's pivot toward ViMUT-anchored wellness residences all target precisely this gap. None has yet achieved national scale, which means the window remains open.

**Five stages of need, one structural gap — assisted living is too light for hospitals and too complex for hospitality**

**Care Intensity / Dependency**

| Active-age | Supported Independence | Assisted Living / Care-Integrated | Skilled Nursing & Dementia | Hospice / Palliative |
|---|---|---|---|---|
| **OS1 / OS2** | **OS1 / OS3** | **OS3** | **OS3 / OS4** | **OS4** |
| **What It Is**<br>Wellness real estate, lifestyle communities, no on-site care | **What It Is**<br>Concierge services, light medical, social programmes | **What It Is**<br>Daily ADL support, supervised meds, dementia programmes | **What It Is**<br>24/7 nursing, post-stroke, dementia care, high acuity | **What It Is**<br>End-of-life, palliative care, family support |
| **Operator Type**<br>Developers, hotels | **Operator Type**<br>Developers + light operators | **Operator Type**<br>Branded chains (Baan Lalisa, Chersery) | **Operator Type**<br>SME nursing homes (~944, REIC 2025) | **Operator Type**<br>Hospital-based, almost no standalone |
| Supply Density<br>**Low** | Supply Density<br>**Very low** | Supply Density<br>**Critical gap** | Supply Density<br>**Fragmented** | Supply Density<br>**Hospital-only** |

**Operator Footprint**

No Thai operator currently spans the full continuum:

- Aspen Tree spans early stages
- THG / Jin partially spans mid-high acuity
- BDMS strong on high acuity
- Health at Home covers home delivery only

**Strategic Gap**

Assisted living / care-integrated residences — too light for hospital licensing, too complex for hospitality, too regulated for casual entrants. The first operator to credibly bridge this stage at scale captures the largest format gap in Thai senior living.

Chapter C

# Where Demand and Supply Are Shifting

Five demand pools meet a fragmented, shallow supply base, the gaps define the opportunity.

# Five Demand Segments, Only Two Are Commercially Attractive at Scale Today

The Thai senior-living market is not one customer. It is five distinct demand pools, with different need states, different payers and different willingness-to-pay levels, and only two of them are commercially attractive at scale today. Treating these as variants of a single segment — a recurring mistake — produces blended products that fit none of them well.

**Five distinct demand pools — only two are commercially attractive at scale today**

| Segment | Need state | Payer | Affordability (THB/month) | Likely format | Score |
|---|---|---|---|---|---|
| Affluent active Thai 60+ | Lifestyle, prevention, light care | Self / family | 60k–200k+ | Premium integrated, retirement village | 5/5 |
| Adult children paying for parents | Assisted living, dementia, nursing | Adult children (urban professional) | 30k–80k | Hospital-linked, branded nursing home | 4/5 |
| Urban upper-middle Thai | Light assisted living, social | Self + children | 20k–40k | Mid-tier residence, day care | 3/5 |
| Foreign retirees (long-stay) | Independent / light assisted, climate, healthcare arbitrage | Self (pension, savings) | USD 1.5k–4.5k | Resort-style village (Phuket, CM, HH) | 3/5 |
| Mass-market Thai elderly | Basic care, ADL support | Family / state | <10k or unaffordable | Home care, public / community | 1/5 |

**Monetisable Demand ≠ Total Demand**
The investable segments make up roughly 10–15% of Thailand's 60+ population, yet they justify a USD 1–2 billion private senior living asset class by 2033.

Source: NSO 2024; NESDC; operator pricing disclosures; LTR Visa data (BOI); Eurogroup Consulting analysis.

Translating these segments into market size requires care. Monetisable demand is not equal to total demand. The investable segments — affluent active Thais, adult-child payers, and the foreign retiree cohort — represent roughly ten to fifteen percent of Thailand's 60-plus population. That is approximately 1.4 to 2.0 million seniors, with willingness to pay sufficient to underwrite a USD 1 to 2 billion private senior-living asset class by 2033. Operators that target the upper-middle Thai segment can expand the addressable market further, but only with operating models designed for THB 20,000-to-40,000 price points from day one.

# The REIC 2025 Supply Landscape

944 facilities with 17,349 beds and 81 percent occupancy; the supply base has not begun to scale.

Against that demand picture, Thailand's formal senior-care supply is strikingly shallow. The Real Estate Information Center's 2025 release identifies 944 licensed senior-care facilities nationwide, with 17,349 total beds, of which approximately ninety-five percent are operated by the private sector. National occupancy stands at 81.1 percent — a strong demand signal — and the premium tier above THB 75,000 per month reports occupancy above 94 percent, indicating that the high end is structurally oversubscribed.

The pricing distribution of Thai nursing homes reveals the supply problem in stark terms. Forty-three percent of facilities price between THB 10,000 and 20,000 per month; thirty-six percent price between THB 20,000 and 30,000; only fourteen percent price between THB 30,000 and 50,000. Just four percent of facilities price in the THB 50,000-to-75,000 band, two percent in the THB 75,000-to-100,000 band, and only two-tenths of one percent above THB 100,000. The premium tier is structurally empty. Conversely, the bottom of the market — facilities below THB 10,000 — is also thin, at just two percent of supply, reflecting the fact that the truly low-cost segment is served by informal home care and government provision rather than licensed formal facilities.

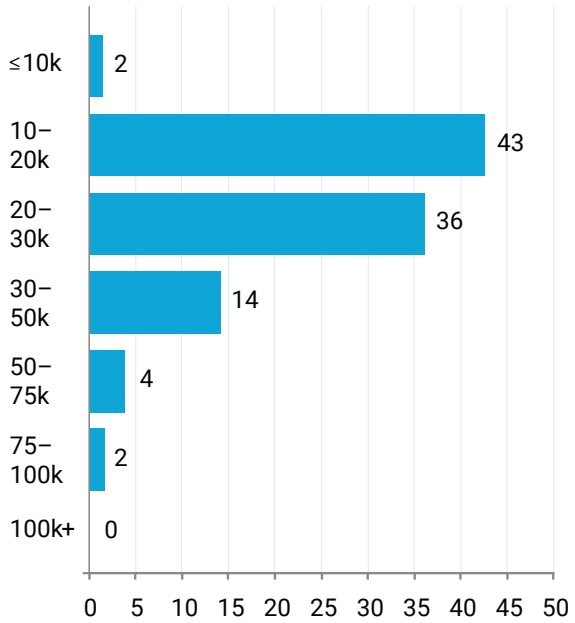
**944**
licensed senior-care facilities (REIC 2025)

**17,349**
total beds 95% private sector

**81.1%**
national occupancy premium tier 94%+

**2,331**
DBD-registered juristic persons (Jun 2025)

## Where supply actually prices
### % of nursing homes by monthly fee band




The Department of Business Development's juristic-person registry tells a complementary story. As of June 2025, there are 2,331 registered juristic entities operating in the senior-care space, up from 533 in 2021 — a twenty-seven percent compound annual growth rate that demonstrates institutional formation is accelerating from a small base. Tenure structures remain almost entirely conventional: ninety-two percent of senior-care facilities operate on a rental tenure, only five percent offer lifetime lease arrangements, and effectively zero use the CCRC entrance-fee model that dominates the US market. The financial architecture of Thai senior living is, in other words, still in its first generation.

## The Premium Tier Is Empty

**79%**
of Thai nursing homes price below THB 30k/month

**Only 0.2%**
of facilities price above THB 100k — the premium tier is structurally empty

**92% rental tenure**
Only 5% offer lifetime lease; effectively zero use the CCRC entrance-fee model

**DBD growth 533 → 679**
registered companies 2021–2023 (+27%) — institutionalisation is accelerating from a small base

# Provincial Supply Heatmap

Three provinces hold half of the national supply, while the remaining 47 share the rest.

Geographic concentration is the supply story's other defining feature. Bangkok alone accounts for 328 of the 944 facilities and 5,327 of the 17,349 beds — thirty-one percent of national capacity concentrated in one province, operating at 87.3 percent occupancy, the highest in the country. Adding Nonthaburi, Pathum Thani and Samut Prakan, the Greater Bangkok region holds fifty-three percent of national beds. The Thai senior-living market is, today, a Greater Bangkok market with regional satellites.

The provincial top ten reads: Bangkok (328 facilities, 5,327 beds, 87.3% occupancy), Nonthaburi (104 facilities, 2,382 beds, 80.0%), Chiang Mai (60 facilities, 1,200 beds, 82.5%), Chonburi (51 facilities, 1,175 beds, 71.3%), Pathum Thani (45 facilities, 810 beds, 82.1%), Nakhon Pathom (35 facilities, 715 beds, 80.6%), Samut Prakan (22 facilities, 506 beds, 75.3%), Nakhon Ratchasima (15 facilities, 368 beds, 82.9%), Songkhla (16 facilities, 340 beds, 62.4%), and Khon Kaen (24 facilities, 301 beds, 71.8%). The remaining forty-seven provinces collectively hold 244 facilities and 4,225 beds. Khon Kaen — a major northeastern regional hub with an elderly population in the millions — has only twenty-four facilities. Provincial Thailand is materially undersupplied relative to its demographic weight.

**Three provinces hold half the national supply — 47 others share the reminder**

| Rank | Province | Projects | Beds | Residents | Occupancy |
|---|---|---|---|---|---|
| 1 | Bangkok | 328 | 5,327 | 4,648 | 87.3% |
| 2 | Nonthaburi | 104 | 2,382 | 1,905 | 80.0% |
| 3 | Chiang Mai | 60 | 1,200 | 990 | 82.5% |
| 4 | Chonburi | 51 | 1,175 | 838 | 71.3% |
| 5 | Pathum Thani | 45 | 810 | 665 | 82.1% |
| 6 | Nakhon Pathom | 35 | 715 | 576 | 80.6% |
| 7 | Samut Prakan | 22 | 506 | 381 | 75.3% |
| 8 | Nakhon Ratchasima | 15 | 368 | 305 | 82.9% |
| 9 | Songkhla | 16 | 340 | 212 | 62.4% |
| 10 | Khon Kaen | 24 | 301 | 216 | 71.8% |
| — | Other 47 provinces | 244 | 4,225 | 3,337 | 79.0% |
| | **TOTAL** | **944** | **17,349** | **14,073** | **81.1%** |

### What the Provincial Data Reveal

**01. Bangkok dominates**
Bangkok alone has 328 of 944 facilities and 5,327 of 17,349 beds, 31% of national capacity at the highest occupancy in the country (87.3%).

**02. Greater Bangkok holds 50%+**
Bangkok + Nonthaburi + Pathum Thani + Samut Prakan account for 53% of national beds. The Thai senior-living market is, today, a Greater Bangkok market.

**03. Provincial gaps are extreme**
47 provinces share just 244 projects and 4,225 beds. Khon Kaen, a major northeastern hub, has 24 facilities for an elderly population in the millions.

