We examine a “regime of anticipation” that has led mostly European entrepreneurs to build and manage new long-term care facilities situated around the city of Chiang Mai, Thailand, an emerging ‘hot spot’ in the relocation and provision of dementia care for an overseas clientele. Anticipations of crisis (and the explosive demand for dementia care) is exciting entrepreneurial imaginations in Thailand and, drawing on ethnographic field work and in-depth interviews, we examine how a transnational care market is being created and made to work. The owners and operators of these care facilities are experimenting with different care models and norms to create a transnational marketplace and to stretch the geographies of care. Yet dementia care is an inherently unstable commodity that might seem to resist outsourcing from the Global North to the Global South; as such, we pay close attention to the strategies deployed to try and stabilize the commodification of this most intimate labor. We detail how intimacy is constructed and circulated for dementia care to go global and the resources of trust required by owners and family members for this uneasy transnational economy to function. Key Words: care, dementia, markets, migration, outsourcing, Thailand.

A friend brought Teddy to the care resort in Chiang Mai from a nursing home in California late in 2018 and then left. No family members ever visited. Teddy definitely needed the care: He had advanced Parkinson's disease, had suffered a couple of strokes, had a pacemaker and neurostimulator implant, and was incontinent. When we stayed at the care facility for the third time in January 2020, Teddy had died the week before in a hospital in Chiang Mai, from what had seemed a routine hip replacement. Without health insurance in Thailand the first operation cost roughly US$9,000. His hip dislocated soon after the operation and there were two further surgeries. The care resort owner said that when the hospital called to ask permission for further surgery, he asked, “Can he really have a second general anesthetic so close to the first in his condition?” And the doctor said, ‘Yes, no problem at all.’ Not mentioning they’d already had the second and he was now planning the third.” Teddy could not sustain three general anesthetics within four days and died, leaving a hospital bill of over US$55,000. The money problems had already begun for the resort owner. Teddy had given the owner two bank drafts to cover the original operation, one as a deposit and the other to complete the transaction. The bank refused the second because Teddy's signatures on the two bank drafts did not seem to match, not surprising given his Parkinson's disease. A representative of the bank visited Teddy in the hospital. Finding him in a coma, they declined to cash the second bank draft. It then came to light that the caregiver who had taken Teddy to the hospital had signed a form that obligated the care resort owner to pay for subsequent surgeries and care. The hospital began to call in threatening ways:

Next day they phoned me up to pay the bill, and I say, ‘I can’t pay, I’m not family.’ And they say, ‘That’s got nothing to do with it.’ And I say, ‘It’s got everything to do with it.’

Consulting with the consulate in Bangkok, the resort owner was told that Teddy's family had hired a U.S. lawyer to prove malpractice, and had made a move to close Teddy's bank account in Thailand before the hospital could collect its fees, not easily accomplished without appointing power of attorney in Thailand. A week since his death, Teddy's body had not been released. The staff were distressed because there had been no cremation, and no ritual commemoration: “No ritual.” “No everything.” “We’re
sad.” The owner said pensively that everyone is “talking about money. Nobody talks about Teddy.”

The care resort where Teddy lived is one of a number of European-run facilities created in Thailand in the last twenty years, offering long-term elder care to Europeans and North Americans, especially those in need of dementia care. The owners of these facilities are banking on a crisis very different from the one just described. They are banking on a crisis precipitated by already existing problems with elder care in the Global North and an anticipated explosion in the number of people requiring complex care, those living with dementia. The number of people living with dementia is predicted to quadruple in the next thirty years (World Health Organization [WHO] 2017). According to Alzheimer’s Disease International (2020), someone in the world develops dementia every three seconds, and there are currently more than 50 million people living with dementia with nearly 10 million cases developing each year. The total number of people with dementia is projected to reach 132 million by 2050 and the WHO (2017) estimates that 40 million new health and social care jobs will be required globally to address these surging numbers. Predictions of the coming dementia tsunami abound (see, e.g., Brookmeyer et al. 2007; Abbott 2011; Nair, Mansfield, and Waller 2016).

Care businesses in Thailand have emerged within what Adams, Murphy, and Clarke (2009) have called “regimes of anticipation”: They are a historically and geographically contingent response shaped by speculation and prediction. “Crucially,” Adams, Murphy, and Clarke (2009) wrote, “the future increasingly not only defines the present but also creates material trajectories of life that unfold as anticipated by those speculative processes” (248). As a lived orientation, “anticipatory regimes offer a future that may or may not arrive, is always uncertain and yet is necessarily coming and so therefore always demanding a response” (249). Anticipatory regimes, Adams and colleagues argued, “leverage new spaces of opportunity and also reconfigure our sense of ‘the possible’” (258). They noted that the dismantling of government services through neoliberal policies, as has been the case for elder care in many countries in the Global North, works hand-in-hand with anticipatory crisis to open space for new forms of capitalist enterprise.

That traveling to Thailand for elder care now exists within the realm of the possible for residents of the Global North is perhaps surprising. Elder care and dementia care are examples of commodification that is “unstable” or “contested” (Radin 2001; Parry 2008). Elder care more generally is positioned somewhere between work and an obligation and expression of familial love. Dementia oscillates between being understood as a disease and (inaccurately) an eventuality of aging, between something that requires professional expertise and something that can be managed informally. In fact, much of dementia care is provided at home by families, often by women. In the United Kingdom, women are 2.5 times more likely than men to provide intensive twenty-four-hour care to persons living with dementia, and 2.3 times more likely to be providing this care for more than five years (Alzheimer’s Research UK 2015). This informal, gendered care work is often expected and naturalized rather than supported: Wives receive less support from friends and family than the relatively small proportion of husbands who provide this care (Alzheimer’s Research UK 2015). The marketization and financialization of elder care beyond the family in the Global North have been a focus of critique for some time (Vreugdenhil 2014; Schiweter, Berndt, and Truong 2018; Armstrong and Armstrong 2019; Polivka and Luo 2019; Horton 2022), a critique that has been amplified during the COVID-19 pandemic as the shockingly poor care in many long-term care facilities throughout the Global North (especially those in the for-profit sector [Molinari and Pratt 2021; Stall et al. 2020]) has caught media and popular attention.

