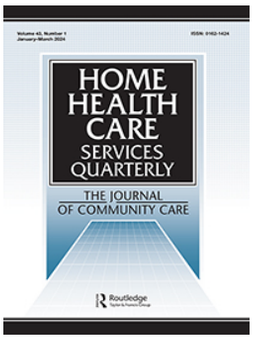

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Motivation for becoming a paid caregiver for older people: a case study in Phuket Province, Thailand

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ABSTRACT

This study aimed to explore the motivations, attitudes, care management strategies and training needs of paid caregivers. Data were collected through 51 semi-structured interviews with paid caregivers and analyzed using thematic analysis. Their motivations included economic stability, the inability to secure other employment, a desire to secure independence through regularly paid employment and a passion and a love of caring. Their role involved being a key communicator of care between medical personnel and relatives, and participants emphasized the importance of paid caregivers being loving, caring, calm, patient, having the ability and willingness to cope with challenging situations. They outlined some specific challenges of the role of caregiving and expressed the importance of gaining recognition for the role as well as the need for bespoke and tailored training to underpin it. This study adds to the growing international literature around the needs of the paid carer workforce and has the potential to inform policy and training around the provision of a better-equipped workforce to meet the growing needs of the aging population.

KEYWORDS

Paid caregiver; older people; caregiving; home care

Introduction

Older people generally want to live in their own homes as they age (Lindquist, Tam, Friesema, & Martin, 2012), but in their final years of life, when they may experience functional decline, many will need to be cared for in some capacity. Thailand became recognized as an aged society in 2022 (Prasartkul et al., 2022) and in 2021, 58.6% of older people had chronic illness: 75.9% had cardiovascular disease, 35.9% had endocrine disorders and 13.2% had musculoskeletal disease (NSO Thailand, 2022)). 51.97% of older people in Thailand are registered as having one or more disability (Ministry of Social Development of Human Security, 2018). Older people, therefore, have increasing need for help with activities of daily living and use of health care services. The Thai government has supported the care of older people through an intervention called "The Home Care Service Volunteers for the Older People Program," and the

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National Health Security Office has created a long-term care program to provide community care facilities. The Department of Local Administration has also launched an initiative whereby full-time volunteers provide care for older people in the community but these interventions have not yet sufficiently responded to all care needs and older people in Thailand still rely mainly on their families and community for personal support (Phetsitonget, Vapattanawong, Sunpuwan, Volker, & Joe, 2019).

Many older Thai families are nuclear with grown-up children who work away – sometimes in other provinces. Those who work as family caregivers need to balance this with their employment responsibilities. Consequently, some families are fatigued, and manage only through the employment of (paid) caregivers (Singtuen, Monkong, & Sirapo-Ngam, 2018). The demand for care is predicted to rise rapidly in coming years (Pagaiya, Sasat, & Wisesrith, 2021) and caregivers will be an essential component of the workforce system, as is seen in other countries (Sims-Gould et al., 2010). However, some caregivers are not formally trained and the Thai government, concerned about the quality of care, brought this to national attention in their '2nd National Plan in Older Adults (2002–2022) (Department of Older Persons, 2018).

Phuket, a southern province in Thailand, consists of the island of Phuket, the country's largest island, and another 32 smaller islands off its coast. The province covers an area of 576 km^2, and is the second-smallest in Thailand. It derives its wealth predominantly from tourism. In 2021, 478 dependent older people in Phuket were in receipt of local long-term care services (Ministry of Public Health, 2022). Others utilize paid caregivers, hired by family members to care for their parents at home or in hospital when necessary. These paid caregivers come from nursing homes/care centers, or are freelance, unattached to any formal agency, and support people's physical, mental, emotional, and social needs. They can help to relieve family caregivers and reduce stress, particularly when family caregivers do not have appropriate caring skills (Pierey & Dunkley, 2004).