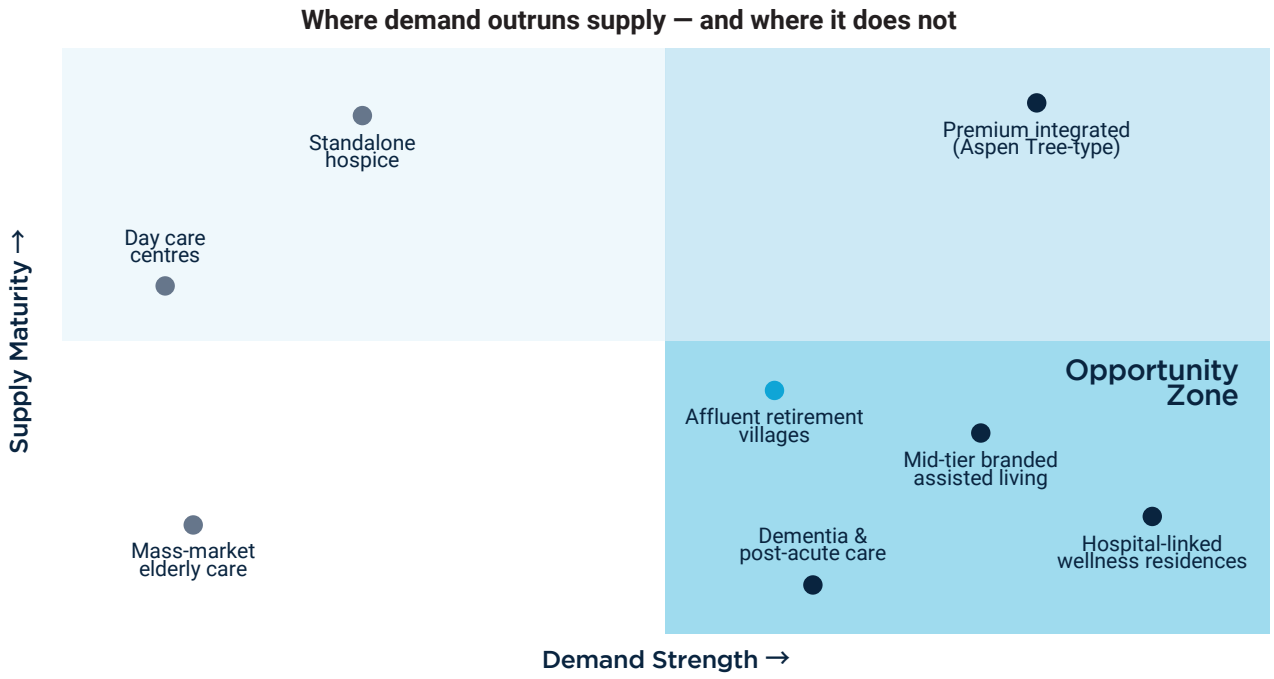
**04. High occupancy = unmet demand**
Bangkok 87%, Nakhon Ratchasima 83%, Chiang Mai 82.5%, the highest occupancy provinces are saturated. New supply will not cannibalise; it will absorb pent-up demand.

Source: REIC 2025 — Nursing Home and Residence Projects Providing Services (mix of public and private, by province).

Four findings emerge from the provincial data. First, Bangkok dominates: one province holds thirty-one percent of national capacity, and its 87.3 percent occupancy rate is the highest in the country, signalling structural undersupply at the metropolitan core. Second, Greater Bangkok holds the majority: the four-province cluster around the capital accounts for fifty-three percent of national beds, which means most national-scale entrants must build a Bangkok proposition first and expand outward. Third, provincial gaps are extreme: forty-seven provinces share only 244 facilities and 4,225 beds, and the gap is widest in the Northeast and the deep South. Fourth, high occupancy equals unmet demand: Bangkok at 87 percent, Nakhon Ratchasima at 83 percent, Chiang Mai at 82.5 percent are all close to saturation. New supply added in these markets will not cannibalise existing operators; it will absorb pent-up demand that currently cannot find quality formal provision.

# The Gap Matrix: Where Demand Outpaces Supply

Combining the demand segmentation with the provincial supply picture produces a gap matrix that identifies four typologies of unmet need. A quality gap exists across most existing nursing homes, which lack standardised training, professional brand identities and consumer trust. A format gap is most acute in branded mid-tier assisted living — the segment between SME nursing homes and luxury flagships, which is almost entirely absent in the Thai market. An affordability gap separates middle-class demand from private pricing in the absence of long-term care insurance or alternative financing instruments. A geography gap concentrates supply in Bangkok and the majors, leaving secondary cities and tertiary provinces materially underserved.




## Gap Typology

### Quality Gap
Most existing nursing homes lack standards, training and brand trust.

### Format Gap
Almost no branded mid-tier assisted living between SME homes and luxury flagships.

### Affordability Gap
Middle-class demand cannot reach private pricing without insurance / financing innovation.

### Geography Gap
Supply is concentrated in BKK & majors; secondary cities are underserved.

### Demand Signal
Premium elderly residence rental occupancy reaches 94.4%, versus the 81% national nursing home average, demonstrating that the top of the market is structurally undersupplied (REIC 2025).

Source: REIC 2025; Eurogroup Consulting synthesis of DBD, MoPH, NESDC and operator data.

The single clearest demand signal in the supply data is the premium elderly residence occupancy rate: 94.4 percent versus the 81 percent national nursing-home average. This is empirical proof that the top of the market is structurally undersupplied. Operators able to credibly deliver premium-tier product in Greater Bangkok can underwrite their occupancy curve with high confidence in the medium term.

Chapter D

# Business Models That Work

Three investable operating systems with distinct economics, capex profiles, and customer logics, validated by listed-company capital.

# Five Operating Models, Three With Scalable Investment Logic

Five operating models can be observed in Thai senior living today, each mapping to one of the five opportunity spaces and each carrying a distinct operating logic, capex profile and proof status. Not all five are equally investable, and the distinctions matter for capital allocation.

**M1** Model M1 is premium integrated senior living, exemplified by Aspen Tree, HERCULES – Wellness Project by BDMS and Otium Phuket. It carries high margin potential, very high capex burden, low scalability and flagship-only replicability. It is the proof point for the price ceiling — confirmation that Thai HNWIs and inbound foreign retirees will pay extreme prices for fully integrated lifetime care — but it does not template a national rollout. Operators pursuing this model build trophy assets, not platforms.

**M2** Model M2 is the hospital-linked care chain, exemplified by Jin Wellbeing County (Thonburi Healthcare Group) and the BDMS post-acute network. It carries high margin potential, high capex burden, medium scalability and hospital-anchored replicability. It is the most clinically defensible model in Thailand and the one most aligned with Vision 2030-style policy ambitions in healthcare convergence. M2 is the model that listed hospital groups can replicate within their existing franchise economics.

**M3** Model M3 is the branded mid-tier nursing chain, exemplified by Chersery Home and Baan Lalisa. It carries medium margin potential, medium capex burden, high scalability and franchise-ready replicability. This is the emerging archetype that listed-developer capital flowed into during the Q4 2023 wave, and it is the model with the highest plausible national rollout potential. It targets the assisted-living gap identified in Chapter B.

**M4** Model M4 is the home and hybrid care platform, exemplified by Health at Home and ViMUT Life Link. It carries medium margin potential, low capex burden, very high scalability and asset-light replicability. It is the only model that can credibly serve provincial demand at price points most Thai families can sustain, and the only one for which listco capital has explicitly endorsed home-care delivery as a strategic adjacency to hospital discharge pathways.

**M5** Model M5 is public or affordable senior housing, exemplified by Sawangkanives (Thai Red Cross) and the NHA Bang Lamung development. It carries low margin potential, medium capex burden, limited scalability and mission-led replicability. It sits outside the commercial perimeter and is investable only through PPP, NGO or impact-capital structures. Its demand signal — Sawangkanives operates at one hundred percent occupancy with a waitlist — is unambiguous, but it is not a private equity play.

**Each model maps to one of the five opportunity spaces with a distinct operating logic and proof status**

| Model | Opportunity space | Thai examples | Margin potential | Capex burden | Scalability | Replicability | Proof status |
|---|---|---|---|---|---|---|---|
| Premium integrated senior living | OS2 Destination wellness | Aspen Tree, HERCULES Project by BDMS, Otium | High | Very high | Low | Flagship-only | **Proven (price ceiling)** |
| Hospital-linked care chain | OS3 / OS4 Care-integrated + post-acute | Jin Wellbeing, BDMS post-acute | High | High | Medium | Hospital-anchored | **Proven (operating)** |
| Branded mid-tier nursing chain | OS3 Care-integrated residences | Chersery Home, Baan Lalisa | Medium | Medium | High | Franchise-ready | **Emerging (capital flowing)** |
| Home & hybrid care platform | OS5 Aging-in-place | Health at Home, ViMUT Life Link | Medium | Low | Very high | Asset-light | **Emerging (early scale)** |
| Public / affordable senior housing | Outside core perimeter | Sawangkanives, NHA Bang Lamung | Low | Medium | Limited | Mission-led | **Policy-led** |

M2 (hospital-linked) and M3 (branded mid-tier) carry operating proof. M4 is the highest-scale emerging play. M1 proves the price ceiling but does not template a national rollout. M5 sits outside the commercial perimeter.

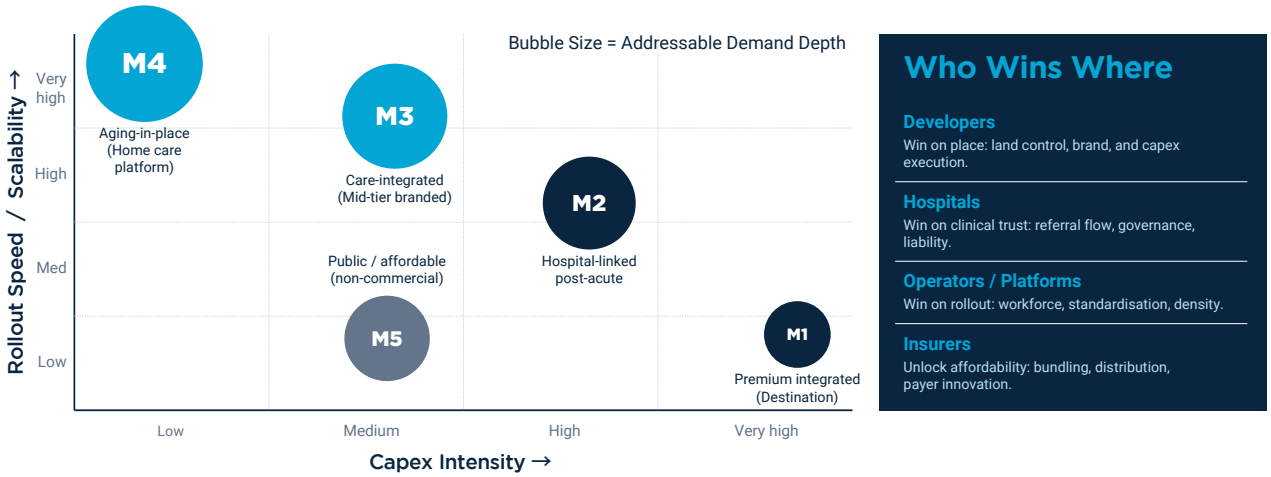
Source: Operator websites and SET disclosures; KPMG Thailand 2024; deep research opportunity-spaces framework; Eurogroup Consulting analysis. Proof status reflects evidence level, not investment merit.