If elder care is an unstable and contested commodity, how much more is this true in the case of dementia, and when the geographies of care are stretched across the globe. First, care facilities created by European investors in Thailand run counter to the common wisdom among economists that care occupations are among the least likely to be outsourced (Jensen and Kletzer 2010; Peck 2017). Second, these facilities defy common understandings that aging is best done “in place,” and that it is profoundly disruptive to move persons living with dementia. Persons living with dementia likely are no longer able to give consent, and their family members must make this decision for them. These families are often judged, for their neglect or avaricious eye on family inheritance (Schiweter, Brütsch, and Pratt 2020). Alert to the disparity in wages in the
Global North and Global South, one of Germany’s largest daily newspapers described finding care for loved ones with dementia in Thailand as a form of modern “gerontological colonialism” and likened it to exporting toxic waste (Prantl 2012). Few families or care providers are under the illusion that the facilities offer anything beyond palliative care: This is not tourism and there is little prospect of returning home. Under such circumstances, one might imagine the desire to keep one’s loved one close to home. Third, from the perspective of investors, these are risky ventures that require substantial investments in infrastructure and navigating a raft of regulations, formulated within currency fluctuations, medical services, and evolving and uncertain politi-
cal contexts. As in the case of Teddy, funds do not flow as easily through financial institutions as is sometimes assumed, the medical infrastructure is not as stable as anticipated, and legal complexities abound. It seems, in short, to be a long and unlikely trajectory from anticipating a crisis in the supply of care to investing in elder and dementia care in Thailand.

In light of all of these complications, how is a transnational market in dementia care created in Thailand? This is the question we address here. Markets are, it is argued, practical accomplishments. They “do not simply fall out of thin air, but are continually produced” through assemblages of heterogeneous elements: material and discursive arrangements, networks and linkages of people, places, and things (MacKenzie, Muniesa, and Siu 2007; Berndt and Boeckler 2009, 536; Çalışkan and Callon 2010; Berndt, Rantisi, and Peck 2020). Markets are processes of attachment and detachment that facilitate exchange between buyers and sellers (Schurr and Militz 2018), with markets in services (as compared to goods) requiring “specific socio-
technical arrangements” to transform them into “packages, ‘things’ which can be valued” and bought and sold (Çalışkan and Callon 2010).

There is “always a host of geographies at work in the marketization process” (Berndt, Rantisi, and Peck 2020, 22), and we draw special attention to the geographies at play in the creation of a market for transnational dementia care. Entrepreneurs in Thailand are accomplishing the unlikely feat of stretching the geographies of the unstable market in dementia care to a global scale. They are creating these global markets by cultivating relations of intimacy, in a new twist on the global intimate (Pratt and Rosner 2012). They are creating assemblages of money, expertise, technology, infrastructure, influence, and intimacy across the Global North and Global South to create a market and world in which Thai caregivers are left to mourn Teddy, being a member of the family “has nothing to do with it,” and the facility owner is left to make decisions on life and death. Concrete markets are framed and exist within a range of noneconomic relations, including emotions and attachments. “The practices which constitute the market,” as Garcia-Parpet (2007) phrased it, “are not market practices” (37).

We explore the scale and scope through which intimacies infiltrate the emerging market of transna-
tional dementia care.

We turn to narrate the efforts and investments made by a small group of entrepreneurs who have built and are managing care facilities in Thailand, mostly in northern Thailand around the city of Chiang Mai, which is an emerging hot spot in the provision for dementia care for overseas visitors. We focus in detail on three entrepreneurs. This is an account of searching forays into emerging economies of care, the foundations and norms of which are only now being established. In a moment of experimen-
tation, these entrepreneurs are entering into and cocreating the global markets of care with consider-
able improvisation. Their investments and ventures are unstable and risky. We follow Parry (2008), who argued that understanding such moments of market creation requires a close consideration of how those involved conceptualize, legitimize, and stabilize commodification and market relations. How are they assessing what is needed to make the market work? We document how uncertainties of valuation, trust, and management are being worked out and stabilized through experimentation.

This documentation draws on field work that we carried out between January 2019 and January 2020 at five facilities that specialize in dementia care for overseas residents. On three occasions, we lived for one week at each of two facilities, one Swiss and one British owned. During our time at these facilities, we carried out in-depth interviews with ten members of management teams (six interviewed multiple times), as well as sixteen nurses and care aides, and thirteen family members (spouses and children) of residents living with dementia, with multiple interviews with several of the same family
members over this time. The range of interviews with owners, workers, and those who purchase care allow us to understand not only the initial investments, but the complex assemblage created to produce the market of dementia care. Dementia is a broad category used to refer to a range of cognitive impairments. One facility that we discuss has developed expertise caring for persons with fronto-temporal dementia, but all facilities provided care across a spectrum of dementias, in terms of type and severity. A good number of residents have early onset or quite advanced dementia, which has made care particularly challenging.

**Landing in Thailand**

At age fifty-five, Peter, British and White, retired with a “final salary pension” from his job in supply chain logistics. Working for the same multinational for thirty-two years, toward the end of this career he ran offices in thirteen countries across Europe, and got paid “an awful lot of money,” “in the hundreds of thousands.” He spent the next four years looking for a resort to buy, with the idea of owning rather than managing it. He had a Thai girlfriend in England, which “got [him] on [his] Thai thing.” He first looked for two years in Phuket in the south of Thailand, but “fell out of love with Phuket”: “it’s all about money.” He began looking in northern Thailand and in 2007 settled on a resort that had been bankrupt for three years. In 2008 Peter and his Thai wife reopened the resort and took over the management. Around that time, he visited his mother in England, who had dementia and was in a care facility there, and “then the world changed.” He saw that his mother “was dying in a care facility without being looked after.” The ratio of nursing staff to residents was four to forty.

I know nothing about care resorts but it doesn’t take a genius to work out that if you walk into a room and there’s six days of meals on the table, something’s been going wrong with the care. So, we came back here and decided, there’s a better way to do this.

Reasoning that they had a nice location and that Thai people would make great carers, they decided to make a care facility “with no experience, no knowledge. I couldn’t see best practice, so I created my own. All from scratch.” His model of care is based on two principles: There is enough care (he has a ratio of 1:1 caregiver to resident) and the place does not look, smell, or feel like a nursing home where residents lead regimented lives. He aims to respect residents’ capacity for autonomy and choice. His mother lived at his resort for four years, before she died at age ninety-five. The resort has ninety-two rooms, thirteen dedicated to memory care (twenty-four-hour supervision for those with advanced dementia), and another sixty-six suitable for less complex long-term care.

Roger, Swiss and White, describes himself as someone who has “100 business ideas every day.” He came to invest in the dementia care business in a more calculated way. An investment manager in Switzerland:

I was always looking for good ideas to invest in and, instead of going to the stock market for my clients, I had the idea, since my wife is Thai, to invest money in Thailand because there are opportunities here of course. … In Asia, Europe, and the United States they have this issue of society aging very fast in the next ten to twenty years. … Our idea was to give solutions for our Swiss people who need care and who deserve a better quality of care, in terms of what they pay now in Switzerland.