Paid caregivers have many different reasons for entering the role. Lindquist, Tam, Friesema, and Martin (2012) reported that 60.7% of paid caregivers chose the job because they enjoyed being with older people while 31.7% were unable to obtain other work and 8.2% undertook it as a prerequisite to a different health-related occupation. In Bangkok, Singtuen, Monkong, and Sirapo-Ngam (2018), found that motivations included the need for income, the love of caregiving, having a good bond with older people, and the desire for knowledge and experience. However more than two-thirds of paid caregivers (69.4%) have no formal training, and some have inadequate health literacy for the role. For example, Lindquist et al. (2010), noted evidence of medication errors due to difficulty in following label directions. Paid caregivers have a 24-hour responsibility and need to adapt to caring activities based on the

individual's needs and condition. The quality of care is likely to be affected by the well-being of the caregiver – some of whom may be burnt out, particularly when providing care in private accommodation, usually without the supervision of a healthcare professional. Research has shown that paid caregivers often lack information about patients and the working environment, lack skills, and training, experience a lack of support and assistance, and lack preparation for facing challenging situations (Smith et al., 2017). Paid caregivers provide care to people with complex healthcare needs including functional impairment and an ever-changing health and psychological status (Reckery et al., 2019). Their jobs are complex and require skill, knowledge, and ability for quick decision-making, particularly when responding to rapid clinical change (Stone & Bryant, 2019). Indeed, the personal attributes and specialist skills of carers influence the satisfaction amongst those being cared for.

Prior research has focused on familial and informal caregivers, with very few studies specifically on paid caregivers (Lindquist et al., 2012). A solid understanding of the experiences of paid caregivers in the home and hospital sectors, is crucial to inform strategies to promote the quality of client care and paid caregivers' satisfaction. This study therefore aimed to explore paid caregivers' motivation, attitudes toward the job, care management strategies and training needs.

Materials and methods

This study followed and is reported by the COREC guidelines (Tong, Sainsbury, & Craig, 2007).

Study design

This study employed a qualitative approach in which paid caregivers' experiences were investigated by in-depth interview in order to help to gain a deeper understanding of their experiences and personal insights. The study was undertaken in three main districts in Phuket province.

Participants and recruitment

Snowball sampling was used to recruit participants. Inclusion criteria were: 1) Thai nationality, 2) carer for older people in the hospital or at home in Phuket province, 3) experience in caring for at least 1 year, and 4) may or may not have passed a formal training course in caring for older people.

The first participant was a paid caregiver who was personally known to one of the research team. They then invited the second participant to take part and snowballing carried on with participants promoting the study throughout

their contacts. The research team then cross-referenced each of the potential participants against the inclusion criteria, they were informed of the aim and procedures of the study, and details of the consent form, and were guaranteed the right to withdraw at any time without negative consequences. In addition, they were informed that all transcripts, the analysis, and the presentation of the results of the study would be anonymous. The interviews started only after participants had signed the informed consent form.

Research tools

Informed by a literature review and a consultation with three experts (two older people's nurses and one physician with experience in Thailand's long-term care system), a semi-structured interview guide was developed and used in the data collection through individual in-depth interviews. Open-ended questions (see Table 1) were used to generate a discussion regarding participants' experiences caring for older people, the reasons for undertaking the caring role and motivations that led them to make the decision to be paid caregivers, their attitude, role, and caring management, and their training needs.

N.B. – the aim of the discussion was to explore motivation factors, attitudes toward the job, care management strategies and training needs.

Data collection

Semi-structured, face-to-face, in-depth, interviews were conducted with fifty-one paid caregivers. The interviews were held at the participant's location of choice, which was often their work (during their break time) or at their own home. All interviews took place in a private area and were conducted by only one researcher with no one else present.

All interviews were audio-recorded and lasted between 30 to 60 minutes. After each interview, the researcher summarized the key points back to the participant to check for correct understanding and appropriate interpretation

Table 1. Questions asked during in-depth interviews.