Models M2 (hospital-linked) and M3 (branded mid-tier) carry the strongest combination of operating proof and scaling logic. Model M4 is the highest-scalability emerging play, with proven listco backing. Model M1 proves the price ceiling but does not template a national rollout. Model M5 sits outside the commercial perimeter and is appropriate only for mission-led capital. Operators and investors should choose between M2, M3 and M4 on the basis of their existing capabilities — hospital groups should anchor in M2, developer-operator JVs in M3, and platform builders in M4 — rather than attempting hybrids that fit none cleanly.

# Cross-Model Economics: Capex Intensity versus Rollout Speed

The five models trade off capex intensity against rollout speed in predictable patterns. Premium integrated (M1) sits at very high capex and low rollout speed: it produces flagship assets, not chains. Hospital-linked (M2) sits at high capex and medium rollout speed: each project requires hospital anchoring but the parent hospital's franchise economics can underwrite multi-site expansion. Branded mid-tier (M3) sits at medium capex and high rollout speed: standardised care protocols and training systems enable scale without proportional capital deployment, and franchise-ready economics support rapid geographic expansion. Aging-in-place (M4) sits at low capex and very high rollout speed: it is the asset-light archetype, scaling through caregiver networks and digital platforms rather than physical assets. Public and affordable (M5) sits outside the commercial economics frame.

**Capex intensity vs rollout speed — bubble size reflects addressable demand depth**




Source: Eurogroup Consulting analysis on operator capex, rollout precedents (Chersery 8 sites, Baan Lalisa 18 sites) and addressable demand depth (REIC 2025; affordability pyramid).

The implication for capital allocators is that no single model serves all investor profiles. Long-duration patient capital — sovereign wealth, life insurance balance sheets, family office multigenerational pools — should anchor in M1 or M2, where the trophy asset or hospital franchise produces enduring brand value. Growth equity and private-equity capital should anchor in M3, where rollout economics permit ten-to-fifteen-site platforms with clear exit pathways through trade sale or listing. Venture and technology-platform capital should anchor in M4, where the operating logic resembles a software-enabled service rather than a real-estate business.

Different players win in different layers. Developers win on place — they control land, brand and capex execution. Hospitals win on clinical trust — they hold the licenses, referral flows and governance frameworks that produce family confidence. Operators and platforms win on rollout — they orchestrate workforce, standardisation and operational density. Insurers unlock affordability — they package payment products, distribute through employer channels and innovate around long-term care risk pooling. None of these capabilities is substitutable, and the most defensible Thai senior-living strategies are partnership architectures that combine three or four of them rather than single-player attempts to own the whole chain.

# Value-Chain Decomposition

Thai senior living's value chain decomposes into four layers: upstream design and development, core clinical and care operations, the customer interface (sales, trust and retention), and value capture (margin and returns). Each layer has different right-to-win logics, different incumbents and different international participation patterns.

Upstream design and development is where Thai regulation, local workforce, land partnerships and cultural adaptation set the operating envelope. Facility design must satisfy both universal-design and dementia-safe requirements while accommodating WELL building standards for the premium tier. Capital and finance require REIT-compatible structures and long-term operating covenants. Brand licensing increasingly relies on international accreditation

— JCI for hospitals, CARF for care, ISO for management systems — to bridge the consumer-trust deficit that limits domestic-only brands.

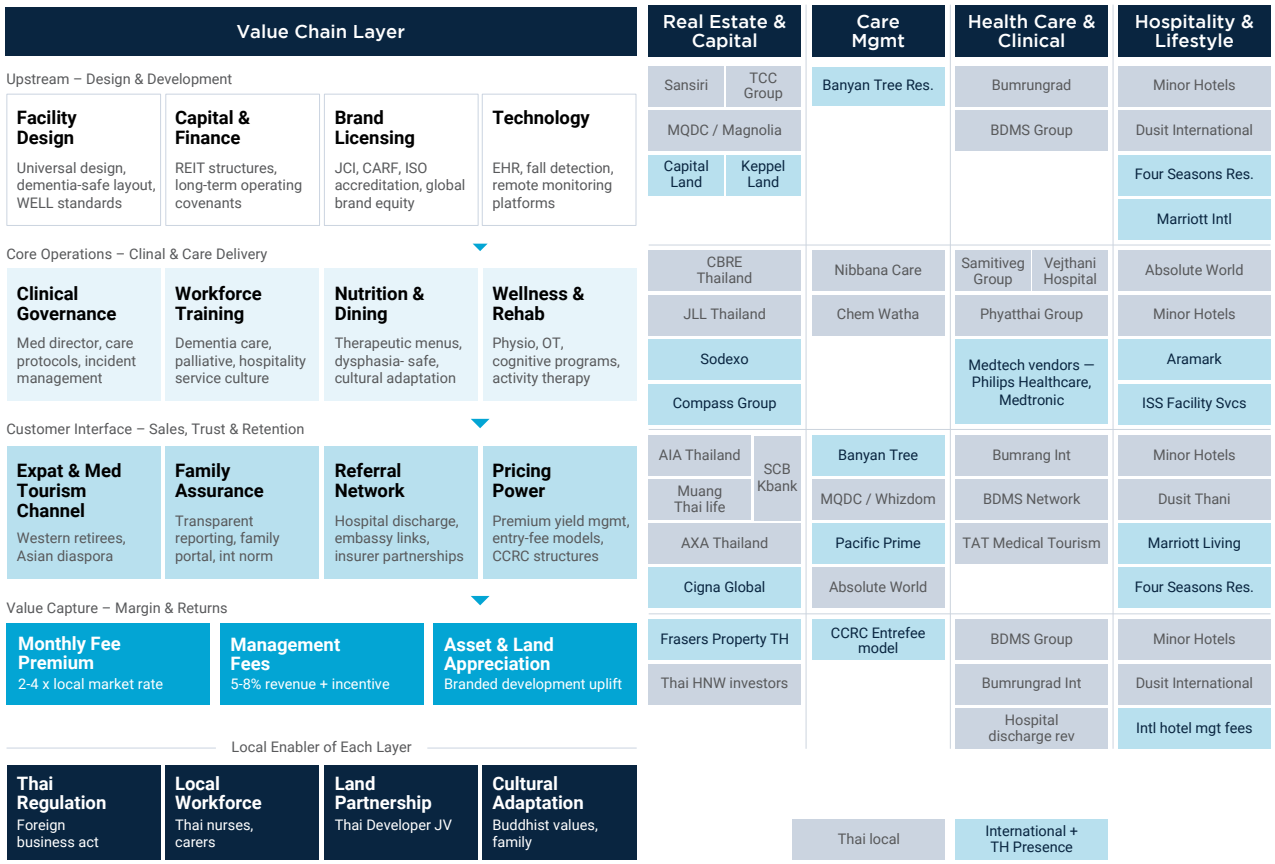
Core clinical and care operations is where the day-to-day business model lives. Technology enablement (electronic health records, fall detection, remote monitoring), clinical

governance (medical director oversight, care protocols, incident management), workforce training (dementia care, palliative practice, hospitality service culture), nutrition and dining (therapeutic menus, dysphagia-safe preparation, cultural adaptation), and wellness and rehabilitation (physiotherapy, occupational therapy, cognitive programmes) together determine the resident experience and the operator's licensing position.

The customer interface is where Thai operators distinguish themselves. Expat and medical-tourism channels reach Western retirees and the Asian diaspora; family-assurance mechanisms (transparent reporting, family portals, international service norms) convert prospects into long-stay residents; referral networks (hospital discharge, embassy links, insurer partnerships) generate the majority of leads for hospital-linked operators.

Value capture varies by model. Premium operators rely on entry-fee and CCRC-style monetisation. Mid-tier operators stack monthly fees at two-to-four times the local market rate and add management fees of five-to-eight percent of revenue plus incentives. Hospital-anchored operators capture episode-based post-acute revenue, monthly LTC fees and medical-tourism crossover. Asset and land appreciation contribute meaningfully in branded developments, with brand uplift typically adding fifteen-to-thirty percent to comparable unbranded land values.

**Thailand's premium senior living is led by local developers, with international operators adding clinical governance and brand standards that justify premium fees.**




The value-chain map reveals an important structural feature of the Thai market: international players add disproportionate value in clinical governance, accreditation and brand standards, but local players retain control of land, regulatory access and workforce. The most defensible operating models combine international clinical and brand standards with local land control and workforce, joined through a partnership architecture rather than wholesale foreign entry. Pure foreign-led models — common in earlier Thai medical tourism — face the regulatory headwind of the Foreign Business Act and the operational headwind of building Thai workforce capability from scratch.

# Who Should Own What in the Senior-Living Ecosystem

Across the value chain, eight functions map to six player archetypes, and no single archetype owns the chain. The right-to-win is in the partnership architecture, not in any single role. A property developer leads on land, capital and development execution but partners with operators on resident experience and hospitality and is enabled by hospitals on clinical governance and by insurers on affordability engineering. A hospital or medical group leads on clinical governance and referral distribution but partners with developers on real-estate execution and with hotel operators on hospitality. A hotel or resort operator leads on resident experience and contributes to destination positioning but defers clinical governance entirely to hospital partners. A care operator leads on daily care operations and workforce training but depends on developer leases and hospital referrals. A platform or startup leads on technology, monitoring and family-portal trust, enabling other players in the chain through software and data services. An insurer or financial institution leads on affordability and payer innovation, enabling the entire chain through bundled products and risk pooling.

**Eight functions, six player archetypes — no single player owns the chain; the partnership architecture defines the right-to-win**

| Function ↓ / Player → | Property developer | Hospital / medical group | Hotel / resort operator | Care operator | Platform / startup | Insurance / finance |
|---|---|---|---|---|---|---|
| Land / capex / development | LEAD | PARTNER | ENABLE | | | ENABLE |
| Clinical governance | | LEAD | | PARTNER | ENABLE | |
| Daily care operations | | PARTNER | | LEAD | ENABLE | |
| Resident experience / hospitality | PARTNER | | LEAD | PARTNER | | |
| Referral / distribution | | LEAD | | PARTNER | ENABLE | PARTNER |
| Affordability / payer innovation | | PARTNER | | ENABLE | | LEAD |
| Tech / monitoring / family portal | | PARTNER | | ENABLE | LEAD | |
| Workforce / training | | PARTNER | ENABLE | LEAD | ENABLE | |

LEAD (primary owner of the function) PARTNER (required handshake for delivery) ENABLE (meaningful contribution, supporting role)

**Key Insight**
Hospitals control clinical governance and referral; developers control land; operators control workforce and daily care; insurers control affordability. The defensible position is the partnership architecture, not any one role.