He had no experience in the care industry and little in Thailand, beyond visiting in 1991 to attend a friend’s wedding. He did not like Thailand much on that first visit: “I was happy to go back home after three weeks.” This unfavorable impression remained fixed until 2009, “when a friend of mine called me and said, ‘I’ve seen a fantastic program/documentary [on television] that covers nursing homes in Thailand. This has a future and could actually be something. We should look at that together some time.’” Roger watched the documentary, about a facility that was created by another Swiss person in Chiang Mai, and thought:

Indeed, that really has potential. Not just to earn money—that is always important when investing—but also to meet the needs that are inherent to the market.

… I know the conditions in Europe a little […] and I thought, ‘Indeed there is a sustainable need, yes.’

He described their approach as “a classical top-down approach.”

Once they had decided to establish a nursing resort in Asia, he and two other Swiss investors asked themselves, “What are the countries, where we would actually go ourselves during old age?”
They thought about the Philippines, “but that is a little far away for Swiss people, when it comes to flying or traveling.” They then took “a conscious look” at Vietnam, but they reasoned that Vietnam “still has a lot of gunsmoke for a lot of older people” for whom Vietnam is associated with war, “especially those who have some kind of neurodegenerative problem.” They reasoned that Malaysia and Indonesia “are indeed beautiful and modern” but ruled them out on the grounds of religion. They felt that Christians would have a “slight discomfort because they are Islamic countries.” This left Thailand as the most viable option:

And there you also have to see that Swiss people always have some kind of family member somewhere who got married to a Thai woman or has friends from Thailand or, at least, likes Thai food a lot or has already been to Thailand him- or herself for vacation. [...] In this regard, Thailand is a stable brand. That is how we ended up with Thailand.

The choice of location within Thailand also took some deliberation and they also weighed Phuket against Chiang Mai. They weighed the beaches of Phuket against its expense and the culture of Chiang Mai (“the rose of the North”), with proximity to the main transport routes and access to good hospitals. “We have the best hospital brand of Asia here in Thailand. So,” Roger reiterated, “it was a classical top-down approach.” He and two other Swiss shareholders opened their facility, which can accommodate ninety residents, in fall 2014.

George, another White British citizen, came to invest in a care business through very different personal relationships. He was already staying at a dementia care resort in Chiang Mai with his wife, Emily, who has advanced dementia, when his two favorite Thai caregivers, the head nurse and the occupational therapist, resigned.

I thought, ‘I can’t believe this: The two people I absolutely adore to be looking after us are both going.’ So, I queried them, and they said they were going to try to work together in some kind of project because all they wanted to do was to look after old people who needed a lot of care. And I said, ‘Well, you don’t have any money. I will do what I can to help. Let’s do it together.’

George, Tanya, and An teamed up in the fall of 2018. He provided capital and business expertise earned in Britain, and they brought their expertise in care. They rented a small, rundown resort available on long-term lease and began to fix it up, with the intent of eventually caring for twenty residents with dementia. At eighty, George’s investment is rooted more in the present than the future—the only return on his investment that he expects and desires is the caregivers’ promise to care for him and Emily until death. The dream of the caregivers is to create a place that they will own and control themselves, and will become a role model for a care facility for people “at the last of their life.” He says that they would love to run the business as a nonprofit, although this has proven to be:

a little bit difficult. But there’s no greed, no. I mean the five rules in business which I was always taught are: What’s. In. It. For. Me. That doesn’t work with these two. They don’t want to be rich. And I just feel fulfilled.

Peter, Roger, and George are among a growing number of European investors creating dementia care for non-Thais in Thailand. Bender and Schweppe (2019) counted nineteen facilities in their research conducted between 2014 and 2018, and we know of a further three started since then. Peter, Roger, and George had no experience in dementia care. What they bring is money; experience in business and investment; knowledge of demand, pricing, and quality of care in the Global North; and a miscellanea of seemingly chance events and attachments: a Thai girlfriend, a wife or mother in need of dementia care, or viewing a documentary. Thailand is a girlfriend, a wife2 (in most circumstances non-Thais cannot legally purchase land), a taste, a vacation experience, or a stable brand.

Roger’s mention of the “best hospital brand in Asia” is significant because excellent international air travel access and high-quality medical services have been essential for building the assemblage necessary to create the market for dementia care. This infrastructure was already in place in Thailand, with its well-developed health services with other economic activities (e.g., airlines, golf courses, luxury spas). It is a top destination for cosmetic surgeries, gender reassignment surgery, stem cell treatments, teeth whitening, assisted reproductive technologies, medical screening, organ transplant, cardiac surgery, and now dementia care. (On the history of medical travel to Thailand and its implications, see Cohen 2008; Aizura 2010; Connell 2011;
NaRanong and NaRanong 2011; Wilson 2011; Kunaviktikul et al. 2015; Abhicharttibutra et al. 2017; Witthayapipopsakul et al. 2019).

The dementia care facilities work closely with different facets of government, another important element of the assemblage making the market. In the words of the manager of one facility, the Thai government “knows us very well” and they receive a “VIP guest” almost every month: from the Ministry of Interior, Ministry of Tourism, Ministry of Public Heath, Ministry of Commerce and Ministry of Labor, and from the Governor of Chiang Mai. Indeed, we witnessed such visits on a number of our stays, highly visible due to the staged photo ops that are integral to the event. He claimed government visitors from Chiang Mai, from Bangkok, “from everywhere in Thailand”: “Everyone would like to see what we are doing.” International medical care has long been a key national development strategy in Thailand (Sunanta 2020), and for the last eighteen years the Chiang Mai Health Services Promotion Association has worked across governments, universities, and the private sector to promote Chiang Mai as the “city of long stay” for healthy aging foreigners, as well as what is termed “end stay” care, in the first instance by standardizing high-quality health care and appealing to the large and long-standing Japanese, German, and Swiss expat communities in the Chiang Mai area. These networks, formal and informal, are essential to creating the transnational market for dementia care.

**Investing in Infrastructure**

Despite their ventures seemingly emerging through chance, Peter, Roger, and George (and partners) are making substantial infrastructure investments to establish and maintain their facilities. Situated forty minutes northeast of Chiang Mai by car near the village of Mae Rim and heading into lush forested hills, the small community of bungalows that form Peter’s facility are situated in a stunning natural setting. Great attention has been given to sculpting and maintaining an open landscape: Giant orchids of white and pink have been carefully grafted onto the sides of established trees, and banana, golden rain, and yang na trees and bamboo grasses encircle a small dug-out lake in which pools of fish can be glimpsed. The nights hum with a symphony of insect life.