What made you decide to work as a paid caregiver?
Why did you choose to care for older people?
How do you feel about your current career as a paid caregiver for older people?
Can you describe the care environment for the older people at the hospital(s) where you work? and at home?
How do you manage the daily care of older people?
From your experience of caring for older people, can you talk through any difficulties you encounter?
Are any elements of care more difficult to provide – if so please talk me through your thinking.
Can you talk about any coping or management strategies you use – and how effective these are?
Do you wish to receive additional training pertaining to caring for older people? Prompt: If yes – explore why and the type of training the participant would like to explore.
Overall, tell me the things you like and dislike about your job.
What do you think has enabled you to be able to pursue and sustain this job over time?

of meaning. The first, the third and the fourth authors were involved in the data collection and together they discussed findings before the first author undertook the initial coding. On agreement that saturation had been achieved, recruitment was halted.

Data analysis

In this study, the qualitative interviews were audio-taped, transcribed verbatim, and analyzed thematically according to the following stages: data familiarization, coding, and theme identification and refinement (Speziale & Carpenter, 2011). The transcribed interviews were read and coded by the first author.

To enhance the rigor of the analysis, coding approaches and subsequent theme generation and refinement were discussed between the first author and the other researchers. Interview quotes from the participants were fully anonymized by the researcher team, by assigning each participant a code (e.g., "Paid caregiver No.1").

Results

Participant demographics and characteristics

Table 2 provides a descriptive overview of the participants' characteristics, including their region of origin from which many had moved to take up the role. Fifty-one participants took part in the individual interviews. The average age of participants was 52.33 years, 94% were female, the average length of time working as a paid caregiver was 11.86 years and the average monthly income was 21,254.80 Baht (590 USD).

The caregivers described the profile of the older people to whom they delivered care. Table 3 shows the mean age of the older people in receipt of care was 76.80 (range 60–96 years) and 60.78% were female. Most older people were dependent on care. Participants were hired predominantly by the daughters of older relatives in need of care. The range of time the hired paid caregivers had been in this employment was 15 days to 10 years. Most had hired paid caregivers for 15 days (17.65%).

The data from the interviews are presented below, organized around the key themes and subthemes, generated from the initial coding framework:

Motivation

Economic stability
Inability to secure alternative employment
Independent employment

Table 2. Paid caregivers characteristics ($n = 51$).

Mean age (range)	52.3 years (26–70)*
The mean length of paid caregiver (range)	11.7 years (1–25)
Gender	
Female	96.0% (47)
Male	4.0% (4)
Region of origin	
Northern Thailand	27.5% (14)
North-eastern Thailand	31.4% (16)
Central Thailand	11.8% (6)
Eastern Thailand	1.9% (1)
Southern Thailand	27.5% (14)
Marital status	
Single	7.9% (4)
Marriage	19.0% (37.25)
Widow	9.0% (17.65)
Divorce	19.0% (37.25)
Education level	
Primary school	58.9% (29)
High school	27.5% (14)
Diploma	9.8% (5)
Bachelor	5.9% (3)
Number of children	
None	11.8% (6)
1	19.6% (10)
2	47.1% (24)
3	15.7% (8)
4	3.9% (2)
6	1.9% (1)
Medical history	
No	54.9% (28)
Yes	45.1% (23)
Hours spent caring per day.	
24 hours	94.0% (47)
8 hours	6.0% (4)
Length of time as a paid caregiver	11.9 years (1–25 years)
Monthly income	21,254.90 Baht (9,000–32,200 USD)
Completed formal training course for caring for older person.	
Yes	54.9% (28)
No	45.1% (23)
Pass the refresh program.	
Yes	96.1% (49)
No	3.9% (2)

*All percentages rounded up to 1 decimal place.

Passion and the love of caring

Role of paid caregivers

Attitude toward for caring older people

A certain type of person

Low expenses

Recognition of merit

Challenges and potential

Table 3. Characteristics of the older people who were in receipt of care characteristics ($n = 51$).