Source: Deep research GTM-by-player-background framework; KPMG Thailand 2024; BOI guidelines; Eurogroup Consulting synthesis.

The matrix produces a clear conclusion. Hospitals control clinical governance and referral; developers control land; operators control workforce and daily care; insurers control affordability. The defensible position for any single entrant is the orchestration of partnerships that combine these capabilities, not the attempt to internalise all of them. The Thai cases that have succeeded — examined in Chapter E — are without exception partnership constructs. Aspen Tree partners MQDC's developer capability with Bumrungrad clinical governance. Jin Wellbeing partners Thonburi's hospital with the group's own real-estate vehicle. Chersery Home partners Prinsiri's developer capital with KPN's clinical brand. Baan Lalisa partners with Principal Capital. The pattern is consistent: no winner has gone alone.

Chapter E

# Who Is Proving It

Three investable operating systems with distinct economics, capex profiles and customer logics, proven with listed-company capital.

Theory becomes thesis when capital follows. The cases below trace nine Thai senior-living ventures, each chosen because it validates a specific model archetype with documented investment and disclosed operating metrics. They are not all profitable yet; the market is too young for that. But each carries enough evidence to be analysed as a proof point rather than a pilot, and together they establish that Thai senior living has moved beyond founder-led SMEs into the institutionalisation phase.

Case Study 01

# Jin Wellbeing County, Pathum Thani

| Model | M2 · Hospital-linked wellness residence |
|---|---|
| **Developer** | Thonburi Healthcare Group (THG) — SET-listed |
| **Location** | 140 rai, Phaholyothin Road, Rangsit, Greater Bangkok |
| **Format** | 13 low-rise buildings, 1,300–1,380 units (43–63 sqm) |
| **Healthcare** | On-site Thonburi Burana Hospital (51–55 beds); dedicated geriatric and 24/7 emergency |
| **Pricing** | From THB 3.6m per unit; rentals available; nursing packages add-on |
| **Investment** | Phase 1 over THB 4 billion |
| **Status** | Operational since 2019; first phase fully occupied |

## Why this case matters

Jin Wellbeing County is the first credible Thai proof that a listed hospital group can extend its franchise into senior real estate and capture multiple revenue streams — unit sale, rental, nursing packages and hospital fees — from the same customer over the course of decades. It sets the template for the hospital-linked model and demonstrates that an integrated wellness residence can achieve full Phase 1 absorption in Greater Bangkok within five years of opening. The replication challenge is the capex requirement and the brand authority needed to underwrite premium pricing; few Thai hospital groups can match Thonburi's combination of clinical credibility and real-estate execution. Jin Wellbeing is therefore the template, not the recipe — the model others must adapt to their own franchise economics rather than copy directly.

> **Our project came a little ahead of its time.**
>
> **Peerapong Peerachotiwatra,** CEO of Thonburi Wellbeing

Case Study 02

# The Aspen Tree at The Forestias, Bangna

| Model | M1 · Premium integrated senior living |
|---|---|
| Developer | Magnolia Quality Development Corporation (MQDC, DTGO) |
| Location | The Forestias, Bangna-Trad, Greater Bangkok (300-rai mixed-use) |
| Format | 22-storey residence tower with dedicated Health & Brain Centre |
| Target | 50-plus affluent Thai HNWIs and regional buyers; lifetime care concept |
| Pricing | THB 28m–70m+ per unit (lifetime lease, primary disclosure); listing range THB 33–88m |
| Investment | Part of the THB 125 billion Forestias master plan |
| Status | Operational; flagship of Thai premium senior living |

## Why this case matters

Aspen Tree is the benchmark for what a fully integrated, lifetime-care senior product looks like in Thailand. It confirms that a top-one-percent market exists at extreme price points and that Thai HNWIs are willing to commit lifetime-lease capital in advance for the assurance of integrated medical, residential and brain-health programming. It also illustrates the limit of the model: Aspen Tree is a real-estate trophy with care embedded, not a scalable care platform. Replicators will need a comparable land bank, brand credibility built over a decade, and capital horizons of seven to ten years. The Aspen Tree is therefore an irreplicable flagship rather than a national platform — its strategic value is to anchor the upper bound of the market and validate willingness to pay at that bound, not to be copied at scale.

> **The Aspen Tree homes are designed as first-class condominiums and sky villas, but with unique design features.**
>
> **Hye June Park,** President of The Aspen Tree (MQDC)

Case Study 03

# Otium Phuket / Kamala Senior Living, Phuket

| Model | M1/M2 · Foreign-retiree luxury village |
|---|---|
| Developer | Nye Estate / Chewathai / LPN / CH Karnchang JV; managed by Otium Living |
| Location | MontAzure development, Kamala Bay, Phuket west coast |
| Format | ~191–200 condominium units plus 29–30 villas; resort amenities |
| Target | Affluent over-50s from Thailand, Singapore, Hong Kong, Malaysia, Europe |
| Pricing | Total project value approximately USD 135m / THB 3.5 billion |
| Consultant | UK Audley Group (luxury retirement specialist) |
| Status | Operational; references international best practice |

## Why this case matters

Otium Phuket validates the foreign-retiree thesis at scale and proves that international operators see Thailand as a regional senior-living hub. It also demonstrates the partnership architecture argued in Chapter D: a Thai developer consortium combined with a UK retirement-specialist consultant produces a product that neither party could deliver alone. The strategic boundary, however, is geographic. The foreign-retiree pool is concentrated and price-elastic; Phuket and Hua Hin can each support two to four such projects, but not twenty. Otium is therefore best understood as a niche play rather than a national-market signal — high-margin, brand-defensible, but limited in absolute deal count.

> **I wanted to design something that when you move in, you'd immediately feel younger, not older.**
>
> **Daniel Holmes,** CEO of Otium Living


Case Study 04

# Sawangkanives, Thai Red Cross, Samut Prakan

| Model | M5 · Affordable lifetime-fee senior housing |
|---|---|
| Operator | Thai Red Cross Society |
| Format | 9-storey condominium, 468–494 units (~33 sqm), 26,800 sqm |
| Model logic | Lifetime occupancy fee — pay once, live for life |
| Pricing | Approximately THB 650,000 entrance fee (~USD 19,000) |
| Target | Middle-class Thai seniors seeking community and safety |
| Occupancy | 100% — fully occupied with waitlist |
| Status | Operational and oversubscribed |

## Why this case matters

Sawangkanives is proof that an affordable, mission-led lifetime-fee model has powerful demand among middle-class Thai seniors. The economics of the project depend on subsidised land and NGO sponsorship and are therefore not directly replicable in private-capital structures. But the demand signal is unambiguous: when the price is right, Thai seniors will actively choose community living over traditional family-based arrangements. This contradicts a cultural assumption that often deters investors — the belief that Thai families will not accept formal senior housing — and reframes the constraint as economic rather than cultural. Sawangkanives is therefore a blueprint for public-private affordable senior housing and a structural argument for policy intervention in the middle of the affordability pyramid.

> **Sawangkanives is the proof that demand among middle-class Thai seniors is substantial when the price is right.**
>
> **Thai Red Cross Society Programme Disclosure**

Case Study 05

# Baan Lalisa Healthcare Service Group, Nationwide

| Model | M3/M4 · Branded rollout nursing and home care |
|---|---|
| Operator | Baan Lalisa Healthcare Service Group |
| Partner | JV with Principal Capital PCL (listed healthcare operator) |
| Format | Branded nursing homes plus home-care services |
| Footprint | 26 branches across Thailand and growing |
| Target | Adult children paying for parents; urban middle-upper |
| Model logic | Operations-led, asset-light, brand-driven rollout |
| Status | Active expansion phase; partnership with listco for capital |

## Why this case matters

Baan Lalisa is the clearest Thai example of a branded, scalable mid-tier care operator, and the partnership with a SET-listed company demonstrates that institutional capital is willing to back the operating-led model. This is the M3 archetype in pure form: capital-light, brand-led, rollout-ready, and the most plausible path to building a national senior-care platform in Thailand. Baan Lalisa's combination of physical care facilities and home-care delivery also bridges into M4, giving the platform optionality across both nursing-home and home-based revenue streams. The strategic implication is that capital-efficient consolidation of fragmented SME nursing supply, behind a single brand and operating system, is the most plausible path to Thai senior-care leadership over the next decade — and Baan Lalisa is currently ahead in that race.

> **Six years ago, I saw an opportunity to expand our business into senior-friendly homes as Thai society is aging.**
>
> **Athiporn Poolsawaddi,** CEO of Baan Lalisa Healthcare

Case Study 06

# Pruksa Holding X Vimut Hospital, Listed-Developer Convergence

| Model | M2 · Real estate and healthcare convergence |
|---|---|
| Parent | Pruksa Holding PCL (SET-listed property developer) |
| Healthcare arm | ViMUT Hospital Holding (in-group hospital network) |
| Strategic shift | Pivot to wellness residences integrating housing with healthcare |
| Target | Recurring-income share to reach 25% of group revenue by 2028 |
| Evidence | ViMUT Group revenue THB 2,187m in 2024 (+20% YoY) |
| Logic | Land + standardised build + in-group clinical brand + recurring service fees |
| Status | Strategy publicly disclosed; first wellness-residence projects in pipeline |

## Why this case matters

The Pruksa-ViMUT case is the only example in Thailand of a major SET-listed developer formally re-orientating its core business model around senior living and healthcare convergence. It validates that institutional capital is moving into the sector at scale and that the M2 hospital-linked model is no longer a one-off (Jin Wellbeing) but an emerging category. The twenty-five percent recurring-income target is the single metric most worth tracking for the entire Thai senior-living thesis. If Pruksa achieves it, the model will be replicated by other listed developers. If it does not, the convergence thesis will face headwinds and capital will retreat to pure-play hospital or operator structures.

> **Pruksa is positioning the group to lead in wellness residences by integrating housing with healthcare.**
>
> **Pruksa Holding Corporate Disclosure**

Case Study 07

# HERCULES – Wellness Project by BDMS, Bangkok

| Model | M2 · Hospital-anchored wellness destination |
|---|---|
| Parent | Bangkok Dusit Medical Services (BDMS) — largest Thai private hospital group |
| Vehicle | BDMS Wellness Clinic / BDMS Wellness Resort |
| Project | Hercules — wellness mixed-use complex on Crown Property Bureau land |
| Investment | Approximately THB 25 billion announced project value |
| Positioning | Wellness destination combining preventive medicine, longevity, residential |
| Target | Affluent Thai and international long-stay; medical-tourism crossover |
| Status | Announced 2025; demonstrates hospital-led real-estate ambition |

## Why this case matters

Hercules Wellness City proves the most ambitious form of the hospital-led model: not a wellness residence next to a hospital, but a hospital-branded wellness city anchored by Thailand's largest private medical group on prime central Bangkok land. It anchors Thailand's positioning as a regional longevity destination and signals that the largest healthcare players see senior living and wellness as a single addressable market rather than two adjacent ones. The scale — THB 25 billion in a single mixed-use development — places this project in a category of its own in Thai senior living capex commitments, and the Crown Property Bureau ground-lease structure provides a financial-engineering template that other listed hospital groups will study closely.