When Peter began renovating the resort in 2007, it was a “complete mess.” The facility had been built fifteen years earlier by a Western architect (also married to a Thai woman) but had been closed for three years and had fallen into disrepair. Peter recalled:

[The] older buildings … had three foot of water in them. So, we took all the roofs off, put new roofs on, redesigned them with the bathrooms inside and we knocked a lot of buildings down and rebuilt, the other side of the lake was rebuilt. … The biggest job of all was rewiring, every piece of wire in this place had to be redone. … It was a death trap [of] electric work.

They rewired and repaired, and built a number of new one-bedroom, semidetached bungalows. A necessity for transnational care, wireless Internet was set up. A new reception area, lobby, restaurant, and security gate were built, and a four-foot-wide path of interlocking bricks was threaded through the grounds so that nursing aides could shuttle residents around in electric utility buggies.

Peter had originally hired “a big Bangkok company” to complete the scheduled work but it soon went bankrupt, at which point his own history in logistics came to the fore:

So I took over the staff management, took over suppliers, but I did it in a different way. I didn’t pay them [laborers] a salary, I paid them 3,000 a month for food, and then said, ‘You can have your money … when this is achieved.’ It was the toughest business year of my life, and I’ve had some tough years.

Opening in 2008, the facility struggled financially in its first years:

Business was terrible, [the] 2008 recession had come in, the Americans had left Thailand. … You could get a five-star hotel in Thailand for 1,900 to 2,500 [baht]. The first years [were] pretty awful.

Peter was forced to take on additional debt to keep things afloat:

When you got no money coming in, you got no money coming out. … Couldn’t pay the bank off, had to renegotiate loans, had no money to spend. I had a [pension] income coming in—quite a big income coming in—but it all went supporting the losses.

Peter (now divorced) has weathered the ups and downs of getting the business established. Twelve years in, the facility now employs more than 100 staff members, including four full-time qualified nurses,
two occupational therapists, along with forty to forty-five nursing aides, kitchen staff, and a cadre of gardeners who keep the grounds immaculate. Although the long-term care half of the business broke even in 2019 (which will enable Peter to phase out the hotel side), he admits to making little profit:

And I’ve been doing this for ten years. So, basically, I’m funding this business. But for me, it’s not about making money, it’s about what I want to do.

In the meantime, he keeps his entrepreneurial eye steady on the future: “You just have to look at the growth in the elderly in the next twenty-five years—it’s a growing business.”

Head east and the landscape quickly changes as one skirts the edge of Chiang Mai, and Roger’s facility emerges dramatically from a surrounding horizon of abundant rice farms in Doi Saket. In 2013, a Swiss company—Vivobene—made a splash in the Thai press announcing its 250-million-baht (US$8 million) investment in the country to build a long-term care facility for Westerners living with dementia. The activity was prompted by investment from three primary Swiss entrepreneurs (with the Swiss honorary consulate in Chiang Mai as general manager) who secured special permission from Thailand’s Board of Investment for legal Swiss ownership of two hectares of land and buildings as well as the hiring of foreign workers. Roger was enlisted as the project’s managing director, and his first move was to pull together a “task force in Switzerland” formed by specialists who could consult on design elements and dementia care. The project drew particular inspiration from Held and Ermini-Fünfschilling’s (2004) book Das Demenzgerechte Heim (The Home for Dementia) which advocates a dementia-friendly design. “It was absolutely crucial for us to build a home suited for people with dementia,” related Roger. “We relied heavily on specialists in Switzerland in that regard. … To this day, I think, that is unique. … It is a dementia-equitable home.” With construction beginning in 2012, Vivobene was conceived on a grand scale and its commitment to design and “Swissness” are self-evident. The reception area is vast and opulent, its welcoming red carpet leads through a tall atrium of paneled hardwood, and Swiss iconography is a recurring motif throughout the lobby and beyond; there are a number of framings of snow-capped mountains casting reflections in turquoise alpine lakes, and entering the restaurant one might be surprised by the large closeup of cow and Treichel set against the monumental backdrop of the Matterhorn. The facility features an elegant Lanna-inspired architectural design organized around six large care pavilions, each with a centralized nursing station and capacity to accommodate twelve residents. The vaulted ceilings provide innate air cooling while channeling natural lighting in such a way that avoids casting shadows (which can accentuate paranoia for those with dementia). The grounds are “designed in circles,” explained Doris—the Swiss head of nursing—because people “with dementia, often they walk, walk, walk. They love to walk. So, they’ll walk and we can bring them back.” At one end of the grounds sit eight palatial villas accommodating visiting family members or retirees, and Vivobene also includes a hair salon, a massage center, and a terraced restaurant where residents can order an excellent espresso or their favorite spatzli; a full continental breakfast is available each morning, and there is a Swiss baker on staff who produces a steady stream of twelve different breads (e.g., jogga, laugen, ciabatta) along with an assortment of amaretti, kokos makronen, and biscotti biscuits.

Opening its doors in November 2014, Vivobene initially struggled; in its first year, it had only two care residents. By the end of their field work in 2020, the situation had improved significantly: There were thirty-two residents requiring full-time care and fifteen or so retirees or shorter term guests. Roger estimates that 60 to 70 percent of their residents are coming from Switzerland, France, or Germany, but they also have people who have traveled from England, the United States, Norway and Bangladesh. The facility employs 100 staff members. The investment and infrastructure have garnered the attention of the Thai state, and it received the highest ranking for Thailand’s Long Stay Standard from the Ministry of Tourism and Sports in 2016, 2017, and 2018. It can currently accommodate eighty residents (the optimal mixture of dementia patients and retirees has been up for debate) with land for further expansion as necessary.

When we first met George early in 2019, he and his two Thai care providers and partners, Tanya and An, were working hard to repurpose a small, rundown resort for which they had a nine-year lease. It was apparent that they had a gargantuan task ahead of them: the building and rooms were very run down. When we visited again in the summer that year, they had one resident (beyond George and his wife, Emily) and two more care staff, but had given up on this place. When the ceiling in one of the main rooms collapsed, they...
found they had termites—“not just two but several million.” The landlady proved disinterested in sharing the investment necessary to refurbish the resort and an architect advised that it would be cheaper to buy land and build something on their own. The architect introduced them to a two-acre piece of land in Mae Rim that was for sale. George put down a deposit and they commissioned the architect for the plans. By the time of our meeting, the plans had been submitted for planning approval and “the girls” had approached banks for financing. They planned to start off “in a small way,” initially with a building that would house four dementia guests, including George and Emily. The rooms would be thirty-five square meters each, surrounding a common lounge. The imaginings around the plans were specific: The lounge would house a piano, in the first instance for Emily but available to all the guests. There would be a long, narrow pool to swim lengths, George’s preferred exercise. Eventually the plan was to build a facility for up to twenty residents. When we visited early in 2020, these plans had been abandoned, the deposit on the land gone. They were attempting to sell the remaining seven years of their lease on the first resort but accepted that the chances were low. New plans were afoot. George and Emily had moved into a gated community surrounding a small artificial lake, home mostly to expats. George favored leasing a number of these houses to create a facility. Meanwhile, Tanya had been approached by a New Zealander (a retired engineer, again with a Thai wife), who owned a resort near the Chiang Mai airport and wanted to create a care facility and retirement home. She was very enthusiastic and the location was good (close to the necessary infrastructure: the airport and a new private hospital). Told just ten minutes before our visit and asked what he thought, George joked, “You can see the tear stains down my cheek can’t you? It’s like having a divorce.” In private conversation later, Tanya made it clear that the continued care of George and Emily would be part of any plan. On the substantial financial losses, George seemed sanguine: “The girls really worry about it. It’s money. It’s gone.”