Mean age (range)	76.80 years60–98)
Gender	
Female	60.78% (31)
Male	39.22% (20)
Hired by	
Daughter	56.86% (29)
Son	19.60% (10)
Spouse	13.72% (7)
Niece	7.85% (4)
Sister	1.96% (1)
The *Barthel Index* for *ADL*	
Total dependence	54.90% (28)
Severe dependence	21.57% (11)
Moderately dependence	7.84% (4)
Mild dependence	15.69% (8)
Range of illness	7 days – 20 years
The range of hired paid caregivers	2 days – 6 years

Difficult conditions for caring

Relative preferences
Caring for patients with psychosis
Caring for patients with Alzheimer's Disease
Caring for patients with pressure ulcers

Training needs

Perception of sufficient experience

Motivation

Participants reflected the motivation for them to be paid caregivers as the following:

Economic stability

The main motivation for participants becoming paid caregivers was economic stability. They perceived that being a paid caregiver led them to secure a good income, in turn allowing them to save money. It also paid better than other work and facilitated their ability to support their family members financially: "It lets me have a good income which I can use in the future. I have a substantial income and even though I have other expenses [we have] enough to support each other. In other jobs, the wage is only 300 Baht per day. I had the money for food, but I didn't save money. You can do this job for 800–900 Baht per day. You can pay house rent of 3,000 Baht per month, and 5,000 can be sent for caring for my sister and grandchildren. I can save 18,000 Baht each month." (Paid caregiver No. 36,

Female, 62 years). Older people's relatives pay the care fee for paid caregivers every day, some of them pay every three or five days depending on mutual agreement between the relatives and paid caregivers, whereas in other jobs would receive their salary once or twice a month. "Salary is ok. Income can be obtained quickly; construction work is hard work. You will receive the salary at the end of the month. Some relatives will ask me how I want them to pay."(Paid caregiver No. 20, Female, 50 years).

Twenty-four (47.06%) of the participants started their paid caring job when they were over 41 years old. Some started following a divorce. Most were educated only to primary school level and so found it difficult to secure an alternative job with a higher salary. They tended to view higher level, more comprehensive education, as unnecessary for the role of paid caregiver. In their minds, if someone had an empathetic disposition and had the appropriate and necessary skills to care for older people, they could further learn by doing the job: "Started this work at the age of 47. Don't know what to do. I can't do other jobs. It is difficult to find the job" (Paid caregiver No. 10, Female, 59 years).

Independent employment

All of the participants managed to secure their employment independently, often through their established networks. When older people's relatives or nurses contact them, if they were ready to take care of the patients, they could decide whether to take up the opportunity for the employment. If they wanted to visit their hometown, they could choose not to take on any new patients. They could set their break times and manage their workloads by themselves. So, they felt that this job was very independent. "I like it. I see, it as a good independent career. Unlike factory or office work. There are no rules. We work under our responsibilities." (Paid caregiver No. 22, Female, 33 years).

Passion and the love of caring

Eighteen of the fifty-one (35.29%) participants described how they had a passion and love of caring for patients. Some had dreamed of studying nursing when they were young, but they were limited by insufficient money to support their studies. They had to find a job to make a living. When they had the opportunity to undertake the paid caring role, they decided on this career based on their passion and happiness in caring for older people and the possibility of being paid for this work.

Role of paid caregivers

The participants had two main roles in caring for older people: being their primary caregiver and the communication of care between health care providers and relatives. The main reason that relatives employed paid caregivers

was to take care of older people with restrictede mobility around the clock. There was recognition that they should be fully compensated for this level of commitment: "I do all the activities of caring change the position every two hours, give juice, observe blood pressure and pulse oxygenation drop."(Paid caregiver No. 4, Female, 63 years).