> **This collaboration is a key step that will help propel Thailand into the top five global wellness tourism destinations.**
>
> **Dr. Tanupol Virunhagarun,** President of Executive Committee, BDMS Wellness

Case Study 08

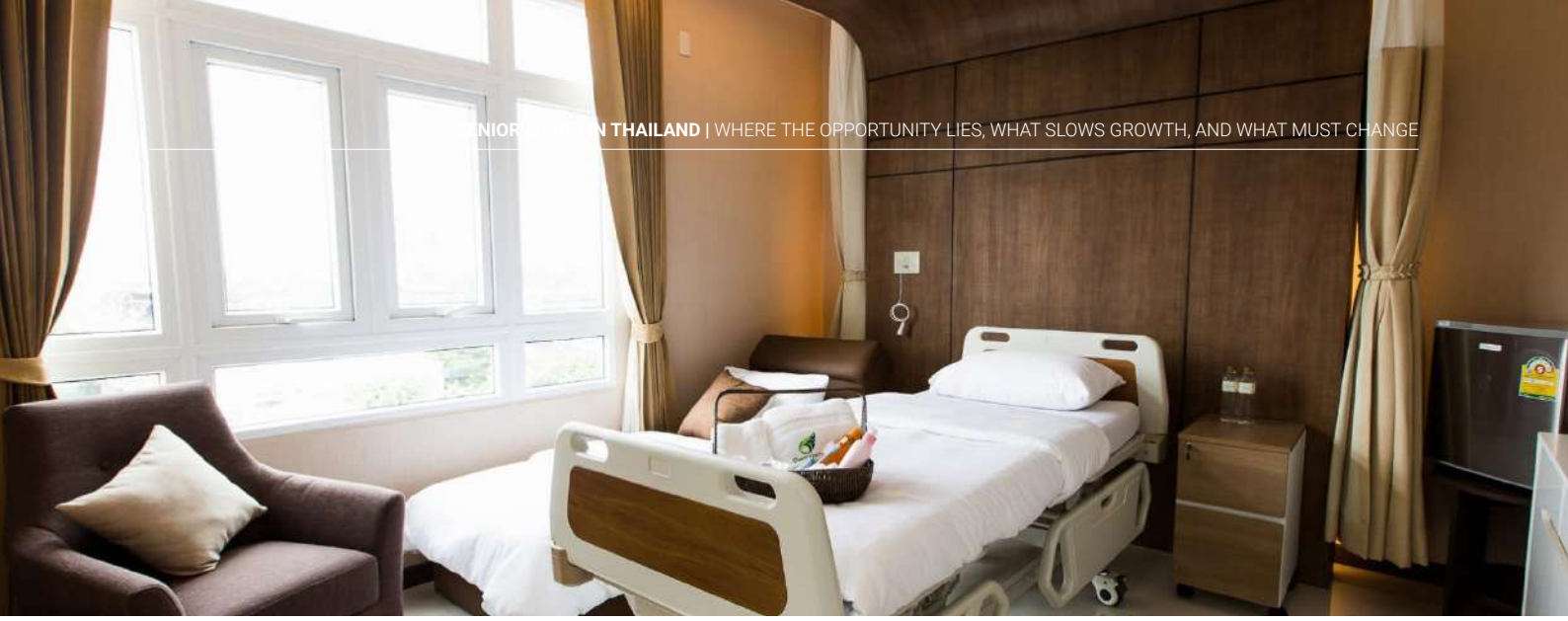
# Health at Home, Bangkok Metro Home-Care Platform

| Model | M4 · Home care platform |
|---|---|
| Operator | Health at Home Co Ltd |
| Format | Home-care delivery platform — caregiver dispatch and family portal |
| Scale | 5,000+ families served (Bangkok metro) |
| Pricing | THB 19,900–34,000 / month package |
| Investor | Principal Healthcare (PRINC) — THB 96 million, 39.5% stake |
| Date | December 2023 — SET-disclosed transaction |
| Integration | PRINC is building hospital → recovery → home continuum |

## Why this case matters

Health at Home is the asset-light proof of concept for Thailand's M4 archetype. It validates that home-care platforms can attract listco capital and achieve metropolitan scale without owning physical assets — the only model that can credibly serve provincial demand at price points most Thai families can sustain. Principal Capital's thirty-nine-point-five percent stake signals something even more strategically important: hospital groups view home care as the natural extension of their discharge pathway, not as a competitor to their inpatient business. The bridge from hospital ward to family home — the segment of the Thai patient journey nobody currently owns at scale — is the white space that Health at Home, and others following the M4 archetype, are racing to capture.

> **We are building the bridge from the hospital ward to the family home, covering the segment of the patient journey that nobody currently owns.**
>
> **Health at Home Leadership**



Case Study 09

# Chersery Home (K.P.N.), Multi-Site Mid-Tier Nursing Chain

| Model | M3 · Branded nursing chain |
|---|---|
| Operator | K.P.N. Senior Hospital network — 8 Bangkok branches |
| Format | Hospital-grade branded nursing chain |
| Pricing | THB 25,000–65,000 / month |
| Investor | Pruksa Holding (PSH, SET-listed developer) |
| Investment | THB 174.6m equity (25%) plus THB 150m convertible note → up to 35% |
| Date | December 2023 — SET-disclosed |
| Significance | First case of listed property developer backing a multi-site care operator |

## Why this case matters

Chersery Home is the mature M3 archetype — a multi-site branded chain with documented unit economics, listed-developer capital, and explicit consolidation logic. Together with Baan Lalisa, it forms the second proof point of the chain-economics thesis: standardised care protocols, training systems and brand consistency enable scale without proportional capex. The Prinsiri investment also demonstrates that listed property developers, not just hospital groups, now see senior care as a strategic adjacency worth backing with equity and convertible capital. Developer-to-operator vertical integration is becoming a recognisable Thai pattern rather than a foreign import, and the Q4 2023 capital wave examined in the next section reinforces this conclusion across three near-simultaneous transactions.

> **Developer-to-operator vertical integration is becoming a real Thai pattern, rather than a foreign import.**
>
> **Eurogroup Consulting Analysis on the Psh × Chersery Transaction Logic, 2024**

# The Institutionalisation Signal, Two Capital Bands Converge

Across the nine cases above, a single underlying signal emerges: institutional capital has begun to flow into Thai senior living, and the flow is now visible in two distinct bands. Band 1 is platform capital deployed into operating businesses — equity stakes in existing care operators, taken by listed property and healthcare groups, designed to consolidate fragmented supply behind a unified brand. Band 2 is greenfield and strategic-adjacency commitments — multi-year development capex and corporate strategy pivots by the largest listed players in Thailand.

## Band 1

**Platform capital deployed**
**(Q4 2023, THB 405m+ in operating-platform stakes)**

In a single quarter, three transactions repositioned Thai senior living from founder-led SME to institutionally-backed category. Pruksa Holding (PSH), through its subsidiary Innotech Services, invested THB 174.6 million in equity for a 25% stake in K.P.N. Senior Hospital / Chersery Home, plus a THB 150 million convertible loan that can increase the holding to 35%. The transaction was disclosed to the SET in December 2023. Principal Capital (PRINC), through Principal Next, took a 45% equity stake in Baan Lalisa for THB 135 million in November 2023, and a thirty-nine-point-five percent stake in Health at Home for THB 96 million in December 2023. Together, these three Q4 2023 transactions deployed THB 405 million-plus into operating platforms, all from SET-listed companies, all targeting different points on the M3-M4 continuum, and all disclosed in formal regulatory filings.

## Band 2

**Greenfield and strategic-adjacency commitments**
**(~THB 25bn+, developer/hospital pivots)**

Beyond platform consolidation, two larger commitments demonstrate the depth of institutional intent. BDMS Silver Wellness & Residence (Project HERCULES) is a THB 25 billion flagship development, one hundred percent owned by Bangkok Dusit Medical Services, on a thirty-plus-thirty-year Crown Property Bureau ground lease in Lumpini, central Bangkok. The project targets a 2030 opening and approximately one thousand units. It represents Thailand's strongest hospital brand committing to a flagship hospital-anchored wellness destination as a strategic adjacency rather than a standalone senior-living operation. Separately, Pruksa Holding has publicly targeted twenty-five percent of group revenue from recurring sources by 2028, anchored in its ViMUT hospital network and the wellness-residence formats described in case study E.6. ViMUT Group revenue reached THB 2,187 million in 2024, up twenty percent year-on-year, indicating that the model is producing growth ahead of the broader Thai property market.

These are different signals and should not be conflated. Band 1 transactions are consolidation plays in the operating-platform layer, conducted at small absolute ticket sizes with disciplined post-money valuations. Band 2 commitments are strategic real-estate development bets at order-of-magnitude larger ticket sizes, conducted on long ground-lease horizons and grounded in branded ecosystem strategies. The fact that both bands are active simultaneously is the strongest single indicator that Thai senior living has crossed from pre-institutional to institutional. Three to five additional listco platforms entering either band over the next twenty-four months would, in our analysis, tip the market into a multi-platform consolidation phase comparable to Thailand's hospital sector consolidation of the 2000s.

# Three Patterns That Repeat

Across every investable Thai case above, three success patterns appear with sufficient consistency to be treated as structural rather than coincidental.

## 01

### Clinical governance is the credibility moat

Most premium-priced or institutionally-backed Thai cases rely on hospital linkage or a recognised care partner — HERCULES – Wellness Project by BDMS, Jin Wellbeing × Thonburi, Chersery × KPN clinical, Baan Lalisa × PRINC, Pruksa × ViMUT. Care competence is non-substitutable under Thai licensing rules, and Thai families exercising choice for elderly parents will not pay premium rates to operators lacking clinical authority. Hospitality-only operators face a structural pricing discount of twenty to forty percent for equivalent physical product.

## 02

### Adjacent-industry capital is building the sector

Developers, hospitals and corporate operators are institutionalising Thai senior living before specialist senior-living funds arrive. Every meaningful transaction in 2023 and 2024 came from MQDC, Prinsiri, Principal Capital, BDMS, Thonburi Healthcare Group or Pruksa — never from a dedicated senior-living fund. This is the inverse of the US market, where dedicated senior-living REITs and private-equity funds drove the institutionalisation phase. The Thai sector is being built from adjacent industries inward, and the strategic implication is that incumbent listed players have a five-to-seven year head start over any pure-play entrants.

## 03

### Partnership architecture determines scalability

No single Thai player owns the value chain. Winners combine clinical trust (hospital), operating discipline (care operator), real-estate execution (developer) and payer access (insurer). Three partnership theses repeat across the cases: clinical governance × operator (Jin Wellbeing, Chersery, Baan Lalisa); operator × insurer (the latent thesis behind PRINC's home-care strategy and the LTC riders described in Chapter F); and operator × workforce institutions (the partnership architecture that has scaled Baan Lalisa from a single site to twenty-six branches). The defensible position is the ecosystem orchestration, not any one role.