**Bringing Transnational Dementia Care to Market: Constructing Intimacy and Managing Trust with Families**

Deep investments in the most compelling infrastructure are worth little if the proposed customer cannot be brought to the market to purchase the service. The commodification of the service they are providing—intimate bodily and emotional care of vulnerable family members—is already unstable, undercut by assumptions that families have an obligation to care, and that such care should be given freely, forged through relations of love or affection and lifelong mutual reciprocity, and desire to be cared for at home. Entrepreneurs creating a market for dementia care in Thailand have to first find their customers and then convince them that the quality and price of their product (dementia care) stabilizes the decision to purchase this service very far from home.

We heard repeatedly in interviews with family members about the stress of making the decision to relocate their loved one with dementia to Thailand. Consider (as but one example) the experience of Mel in the United Kingdom, who took the difficult decision to move her father (and only remaining biological relative) to Thailand in 2019 after futile attempts to secure quality care closer to home. “It was the right decision for sure,” she stated before qualifying:

But, um, he’s my only relative in the UK. I don’t have any other blood relatives. … My mum passed away when I was in my twenties. So, to send away the only relative I’ve got left on the planet, really, that was quite difficult.

Family members are alert to negative judgments. For one woman we spoke to at a facility in Thailand, “They don’t say it, but you can hear that they think, ‘Oh how can she dump him just there? … And these people who earn nothing take care of him.’” Owners and caregivers in Thailand are keenly aware of this emotional strain and their ambitions to establish a care market in Thailand require substantive efforts to build (and maintain) trust and confidence with overseas family members.

It has taken some trial and error for dementia care entrepreneurs in Thailand to understand the geographical scope of their marketplace. Vivobene’s strategy was to first open an office in Switzerland to focus exclusively on the Swiss aging market, but this had its challenges (and costs). The resort CEO lamented:

The Swiss take ten times more [time to decide] than compared to the French or other European countries. [The family members] all think about this. They talk it [over] within the family. They’re talking to specialists, family doctors, etcetera, etcetera. They do a lot of research, and it takes a least one year to make a
decision. And then they say, ‘Okay, we’re coming in five years.’ Of course, [the relative with dementia] is already ninety-three years old. So, we have very high cancelation calls. It’s almost 50 percent. But it’s not because they do not want to come. It’s because of health issues: they cannot travel anymore. Or they died. Other nationalities are much more spontaneous in that regard. Even the Germans, they are much more spontaneous.

An office in Switzerland, participation in the Internationale Tourismus-Börse convention (the world’s largest tourism trade fair) and traditional forms of television and print advertising in Switzerland appear to have had little effect attracting a Swiss clientele. We were told that the business had:

wasted [an] enormous amount of money with advertisement—even on TV, and print media and online, too. Really, an unbelievable amount of money. Introducing Vivobene during prime time, that is not sustainable.

The resort manager told us that when they realized that they must “open for the whole world … to make the marketing to the whole world … this was the first success.”

Tapping into a global care market, owners rely heavily on online presence, and a number stressed the importance of having what one describes as a robust “Google campaign … since we have our new homepage, we’ve noticed that requests have increased tenfold within days, yes.” His business tracks Web site user behavior carefully: “We also see … how they move, what they are looking at and we generally get a feeling what kind of people are there.” Other owners cautioned, however, about the low returns from online marketing. One commented:

You get a lot of inquiries, so marketing’s not hard. I don’t know, I’ve probably done well over 4,000 inquiries. And if you had a one in ten success rate, we’d be full ten times over. And that’s inquiries, that’s a person inquiring, not per inquiry. Because some people will e-mail you twenty or thirty times and then disappear. What they now seem to call ghosting … They just stop.

Yet some do come through Web site recruitment. Trudy, an American living in Florida, described finding the care resort online:

I had friends whose husbands were farther along this path than [mine] and I kept hearing some of these stories about, you know, what happened in the hospital, what happened in the rehab facility and moving back from the hospital to the rehab facility and the falls and the miscommunications. And I just kept thinking, ‘You know what? There must be something better than this.’ And just kind of for a lark I looked things up on the Internet. You know, just because I can, I thought, ‘I’m going look up dementia care in other countries.’ And so, I put that in. And the first thing that came up was the Care Resort Chiang Mai. And so, I read about it, I looked at the pictures, showing these little bungalows. I thought, ‘Whoa, I could get into that in a heartbeat.’ [Laughs] You know, ‘This would be easy.’ And so, I thought, ‘I’m going to put this on the back burner.’ And to this day I don’t know what made me switch but I thought, ‘This is going on the front burner.’ It was in a very short period of time before I was contacting [the manager] and inquiring about how it worked, how much did it cost, so on and so forth. … I mean, and it really is pretty wild that I just put the subject in and up pops the Care Resort and I think let’s go.

Nearly four years later her husband has never returned to the United States, and Trudy has returned only to manage the sale of their house and belongings and to transport their household pets to Thailand. A number of other families with whom we spoke related a similar discovery. From Rosalie:

[We] saw on the Internet that there are care homes in Thailand and immigration is not a big issue. … Within a month we made the decision. … It looked perfect.

“We did a bit of research [online],” Sarah told us, “and what popped up was this Englishman. … So, we agreed we’d bring mom out for a year.” Now in her nineties, Sarah’s mother remains in Thailand. From Mel we heard this:

I was desperate. And I said to these friends of mine, ‘My goodness, I can’t bear this. I always said I would never, ever put Dad in a home. I would never do it. And here I am, I’m stuck. What other solutions do I have?’ … And she said, ‘Well, why don’t you send him to Thailand?’ And I said, ‘Why on earth would I send him to Thailand?’ … [But] I went online and I came across this care resort. … I looked at a few videos online and Steph and I booked to go out there. And that was it. I said, ‘Do you have availability?’ About six weeks later, we came out.