As a key communicator of care between healthcare providers and families, participants accompanied older people to hospital appointments for follow-up care. They were therefore in a position to communicate with the medical and nursing teams about the general condition and circumstances of the patients since their last interaction with the hospital staff. At the same time, they were able to listen to healthcare providers' advice and implement this on return home. If relatives did not attend the hospital, the paid caregiver communicated the experience and instructions regarding ongoing care or further follow-up, back to the relatives at home.

Attitude toward for caring older people

The participants demonstrated a positive attitude toward their role as paid caregivers:

A certain type of person

Participants claimed that those who undertake the role of a paid caregiver must be passionate, loving, calm, and patient. Each older person requires individualized care, and their health problems are unique and often complex. In addition, participants are also confronted with the emotions of older people and their relatives and have to be adaptable and able to cope with difficult circumstances: "It is a good job. Those who can do it must love, like it, we can do it, and those who don't like, can't do this job." (Paid caregiver No. 6, Female, 61 years).

Low expenses

Participants reflected that the job has low expenses, relative to other sectors of employment, especially for those who care for older people at home. If they care for older people at the hospital, they buy meals for themselves which can be costly. In contrast, if they care for older people at home, they have low expenses; no accommodation costs (as they usually move into the house where older people live), and meals are provided free of charge. Caring at home tended to save more money than caring for older people in the hospital.

Recognition of merit

Participants valued and felt priviliged to have the opportunity to care for older people yet, at the same time felt it was mutually beneficial as in return they

received satisfying employment: “This job is good. I have helped him a lot and gained merit”. (Paid caregiver No. 17, Female, 59 years).

Challenges and potential

Some older people were wholly reliant on their relatives to make decisions on their behalf and also often varied in the degree and nature of support required. Participants explained how they need to find ways to manage when the person in their care experienced a change in their condition. Participants described how they need to be able to adapt and apply their experiences and ability to deliver optimal care. They felt that their role allowed them to show their potential: “Caring for an older person is a challenging task. [I need] to use my brain all the time. If the older person has a change of condition, I should solve the problem by applying my experience”. (Paid caregiver No. 33, Female, 51 years).

Difficult conditions for caring

The results of the study also show that sometimes participants confront the difficult conditions of caring for older people and recognized the need to develop coping mechanisms for challenging situations:

Relative preferences

Some specific situations were identified by the participants. For some families certain aspects of care can be disruptive. For example, suction during the nighttime interrupts the sleep periods of relatives. Participants found another method to decrease the time of suction by applying their previous experiences: “The last older person had a lot of secretion, but the employer didn't like me to suction at night. She couldn't sleep. I let them lie on their left or right side and head high at 45 degrees. The secretion was drained at the angular of the mouth. The nurse used to teach me while I cared for patients in the hospital.” (Paid caregiver No. 6, Female, 61 years).

Caring for patients with psychosis

The participants explained how they had sometimes found patients with psychosis to exhibit mood swings and signs of confusion and explained how they might need suppport to be able to understand their needs and communicate effectively: ”[It is] difficult to care for patients with psychosis. They won’t listen to us. They will do it by their mood, according to their imagination. We have to follow them. We couldn’t resist him. We had to talk little by little. What he did, he didn’t know. Maybe we walk away and come back when he calms down or had a good mood.” (Paid caregiver No. 42, Female, 51 years).

Caring for patients with Alzheimer's disease

Alzheimer's disease may impair memory and lead older people to forget recent events and ultimately lose the ability to independently carry out their activities of daily living (ADL). Older people may also have emotional disturbance and disorientation and may not sleep during periods of bad dreams or nightmares, which in turn, will disturb the sleep patterns of relatives and paid caregivers, many of whom suffer from some degree of sleep deprivation. "Alzheimer's patients are very difficult to care for and have a bad temper. They usually ask repeated questions and say they didn't eat. In the fact, he has a meal already. Sometimes I don't like it, and sometimes he throws things at me. I used to care 7 days and off the case." (Paid caregiver No. 1, Female, 49 years).