The cumulative implication is that operators and investors building now have a five-to-seven year head start over latecomers. Thailand is at least seven years behind where Japan's senior care market was when it began its institutionalisation in the mid-2000s, which means the formative period is happening now. Strategic positions taken in 2025 to 2027 will define competitive structure through the 2030s.


# Voices From the Market

Six executive perspectives, drawn from public interviews and corporate disclosures across 2023 to 2025, converge on a single thesis: senior living in Thailand is a wellness, convergence and trust play. The rebranding away from 'senior' framing, the explicit hospital-led convergence strategy, the bundling of senior living with wellness tourism and longevity, the rollout-led mid-tier consolidation, the cultural-fit requirement, and the aspirational identity positioning of premium retirement — each voice articulates one dimension of the same emerging market logic.

> **Our project came a little ahead of its time.**
>
> **Peerapong Peerachotiwatra**, CEO of Thonburi Wellbeing

**On rebranding:** the 'senior' framing depresses adoption among Thai families and the residents themselves. Winning operators reposition around wellness and active living.

> **We are advancing on our holistic hospital strategy to cater to the aged society.**
>
> **Somsak Akksilp,** CEO of Vimut Hospital

**On convergence:** hospitals see ageing not as case-mix drift but as a strategic vertical with new service lines that must be deliberately built rather than passively absorbed.

> **This collaboration is a key step that will help propel Thailand into the top five global wellness tourism destinations.**
>
> **Dr. Tanupol Virunhagarun,** BDMS Wellness

**On wellness gravity:** senior living, longevity medicine and wellness tourism are being bundled into a single destination thesis at the largest scale Thai healthcare has yet attempted.

> **Six years ago, I saw an opportunity to expand our business into senior-friendly homes as Thai society is aging.**
>
> **Athiporn Poolsawaddi,** CEO of Baan Lalisa Healthcare

**On rollout:** branded mid-tier roll-up is the most plausible path to a national senior-care platform, and the operators executing it now will hold the strongest positions when consolidation accelerates.

> **Thailand is building its own Southeast Asian model of senior living, rooted in family, culture, wellness, and quality of life.**
>
> **Dr. Nart Fongsmut,** Director of Health and Wellness, LivWell Living

**On model fit:** Western institutional templates fail when transplanted directly. The winning Thai model will be hybrid and culturally anchored, blending family-orientation with professional clinical and hospitality standards.

> **I wanted to design something that when you move in, you'd immediately feel younger, not older.**
>
> **Daniel Holmes,** CEO of Otium Living

**On identity:** premium retirement competes on aspiration. The care infrastructure must be embedded but invisible; visible clinical apparatus repels the target customer.

# Go-To-Market by Player Background

Different players entering Thai senior living should make different first moves. The right-to-win, required partners, revenue logic and key risks differ materially across six player archetypes — property developers, hospital and medical groups, hotel and resort operators, dedicated care operators, technology platforms or startups, and insurers or financial institutions. Generic strategy advice fails in this market because the entry decisions are sequential and the path-dependence is high.

A property developer should enter through active-age communities or destination wellness (OS1 or OS2), where regulated-care exposure is lower and the developer's land control and capex execution are most directly monetisable. The required partners are care operators for daily operations and hospital groups for clinical governance. Revenue logic is unit sale plus leasehold plus recurring service fees, with care fees billed by the partner. The key risk is willingness-to-move in Thai family-living culture; the mitigation is family-relief positioning rather than senior-only marketing.

A hospital or medical group should enter through hospital-linked step-down and rehabilitation capacity adjacent to existing facilities. Right-to-win is the clinical license, brand trust, referral flow and medical-risk management already in place. Required partners are developers for real-estate execution and hospitality operators for resident experience. Revenue logic is episode-based post-acute care, monthly LTC fees and medical-tourism crossover. The key risk is reputational exposure outside the core hospital setting; the mitigation is strict governance and standardised clinical pathways.

A hotel or resort operator should enter through destination wellness retirement via management contract — an asset-light entry that leverages world-class hospitality operations and brand equity without balance-sheet exposure to regulated-care liability. The required partners are hospital groups for clinical pathways and insurers for affordability bundling. Revenue logic is management fee plus brand royalty. The key risk is regulated-care compliance and clinical liability creep; the mitigation is keeping clinical governance fully external and contractually clear.

A care operator should enter through aging-in-place and home care, where the model is capital-light and scalable from day one and the operator's care-management, workforce systems and daily operating discipline are the right-to-win. Required partners are developers for lease tenure, hospitals for referral and insurers for distribution. Revenue logic combines hourly visit fees, monthly subscriptions and bed fees under lease structures. The key risk is caregiver scarcity; the mitigation is investment in training pipelines and tech-enabled productivity tools.

A platform or startup should enter through B2B2C aging-in-place delivered through white-label arrangements with hospitals, insurers and employers. Right-to-win is platform orchestration, data-driven coordination and family-portal trust. Required partners are licensed care providers and accredited training institutions. Revenue logic combines subscription, transaction fees and insurer-channel referral revenue. The key risk is the trust deficit and quality incidents in early operations; the mitigation is accreditation pathways and integration only with licensed providers.

An insurer or financial institution should enter through preferred-provider network construction and the launch of LTC riders and episode-based bundles. Right-to-win is distribution, affordability engineering and risk pooling. Required partners are operator networks for delivery and employer groups for B2B2C distribution. Revenue logic is premium income plus payer-provider bundled product margin. The key risk is adverse selection and cost escalation; the mitigation is care management and outcomes contracting.

### Six player archetypes — best first move, right-to-win, required partner, revenue logic, key risk

| Player | Best first move | Right-to-win | Required partner(s) | Revenue logic | Key risk |
|---|---|---|---|---|---|
| Property developer | Active-age communities or destination wellness — lower regulated-care exposure | Land control, capex execution, real estate + service-fee monetisation | Care operator (ops) + hospital (clinical governance) | Sale + leasehold + recurring service fee; care fees billed by partner | Willingness-to-move in family-living culture; mitigate via family-relief positioning |
| Hospital / medical group | Hospital-linked step-down + rehab capacity adjacent to existing facilities | Clinical license, brand trust, referral flow, medical risk management | Developer (real estate execution) + hospitality operator (resident exp) | Episode-based post-acute; monthly LTC fees; medical-tourism crossover | Reputational risk outside core hospital settings; mitigate via strict governance and standardised pathways |
| Hotel / resort operator | Destination wellness retirement via management contract — asset-light entry | World-class hospitality operations, brand equity, destination positioning | Hospital (clinical pathways) + insurer (affordability bundling) | Management fee + brand royalty; minimal balance sheet exposure | Regulated-care compliance and clinical liability; mitigate by keeping clinical governance external |
| Care operator | Aging-in-place + home care — capital-light, scalable from day one | Care management, workforce systems, daily operating discipline | Developer (lease) + hospital (referral) + insurer (distribution) | Hourly visit fees, monthly subscriptions and bed fees under lease structures | Caregiver scarcity; mitigate via training pipelines and tech-enabled productivity |
| Platform / startup | B2B2C aging-in-place via white-label through hospitals, insurers, employers | Platform orchestration, data-driven coordination, family portal trust | Licensed care providers + accredited training institutions | Subscription + transaction fee + insurer-channel referral | Trust deficit and quality incidents; mitigate via accredited training and licensed-provider integration |
| Insurer / finance | Build preferred-provider network and launch LTC riders / episode-based bundles | Distribution, affordability engineering, risk pooling | Operator network (delivery) + employer groups (B2B2C distribution) | Premium income + payer-provider bundled product margin | Adverse selection and cost escalation; mitigate via care management and outcomes contracts |

Three partnership theses are most investable: clinical governance (hospital + operator), distribution + affordability (insurer + operator + employer), workforce + training (operator + public institutions + tech)

Source: Deep research GTM-by-player-background framework; KPMG Thailand 2024; BOI 2025 incentive guidelines; ILO Thailand 2024; Eurogroup Consulting synthesis.

Three partnership theses are the most investable in the current market. Clinical governance (hospital plus operator) is the foundation of the M2 archetype. Distribution plus affordability (insurer plus operator plus employer) is the largest unlock for the M3-M4 expansion into middle-class demand. Workforce plus training (operator plus public institutions plus technology) is the binding constraint on scale, and the partnership architecture that solves it will define the operators that reach national footprint.

### Six player archetypes, five opportunity spaces — and the partnership map that defines right-to-win

| Player → / Function ↓ | Property developer | Hospital / medical group | Hotel / resort operator | Healthcare operator | Platform / startup | Insurance / finance |
|---|---|---|---|---|---|---|
| Active-age communities | CORE | ENABLE | ENABLE | PARTNER | ENABLE | ENABLE |
| Destination wellness retirement | CORE | ENABLE | CORE | PARTNER | ENABLE | ENABLE |
| Care-integrated residences | ENABLE | CORE | ENABLE | CORE | ENABLE | ENABLE |
| Hospital-linked post-acute / LTC | PARTNER | CORE | PARTNER | CORE | ENABLE | ENABLE |
| Aging-in-place home care | ENABLE | PARTNER | PARTNER | CORE | CORE | CORE |

CORE (primary right-to-win)
ENABLE (meaningful contribution)
PARTNER (required handshake)

**Key Insight**
No single player owns the chain. Hospitals control clinical governance; developers control land; operators control workforce; insurers control affordability. The defensible position is the partnership architecture, not any one role.

Source: Eurogroup Consulting synthesis based on KPMG, BOI, ILO, World Bank Thailand and operator disclosures.

Chapter F

# Outlook and Implications

Where the opportunity lies, what slows growth, and what must change for the market to mature.

# Geography Prioritisation

Six geographies, six criteria, and two distinct opportunities.

Not all Thai geographies offer the same senior-living opportunity, and the criteria that determine attractiveness differ between domestic self-pay demand and foreign-destination demand. Eurogroup Consulting's weighted scoring uses six explicit criteria: senior demand depth, affluence and willingness-to-pay, healthcare infrastructure, caregiver and operator depth, foreign-retiree pull, and land and operating economics. Scored against these criteria, six geographies produce distinct profiles.

Greater Bangkok scores highest for domestic fit (five out of five) and moderate for foreign fit (three out of five), with depth, affluence and healthcare infrastructure all at maximum and operating economics constrained only by land prices. Chiang Mai scores three out of five for domestic and a maximum five for foreign — the strongest combination of climate, cost arbitrage and foreign-retiree pull in the country. Phuket scores two out of five for domestic but five out of five for foreign, with land and operating economics constrained by tourism-driven cost inflation. Pattaya and Chonburi score three for domestic and four for foreign, a hybrid market drawing both Bangkok adult-children flows and foreign retiree demand. Hua Hin and Cha-am score three for domestic and four for foreign — strong on climate and operating economics, weaker on caregiver depth. Khon Kaen and other regional capitals score two for domestic and one for foreign — investable only for affordable PPP models, not commercial bed-based formats.