To establish and connect with a predominantly European and North American aging marketplace, facility operators place a heavy emphasis on search
engine optimization and build trust by emphasizing in their content both ends of the global intimate: professionalism and intimacy. This dichotomy no doubt works within tropes of European efficiency and professionalism and Thai emotionality and culture that are rooted in and recirculate imperial logics of racial and cultural hierarchy. They have a performative impact cultivating a European clientele. Together, these discourses convey and convince that family-based care is replaceable by the particular commodified care on offer in Thailand. Some owners stress their superior professional training and years of experience providing specialized dementia care in the Global North and their capacity to gain results unattainable in Western contexts because of the quality of their care that combines Western expertise and Thai cultures of care.5

All owners are aware of how their European-ness applies. One owner stressed the importance of European management to shore up consumer confidence:

I’m the Western face. If you put a Thai person in my position, we would have half the business. It’s as simple as that. … I’m very much the face of the business.

European-ness is marketed as a guarantor of quality and trusted stewardship. The owners and managers understood that their professionalism can be expressed through the Web page in other ways as well. One owner placed prominence on having “the greatest transparency possible in your Internet representation.” In 2019, his Web site had just undergone its fifth revision so that:

You can see and read everything and see the prices. We also [now] have an online calculator, where you can say: ‘I need this and that and what does that cost me?’ And book. Book now! [laughs]. That is just very important.

The sales and marketing manager at the same facility stressed the need for a speedy reply to overseas inquiries:

[A] fast reaction [is necessary] because most of them, they have [an urgent] problem, they cannot take care of the family. … That’s why within twelve hours, we have to reply, or sometimes we will call immediately to ask them: … How we can help? … That also shows our professionalism.

Building intimacies into the frictionless space of the Internet is also a critical component in concerted appeals to a customer base situated across the Global North. Marketing strategies attempt to build intimacy in a number of ways. Web sites often mobilize and circulate imaginings of Thais’ propensity to care, respect for the elderly, and strong family values, and stress that you will be cared for lovingly, respectfully, and individually. A Swiss manager noted:

We take some Swiss skills to marry with the Thai skills, which I think is a very good combination. So, it is the peaceful, heartfelt style of the Thai people with the attitudes from Switzerland: clear, proper, exacting. … We just [worked with] this IT specialist four months ago, and now, boom, boom, boom, it comes.

(For a further analysis of facilities’ marketing through Web sites see Kolarova 2015; Horn et al. 2016.)

The intimate global is also produced through owners’ and managers’ close personal connections to dementia. Some of this is marketed on Web sites; for instance:

Previously, my 95-year-old mother was here, suffering dementia until she passed in March 2018. She is the inspiration for what we do here. I pay close attention to the running of the resort and the care and happiness of my guests.

The medical manager from another facility tells Web site visitors:

I have a lovely grandmother who has lived with the dementia syndrome for 10 years. I have needed to take care of her and support her through every condition, element and duration of her dementia. My aim now is to use all of the experiences and skills which I have gained so that I may take care of relatives of others to ensure that they have a good quality of life when they are faced with the instability brought on by dementia during their declining years.

The personal connection is written into media accounts of other facilities, for instance, “Baan Kamlangchay was established by Martin Woodtli, a psychologist and social worker who spent four years in Thailand with the group Doctors Without Borders before returning home to Switzerland to care for his Alzheimer’s diagnosed mother” (Medical Tourism Magazine 2020). The wife of a resident of Baan Kamlangchay spoke of how important this personal connection was to her: she was very moved by the story of Woodtli coming to Thailand with his own mother and was drawn to this facility because
of “the heart” that lay at its foundation. She distinguished among other facilities in the area on the basis of whether or not the owner was simply making a business or doing this from their own experience and “heart.”

Woodtli’s facility, in particular, has benefited from extensive documentation by media, through a number of documentary films, at least one of which has been aired on television in Switzerland, and an operatic play staged in a large state theater in Bern. The television program, as noted earlier, sparked the creation of Vivobene, and the wife of a current resident at Baan Kamlangchay spoke of the significance of this television program for her. She had never been to Thailand but “tucked away” the knowledge of this facility after watching the program and remembered it when her husband’s condition deteriorated. Another Swiss woman, whose husband was also at Baan Kamlangchay, had read about it in her community newspaper in Lausanne. When we met in summer 2019, she told of recently meeting some Swiss people in the village where Baan Kamlangchay is located; they were there taking a massage therapy course. She was surprised by the fact that they did not know about Baan Kamlangchay: “Everybody [in Switzerland] knows about it.” Peter said of his resort, “I had my reputation started with a Canadian radio program.” This was followed by a short Canadian television program, which got picked up in U.S.-based blogs. He thinks that blogs originating in the United States have been critical to cultivating his substantial U.S. clientele. A step away from advertising, these various media might be more trusted as less self-interested and thus more honest representations of life in these facilities. They have proven highly beneficial as a type of arm’s-length marketing and a number of facility Web sites make direct links to them.

Trust is also built through personal networks, word-of-mouth referrals, and, in the case of some facilities, labor-intensive shuttling across borders. At one facility, the Swiss nursing manager recruits actively in Switzerland and Germany by attending conferences of dementia organizations, and through personal relationships cultivated with psychiatrists, who refer more challenging dementia cases to the facility in Thailand. She meets with prospective customers on her vacations in Europe to answer questions and establish a relationship. Even calling from Thailand, “Always when I call them, actually that’s also my goal: to convince them to get into a relationship, that we have some emotional connection.” In some cases, she has had to fly with a new dementia resident to Malaysia for the day to secure the proper resident visa that allows them to stay long term. Doing the work of outsourcing care labor, in other words, requires considerable, highly personalized, transnational labor.

The doing of this transnational care also involves maintaining trust and ongoing communication with overseas family members once their loved one has relocated to Thailand. This labor is mostly the responsibility of caregivers who take full advantage of the rapid development and accessibility of different online messaging and video calling applications. This technology enables practices of “digital kinning” among family members (Baldassar and Wilding 2020) and allows staff to become intermediaries and even part of kin relations, further stabilizing and legitimating the commodification of care. It allows siblings who live across the world to be in constant touch with their parent in care and each other. Within one facility, residents are assigned their own messaging group that links family members and nurses, caregivers, and occupational therapists. “We’re calling them every now and then,” described one nurse, “sending them pictures every day. … We’re updating, what’s happening with their mom or dad.” From another nurse at a different facility, we heard this:

I try and make a phone call, send a photo, and report everything almost every day. And every special day, birthday, I send them [photos]. And if they have any photo to send to me, I show them here, so they’ll feel like they still have their own family. It’s just different.