The strategic conclusion is that Thailand offers two distinct senior-living opportunities, not one. Domestic self-pay demand is dominated by Greater Bangkok, where depth, affluence and healthcare infrastructure converge. Foreign-destination demand is dominated by Chiang Mai and Phuket, where climate, cost arbitrage and foreign-retiree pull are strongest. Operators should pick one and build for it; attempting both with a single physical product produces compromises that satisfy neither. Khon Kaen and other secondary cities are PPP-only — investable for affordable models with subsidy support, not for commercial premium or mid-tier formats at current affordability levels.

**Six geographies, six explicit criteria — and two distinct opportunities (domestic self-pay vs foreign destination)**

**Weighted Criteria** Scored 1 (low) to 5 (high) Domestic-fit and foreign-fit shown separately

| Geography | Senior demand depth | Affluence / WTP | Healthcare infra | Caregiver / operator depth | Foreign-retiree pull | Land / operating economics | Domestic fit | Foreign fit |
|---|---|---|---|---|---|---|---|---|
| Greater Bangkok | 5 | 5 | 5 | 5 | 3 | 3 | 5/5 | 3/5 |
| Chiang Mai | 4 | 3 | 4 | 3 | 5 | 4 | 3/5 | 5/5 |
| Phuket | 3 | 5 | 4 | 3 | 5 | 2 | 2/5 | 5/5 |
| Pattaya / Chonburi | 4 | 4 | 4 | 3 | 4 | 3 | 3/5 | 4/5 |
| Hua Hin / Cha-am | 3 | 4 | 3 | 2 | 4 | 4 | 3/5 | 4/5 |
| Khon Kaen / regional | 5 | 2 | 3 | 2 | 1 | 5 | 2/5 PPP | 1/5 |

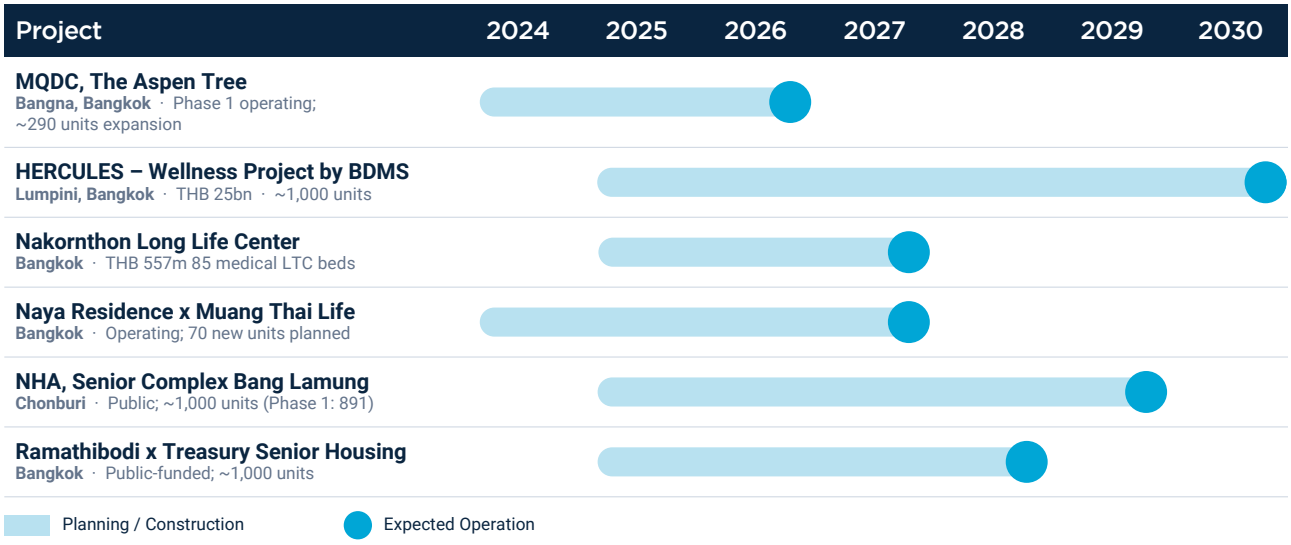
- **Domestic Self-Pay:** Greater Bangkok dominates (depth + affluence + healthcare)
- **Foreign Destination:** Chiang Mai and Phuket lead (climate + cost arbitrage + foreign-retiree pull)
- **Khon Kaen and other provinces are PPP-only:** Investable for affordable models, not commercial bed-based formats.

Source: Eurogroup Consulting synthesis based on KPMG, BOI, ILO, World Bank Thailand and operator disclosures.

# Institutional Supply Wave 2026 to 2030

Six institutional projects will reshape the Thai senior-living landscape

**Institutional Supply Wave 2026–2030**




**Key Insight**

Hospital-led projects involve the largest capex commitments. Multi-year builds indicate long-term strategic positioning rather than pilot initiatives, showing that Thailand's senior living market is moving toward institutional, vertically integrated players.

Source: Company websites and announcements; SET disclosures; National Housing Authority; Ramathibodi Hospital communications; Eurogroup Consulting tracking.

# Outlook 2025 to 2035: Three Growth Waves and Three Scenarios

The market will move through three sequential growth waves over the coming decade. Wave 1 (2025 to 2027) is branded mid-tier consolidation: SME nursing homes consolidate behind branded operators (Baan Lalisa and Chersery archetypes), private-equity platforms emerge, and the first multi-site assisted-living chains reach ten-to-twenty sites. Wave 2 (2027 to 2030) is hospital-linked rollout: SET-listed hospital groups (BDMS, BCH, Thonburi Healthcare Group, Principal Capital) launch wellness-residence formats next to existing hospitals, and insurance products begin to bundle care delivery. Wave 3 (2030 to 2035) is affordability innovation: LTC insurance, reverse mortgages and PPP subsidised housing unlock the underserved middle, and home-care platforms scale via technology to reach provincial demand.

Three auditable scenarios bracket the range of plausible 2034 outcomes for facility-based senior-care revenue (excluding home-care delivery, which adds approximately thirty-to-fifty percent on top in the base case). The conservative scenario — characterised by persistent severe workforce gaps, no LTC insurance, multi-window licensing complexity and only one or two listco platforms — produces a 2034 market size of THB 8 to 14 billion. The base scenario — gradual training scale-up, pilot LTC riders, selective regulatory fast-tracks, and three to five listco platforms — produces THB 17 to 27 billion, implying an eleven-to-sixteen percent compound annual growth rate from current levels. The accelerated scenario — opened foreign-caregiver visa pathway, OIC-backed LTC product launches, single-window licensing, and six-plus listco platforms with foreign entrants — produces THB 34 to 50 billion.

### Three growth waves and three auditable scenarios — outcomes depend on four explicit drivers

| | | |
|---|---|---|
| **2025–2027** Branded mid-tier consolidation | Wave 1 | SME nursing homes consolidate behind branded operators (Baan Lalisa, Chersery archetypes). PE platforms emerge. First multi-site assisted living chains reach 10–20 sites. |
| **2027–2030** Hospital-linked roll-out | Wave 2 | Listed hospital groups (BDMS, BCH, THG, Principal Capital) launch wellness residence formats next to existing hospitals. Insurance products start to bundle care. |
| **2030–2035** Affordability innovation | Wave 3 | LTC insurance, reverse mortgages, and PPP subsidised housing unlock the underserved middle. Home-care platforms scale via tech. |

**Auditable Scenario Model**

Facility-based senior care, THB billions

Excludes home care delivery (which adds ~30–50% on top in base case)

| Driver | Conservative 2034 | Base 2034 | Accelerated 2034 |
|---|---|---|---|
| Workforce availability | Severe gap persists | Gradual training scale-up | Foreign caregiver pathway opens |
| Payer innovation | No LTC insurance | Pilot LTC riders | OIC-backed LTC product launches |
| Regulatory clarity | Multi-window persists | Selective fast-tracks | Single-window licensing |
| Corporate rollout intensity | 1–2 listco platforms | 3–5 listco platforms | 6+ listco + foreign entrants |
| **Market Size 2034** | **THB 8–14bn** | **THB 17–27bn** | **THB 34–50bn** |

Source: Eurogroup Consulting outlook framework. Market scope: licensed facility-based senior-care revenue only (excludes home-care delivery, which adds ~30–50% in base case). Scenario probabilities are not shown and are therefore excluded. Base case implies 11–16% CAGR.

Which scenario materialises depends on four explicit drivers: workforce availability, payer innovation, regulatory clarity and corporate rollout intensity. None of these are inherent ceilings; all four can be unlocked through deliberate policy and capital choices. The probability weighting between scenarios is a function of the choices made in 2025 to 2027 — by regulators, by insurers and by the listed corporates whose platform investments are now underway.

# What Must Change: Four Constraints, Four Economic Effects, Four Unlocks

Four binding constraints currently slow the institutionalisation of Thai senior living. Each carries a specific economic effect, a specific action owner, and a specific unlock that, if executed, would materially accelerate the trajectory.

## 01

### Workforce Shortage

Thailand has 0.7 formal long-term care workers per hundred elderly, compared with Australia's 4.4 — a six-fold gap. The economic effect is to raise staffing cost, limit occupancy ramp-up speeds and compress operating margins below their potential. Action owners are the state (visa policy, occupational standards), providers (in-house training pipelines), and training institutions (curriculum development and certification at scale). The unlock combines scaling caregiver certification, opening a foreign caregiver visa pathway modelled on Japan's EPA caregiver programme, and deploying technology-enabled productivity tools — scheduling platforms, monitoring devices, family-reporting systems — that increase caregiver-to-resident ratios without compromising care quality.

## 02

### Affordability Wall

Without long-term care insurance, reverse mortgages or employer-sponsored elder-care benefits, the commercial market is constrained to the top twenty-five-to-thirty percent of households. Middle-income families are priced out and the market remains narrow. Action owners are insurers (OIC product approval pathways), employers (group benefit design) and the state (tax incentives for adult-child care payments). The unlocks are LTC insurance riders integrated with mainstream life and health products, reverse mortgage instruments backed by state guarantee structures, adult-child tax incentives for documented elder-care payments, and employer-sponsored elder-care benefit packages modelled on existing childcare benefit precedents.

## 03

### Regulatory Complexity

The current licensing pathway for an integrated senior-living development spans twelve to twenty-four months and involves coordination between MoPH, DOP, BOI and local government authorities, with multiple parallel windows that do not share documentation requirements. This slows investment timelines, deters foreign operators and means that consumer trust is built brand-by-brand rather than system-wide. Action owners are MoPH, DOP, BOI and provincial government. The unlocks are a single-window licensing process for integrated senior-living developments, a national accreditation framework with published quality ratings comparable to JCI for hospitals, and explicit ownership-rule clarity for foreign minority partners in joint ventures.

## 04

### Capital and Exit Limitations

There is no Thai senior-living REIT format, and private-equity comparables are limited. The economic effect is to lengthen payback timelines to eight-to-twelve years and narrow the investor pool to strategic capital and patient family-office balance sheets. Action owners are capital markets regulators (SEC and SET), BOI (promotional incentive design) and institutional sponsors (REIT seeding). The unlocks are extension of the Thai healthcare REIT framework to include senior-living assets, BOI senior-living promotional incentive packages comparable to those offered for medical tourism, dedicated infrastructure or impact fund structures with concessional capital pools, and payor-provider integration that allows operating cash flows to underwrite longer-duration debt instruments.

Eurogroup Point of View

# Senior Living in Thailand: The Next Investable Healthcare Frontier

Where the opportunity lies, what slows growth, and what must change for the market to mature.

# Where the opportunity lies

Hospital-linked wellness residences (Model 2) and branded mid-tier rollouts (Model 3) offer the best risk-adjusted entry into Thai senior living. Greater Bangkok, Chiang Mai and Phuket together capture approximately seventy percent of monetisable demand, with Greater Bangkok dominating domestic self-pay and Chiang Mai and Phuket leading foreign-destination demand. The continuum-of-care brand is unclaimed — no Thai operator currently spans from active-age through to high-acuity nursing and palliative care under a single brand. The first credible national platform to bridge that continuum will capture disproportionate value, both because of the recurring-revenue economics of holding customers across life stages and because of the brand defensibility that comes from being the trusted name across an extended family decision.

# What slows growth

Affordability remains the dominant constraint. Only the top ten-to-fifteen percent of Thai seniors can sustain private monthly rates without insurance support, and the absence of mainstream LTC products keeps the addressable market narrow. Workforce shortages compress operating margins and slow the occupancy ramp-up at new sites. Regulatory fragmentation across MoPH, DOP, BOI and provincial authorities lengthens investment timelines to twelve-to-twenty-four months and deters foreign operators who cannot navigate parallel licensing windows. Foreign-retiree demand is real and growing, but it is too concentrated and too price-elastic to underwrite a national thesis alone.

# What must change

Three unlocks would materially accelerate the institutionalisation trajectory. First, a long-term care insurance product — whether as a standalone LTC policy or as a rider on existing life and health products — would widen the payer base from the top quartile to the top half of Thai households and double the addressable market overnight. Second, a national quality framework with published ratings would build the system-wide consumer trust that no individual brand can achieve alone, accelerating willingness to move into formal senior living among middle-class Thai families. Third, a senior-living REIT format — extending the existing Thai healthcare REIT framework — would unlock long-duration institutional capital and provide an exit pathway for the platform investments now being seeded. Without these unlocks, growth in Thai senior living will be real, but bounded to the current top-quartile commercial market.

> **The operators and investors building now are not ahead of the market. They are at least seven years behind Japan's senior care market when it began institutionalization. Thailand's window is not closing; it has barely opened.**
>
> **Eurogroup Consulting**

Sources & Methodology

# Public, Primary and Operator Data Triangulated for a Thailand-Specific View

This white paper is built on a triangulation of three evidence streams: Thai public-sector data (statistical, regulatory and policy); operator and SET-listed company disclosures (project announcements, investor presentations, financial filings); and Thai and international sector research (consulting reports, academic studies and trade-press coverage). Where data sources differ — most notably between REIC bed-count releases and earlier MoPH licensing data — we use the most recent published figure and note the methodology difference. Assumptions on willingness to pay, segment sizing and scenario probabilities are Eurogroup Consulting analytical judgement, grounded in operator interviews and benchmarked against comparable Asian markets.

## Public, Government and Institutional Sources


- National Statistical Office of Thailand — Survey of Older Persons 2024 (8th edition)
- NESDC — Population projections and ageing reports 2024
- REIC — Nursing Home and Residence Projects 2025 (provincial supply, occupancy, pricing distribution)
- Ministry of Public Health — care-facility licensing and HSS survey data
- Department of Older Persons — Old Age Allowance programme; home modification programme
- Department of Business Development — senior-care juristic-person registry 2021–2025
- BOI — Long-Term Resident visa programme and senior/dependent care centre incentive guidelines
- ILO — Thailand care workforce gap projection (250,000 additional caregivers needed by 2037); Decent Work in Care reports
- World Bank — Caring for Thailand's Aging Population
- WHO Thailand — Healthy Ageing fact sheets 2024
- OECD — Pensions at a Glance
- UN Population Division — World Population Prospects 2024.


## Operator, Listed-Company and Media Evidence


- MQDC — The Aspen Tree / The Forestias project disclosures; PR Newswire, May 2023
- BDMS — HERCULES – Wellness Project by BDMS; Forbes Thailand, January 2025
- Pruksa Holding PCL — strategy disclosures and ViMUT Group revenue (2024)
- Thonburi Healthcare Group — Jin Wellbeing County; CEO interview, Bangkok Post Property, October 2025
- Pruksa Holding (PSH) into K.P.N. Senior Hospital / Chersery Home — SET disclosure, December 2023
- Principal Capital (PRINC) into Baan Lalisa — SET disclosure, November 2023; Nikkei Asia / KrASIA, April 2025
- Principal Capital (PRINC) into Health at Home — SET disclosure, December 2023
- Vimut Hospital — CEO interview, The Thaiger, May 2023
- Nakornthon Hospital — Long Life Center announcements
- Naya Residence × Muang Thai Life Assurance — public disclosures
- National Housing Authority — Senior Complex Bang Lamung
- KPMG Thailand; Kasikorn Research; Krungsri Research; TTB Analytics — sector reports
- Global Wellness Institute — Thailand wellness market data.

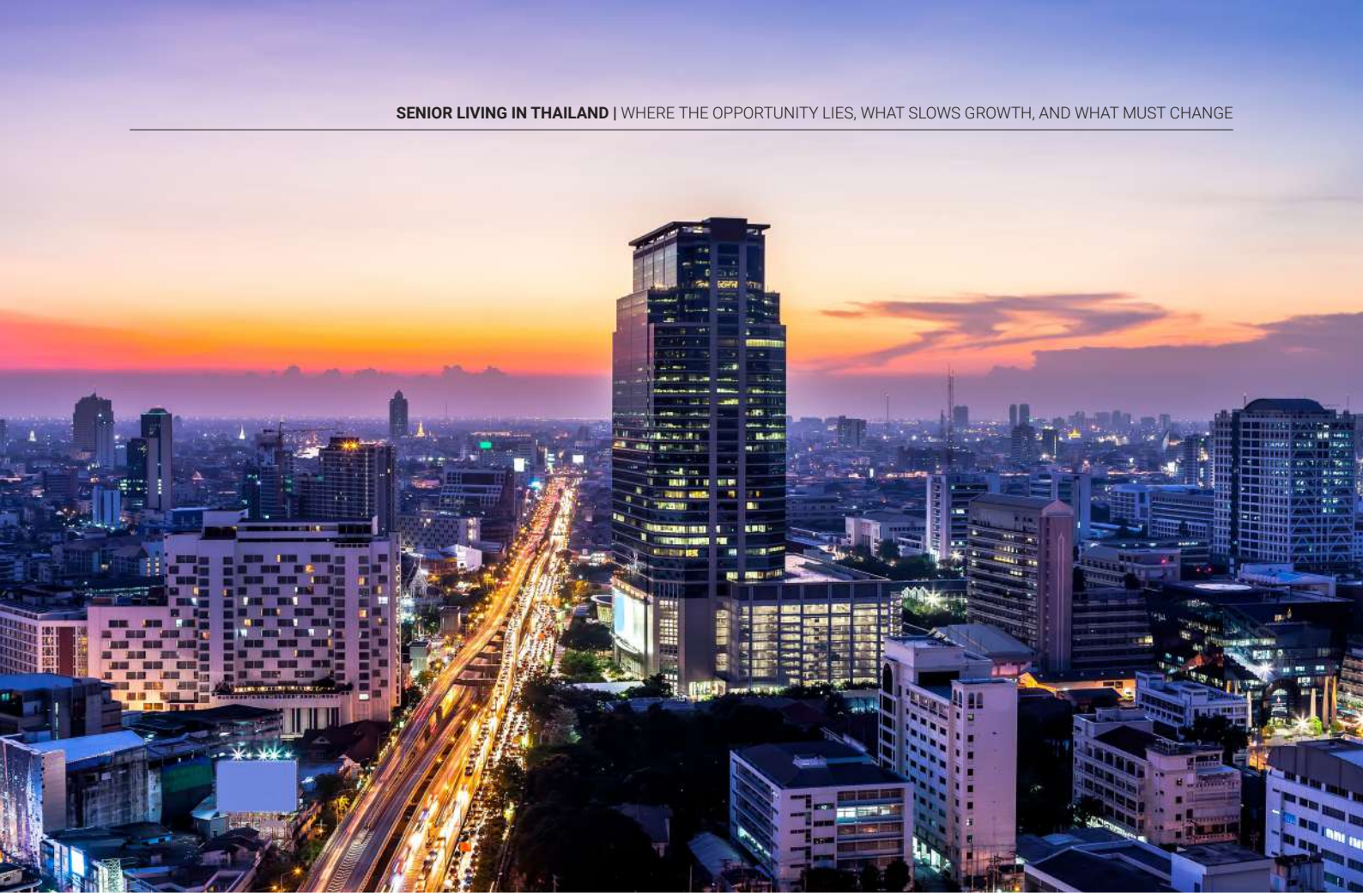
# Strategy and Management Consulting Since 1982

We operate across Europe, the Americas, Africa, the Middle East and Asia. Our expertise spans frontier markets, developing nations and developed economies, with industry coverage including supply chain and logistics, energy and the environment, mobility, financial services, healthcare and life sciences, food and beverage, and aerospace. In Asia, our work in Thailand and across Southeast Asia combines market intelligence, growth strategy, transformation support, operations excellence and logistics design to help clients capture value and transform their businesses positively.

## How we support senior-living investors and operators in Thailand

Eurogroup Consulting works with developers, hospital groups, hotel operators, dedicated care platforms and institutional investors across the full life cycle of senior-living strategy and execution. Our market-entry diagnostics combine demand sizing from affordability upward with regulatory pathway mapping and partnership architecture design. Our growth-strategy work supports operators considering platform consolidation, geographic expansion or vertical integration into clinical or insurance partnerships. Our transformation support helps incumbents pivoting from adjacent industries — typically property developers and hospital groups — to design and execute the operating systems required for senior-living delivery. We work with confidentiality and discretion, and our engagements range from short-form strategy diagnostics to multi-year transformation programmes.

For further information, briefings or to commission a tailored analysis of any of the themes addressed in this paper, please contact our Bangkok or Singapore office.



## About Eurogroup Consulting

Eurogroup Consulting is an independent strategy and management consulting firm with more than 40 years of client success stories. Since 1982, we have been supporting governments, large groups and mid-size companies in their strategic and transformational changes. Operating within a global network of 3,000 consultants, we bring a unique approach to consulting: Positive Transformation.

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