Line, WhatsApp, Skype, and other online tools are not only an easy means to facilitate familial relations by circulating photos and updates, but also an efficient way for nursing staff and managers to obtain permission for doctor visits, changes in medication, or hospitalization. As one husband put it:

They put out pictures and notices on a regular basis, so you see what’s going on. It’s how we, you know, for instance, if Nicole has to go and see a doctor, it’s how they get my permission. … We rarely go a week without some form of communication about Nicole or pictures or something like that. For instance, last week, Bee sent me a picture. Nicole had gone out on the porch at the facility and said she was going to sit there
until I showed up. [chuckle]. So they send you a picture of that. –… [chuckle] If it’s to do with meds, or occasionally Nicole will have an episode which requires hospitalization, then they’ll contact me immediately and tell me what’s going on and typically I have to authorize something.

These digital circulations are also a means of communicating more touching, intimate moments of celebration and life. One daughter described:

We have pictures of my mum’s birthday. I’ll show you! They call my mum the queen because she wears a big hat. Let’s see. I’ve got fifty-two messages on my WhatsApp [with photos of the birthday celebration.] So that was yesterday for my mum.

For this family member (who lives in the United Kingdom), however, updates on social media only go so far in reassuring her about her mother’s daily care. She and her brother have placed a small camera in their mother’s room:

so we can see my mum wherever we are. Oh, there’s no way she’d be here if we didn’t, if we couldn’t see. To be honest, it’s not often that we look at it, but you know it’s like if anything … it’s more to do with us. We want to be able to see that she’s okay for our own peace of mind.

Despite their best efforts to maintain trust over great physical distance through a regular stream of digital updates, caregivers (and managers) often face the difficult task of managing the expectations and grieving of family members for whom witnessing the mental and physical deterioration of a loved one is an agonizing process. “A week before the family comes to visit,” a Thai occupational therapist noted, “we will get the patients ready by reminding them about their family, [by] showing them some photos. Even [if] they cannot fully remember, they will have a feeling of familiarity.” These challenges deepen as the dementia progresses and losses often come into focus more sharply during family visits to Thailand. One owner described the moment when people with dementia might no longer recognize their family members, who are understandably distraught and desperate to maintain a sense of familiarity.

It’s always, the key question for them [the family]: ‘Does she or he still recognize me?’ And this question is difficult to answer, because some, they cannot express. They may still feel something but they can’t express it. Sometimes you don’t know even if they don’t react.

The occupational therapist said:

If the patient cannot remember their family, the family may have a bad feeling about sending the patient here. They may think that they should not send them here at all. They should keep them near so that they can visit more often.

Responding to and managing this bad feeling is essential to maintaining the market for transnational dementia care.

Unstable Commodity and the Global Intimate of Dementia Care

In August 2020, an e-mail arrived from one of the nursing staff at one facility to tell us that two senior European staff members had rented a hotel and moved almost all of the care guests there, along with sixty staff members:

[They] took all the guests during the night after 10 p.m. because the front desk closes at 10 p.m. They waited for them to leave before bringing in the movers. I came the next morning to find all the guests gone.

Some management and staff established a new facility and the new Web site was up and running. A few weeks later a journalist with the Economist with whom we had been in contact e-mailed to tell us about speculation that this facility would be sold to Chinese investors to be run as a long-term-care facility. (This seems not to have happened.) Within the same time frame, we received an e-mail from one of the Thai nurses attempting to open a small dementia center with George. Tanya is now medical manager of a small exclusive dementia center in Chiang Mai, opened just before the pandemic. Another care facility we visited has expanded to provide home care to European expats. In the course of this field work, we have been contacted by others elsewhere in the world: an entrepreneur in the United States, with a history in medical information technology, now designing a care facility in Costa Rica for a North American market, another from an existing facility outside Colombo run by a son and his mother, a dementia specialist who worked in the United Kingdom for twenty-five years.
This entrepreneurial activity is taking shape within a regime of anticipation. Predictions abound of an increasingly aged population, high rates of dementia, and a shortage of care workers. We have traced how Western entrepreneurs in Thailand are crafting a market in elder care (with a specialization in dementia care) by creating an assemblage of heterogeneous elements: networks, computer technologies, infrastructural investments, relationships with government, hospitals, and nursing training schools, discursive constructions of professionalism and intimate Thai care: elaborate arrangements of what Caliskan and Callon (2010) called mediation devices. Care facilities in Thailand do not follow a plotted trajectory or reach toward a single horizon. A number are purposely small scale with little or no ambition for substantive growth. “I started with one house and then another house,” one European operator in Chiang Mai reported. He has now built eight houses and is committed to providing care to a maximum of fourteen guests at one time. Yet another owner expressed more global ambition with aspirations of scaling up his care model by opening sister facilities in Bangladesh and Dakar while exploring the possibility of exporting Thai caregivers to Germany: “We are trying to offer a new kind of concept, and, of course, at the end of the day, we want to make money with that.” Given the importance of the personal histories of many of the owners to prospective customers, both scaling up in this way and long-term viability are unclear.

In line with the geographical literature on markets, there are a host of geographies at work in the creation of a market in elder care in Thailand. Western entrepreneurs are not only responding to an anticipated demand in care for persons living with dementia, whether they run small businesses or have ambitions for global expansion, they are stretching the geographies of elder care, and in particular dementia care, from the very local to the global, and effectively creating a demand and a market for transnational care. The commodification of elder care is hotly debated across the Global North and creating for-profit markets for elder care is an unstable, contested process. How much truer is this when care provision is stretched across the globe? Entrepreneurs in Thailand are both calling up and deploying existing geographies (the branding of Thailand, lifetimes of uneven economic development that fund investment and structure labor costs, discursive geographies that attach professionalism to Europe and familial care to Thailand), and creating new spatialities of care. Cultivating intimacy at a global scale has been central to this process. Some of those who buy elder (and often dementia) care in Thailand have previously purchased care in their home country (and found it to be both expensive and deficient); in other cases they are buying care for the first time (i.e., they have previously struggled to provide care at home). In both cases, the challenge exists of establishing the required relations of trust over a distance. Entrepreneurs are stabilizing the commodification of an intimate labor by playing with two opposite strategies, sometimes at the same time, both of which release dementia care from its uncommodified life within the nuclear family and build trust across distance. They offer the opportunity to replace familial or inadequate market-based care with a new expanded set of kin relations, Thai care and dedication to the family and the elderly, and European medical expertise and management efficiency. If so many of the managers have cared for their own mothers or grandmothers with dementia, might they care with compassion for yours as well?

We have narrated the construction of markets in Western elder care in Thailand through the experiences and voices of three clusters of entrepreneurs. It should be clear, however, that they have developed business strategies within a structured context of global capitalist development and underdevelopment and neoliberal government policy. Digital technology and air travel infrastructure support this new, extended quasi-kin network, and private-public partnerships invested in medical tourism as a development strategy gird entrepreneurial ambitions. State disinvestment in social care in the Global North drives consumers of elder (and in particular dementia) care to seek options far from home. Consumers from the Global North in turn are able to leverage their resources (in a process Hayes and Pérez-Gañán [2016] termed “geoarbitrage”) to purchase care in the Global South. This is likely a repetition with difference of an old story of the Global South servicing and underwriting the reproduction of those in the Global North. In this, a close study in the creation of a market for superior institutionalized elder and dementia care in Thailand extends, from a different angle, the critique of disinvestment in social care in the Global North.
We also hold out the possibility that the transnational market in dementia care might be creating new possibilities, depending on how the Thai state and local Thai entrepreneurs enter into this market. In this, we resist the anticipatory spirit of our age and decline to predict.6

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Notes

1. We accept that this is an unusual, possibly imprecise use of the term outsourcing, especially because the consumers travel Thailand to purchase commodified care. We retain this term precisely because investors are moving their capital to create care facilities to Thailand because skilled care labor in Thailand costs less than it does in the Global North. The care work is being outsourced in a meaningful sense: Capital from the Global North is being invested in facilities in Thailand and care labor is being purchased at a price much lower than it costs in the Global North. At another scale, it could be said that governments in the Global North are devolving their responsibilities to provide social care and are thus essentially outsourcing the provision of elder care to Thailand.

2. Referees rightly note that Thai wives (and wives more generally) remain shadowy in our account. This risks their commodification and orientalization, and veils their labor and other contributions to the businesses. Their invisibility in our account reflects their relative invisibility in owners’ accounts. These wives were never identified by name and we did not meet or see them. They are no longer married to the owners with whom we spoke and appeared not to be involved in the business—at least not on a day-to-day basis. With the exception of Vivobene, which had obtained permission from the Board of Investment (BOI) for legal Swiss ownership of land, Thai citizenship was critical to the purchase of land. It is true that our narrative of entrepreneurship is contrast, not just to facilities in the Global North, but also to other facilities in Thailand: “More and more people they jump on this train to take care of old people. Most of them are definitely not educated for that. They don’t have the right approach, they don’t have the right background from studying and experience to do this job. They just do it for money, and it’s difficult for us to separate us from them.”

3. To legally own land, nonnationals must obtain special license from the BOI.

4. There is considerable variation in price depending on facility and the amount of care desired. Most families mentioned cost as being a significant factor in their decision to move their loved one to Thailand. At one of the more expensive care facilities, 1:1 care on a twenty-four-hour basis costs up to US$60,000 a year, which is highly favorable to the cost of comparable care in the Global North. Beyond direct costs, country-specific factors complicate an assessment of relative costs. In the United Kingdom and Switzerland, for instance, a person must sell most of their assets (including home) to qualify for state funding. In the words of one UK-based daughter of a person living with dementia at a care resort in Chiang Mai, “Dad’s pension more or less pays for this. We have to find another £500 a month. But what we did was we sold Dad’s houses. He had some buy-to-lets and his main house. Sold them all. So, we’ve got a pot of cash in the UK that we’re going to buy a property, rent it out, that rental income will pay for the extra money for [this care facility].” The capital is thus protected.

5. In some cases, owners pitched their professionalism and superior European experience and training in contrast, not just to facilities in the Global North, but also to other facilities in Thailand: “More and more people they jump on this train to take care of old people. Most of them are definitely not educated for that. They don’t have the right approach, they don’t have the right background from studying and experience to do this job. They just do it for money, and it’s difficult for us to separate us from them.”

References

Abbott, A. 2011. Dementia: A problem for our age. Nature 475 (7355):S2–S4. doi: 10.1038/475S2a.

Abhicharttibutra, K., W. Kunaviktikul, S. Turale, O.-A. Wichaikhum, and W. Srissuphan. 2017. Analysis of a government policy to address nursing shortage and nursing education quality. International Nursing Review 64 (1):22–32. doi:10.1111/inr.12257.

Adams, V., M. Murphy, and A. Clarke. 2009. Anticipation: Technoscience, life, affect, temporality. Subjectivity 28 (1):246–65. doi: 10.1057/sub.2009.18.

Aizura, A. 2010. Feminine transformations: Gender reassignment surgical tourism in Thailand. Medical Anthropology 29 (4):424–43. doi: 10.1080/01459740.2010.501314.

Alzheimer’s Disease International. 2020. Dementia statistics. Accessed August 3, 2020. https://www.alz.co.uk/research/statistics.

Alzheimer’s Research UK. 2015. Women and dementia: A marginalised majority. https://www.alzheimersresearchuk.org/wp-content/uploads/2015/03/Women-and-Dementia-A-Marginalised-Majority1.pdf.

Armstrong, P., and H. Armstrong, eds. 2019. The privatization of care: The case of nursing homes. London and New York: Routledge.
outsourcing of care for the elderly. Global Networks 20 (1):106–25. doi: 10.1111/glob.12231.

Stall, N. M., A. Jones, K. A. Brown, P. A. Rochon, and A. P. Costa. and 2020. For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths. CMAJ: Canadian Medical Association Journal/Journal de L’Association Medicale Canadienne 192 (33):E946–E955. doi: 10.1503/cmaj.201197.

Sunanta, S. 2020. Globalising the Thai “high-touch” industry: Exports of care and body work and gendered mobilities to and from Thailand. Journal of Ethnic and Migration Studies 46 (8):1543–61. doi: 10.1080/1369183X.2020.1711568.

Vreugdenhil, A. 2014. “Ageing-in-place”: Frontline experiences of intergenerational family carers of people with dementia. Health Sociology Review 23 (1):43–52. doi: 10.5172/hsr.2014.23.1.43.

Wilson, A. 2011. Foreign bodies and national scales: Medical tourism in Thailand. Body & Society 17 (2–3):121–37. doi: 10.1177/1357034X11400923.

Witthayapipopsakul, W., N. Cetthakrikul, R. Suphanchaimat, N. Thinakorn, and K. Sawaengdee. 2019. Equity of health workforce distribution in Thailand: An implication of concentration index. Risk Management and Healthcare Policy 12:13–21. doi: 10.2147/RMHP.S181174.

World Health Organization (WHO). 2017. Global action plan on the public health response to dementia 2017–2025. Accessed August 9, 2020. https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/.

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