Caring for patients with pressure ulcers

Pressure ulcers most often develop in older people who have restricted mobility or who have to spend long periods of time in bedespecially if they are not assisted to change position regularly. When pressure sores become well established and/or become infected, they require great attention and take a long time to heal, often requiring specialist training and ongoing assessment and treatment and equipment, which in turn has cost implications for delivering adequate care. "The case that I think is difficult is the big wound, thin skin, it will swell. [It is] difficult for dressing. It may be dressed by a professional." (Paid caregiver No. 43, Female, 46 years).

Training needs

Caregivers need to be equipped with the appropriate knowledge and skills which are of central importance in caring for older people. Most of the participants in this study were trained in their caring skills by nurses at the bedside when they took care of older people in the hospital. Some, therefore were never trained in specific courses tailored to caring for older people. On 27 January 2021, the Thai government started enforcing the law to control the care business affecting older people. Both new and old business owners in the care sector are now required to obtain a license and all service providers must be registered.

In Phuket, one tertiary hospital has asystem for paid caregivers who would like to care for patients during ahospital stay: the hospital gives them acard, which they must renew every year (The Refresh Program), and they are required to attend alecture on delivering care prior to the renewal of the card. Alternatively, they can attend training courses organized by both the government and private sector for reskilling, and upskilling.

The results of our study showed two groups of paid caregivers: those who reported training needs and those who did not feel it neccessary to undertake

a training course: 54.90% of participants did not recognize their need for formal training. Specifically, we noted:

(1) Caring for older people at the hospital has the potential to build knowledge and allows carers to discuss any doubts with doctors or nurses. Inpatient wards were seen to be like classrooms where carers can learn constantly and practice skills at the bedside under supervision. This led so some participants feeling that there was no need for additional training: "Didn't go to training. I have been here for about 10 years. Patients at the hospital are the cases to learn from. I work here, the work will teach me. I see the doctors or nurses. Patients are my best teachers. Working in the hospital, I have more knowledge." (Paid caregiver No. 43, Female, 46 years).
(2) Some felt they could care for older people with their current skills and experiences and therefore felt there was no need for further training: "No [need to] train. I can do it. I think my technique is done correctly. For example, if the patient has a wound, the nurses will show me the dressing. If it is not the correct dressing technique, the nurses will tell me." (Paid caregiver No. 6, Female, 61 years).

Perception of sufficient experience

Twelve of the paid caregivers considered themselves to be sufficiently old and experienced enough in caring that they did not need to undertake any further training. "No more training, that's enough. I can do it. I am very old." (Paid caregiver No. 40, Female, 56 years).

On the other hand, some participants recognized the need to attend training for two reasons. Firstly, they had an understanding that in the future it would be compulsory for those who want to be paid caregivers, to have a training certificate in caring for older people. So, they want to prepare for this requirement: "I want to go to training. I want the certificate. May be used in the future." (Paid caregiver No. 34, Female, 50 years).

Secondly, they wanted to gain more knowledge. This is because knowledge can be learned infinitely. In addition, the body of medical knowledge changes all the time. So, 45.10% of participants wanted to go to training: "I want to learn more. Sometimes theory and practice are not the same. If I don't understand, I can ask, look and remember." (Paid caregiver No. 43, Female, 46 years).

Participants also described some specific opinions about the advantages and disadvantages of providing care in the home and hospital environments and there are elaborated upon below. Most of the participants cared for older people both during hospitalization and at home. In their minds, both settings have advantages and disadvantages as shown in Tables 4 and 5

Table 4. Pros and cons of for caring older people at home.

Pros	Cons
1. Care consistently for the same patient 2. Quiet work environment. 3. Carers have the time to rest and sleep well. 4. Provides a continuous income 5. Potential to save money on rent (when living in the home). 6. High levels of privacy 7. Able to work directly with patient and family 8. Low risk of infection. 9. Self-adjusting time for patient care activities.	1. Have to get to know new families each time2. Carers have to work largely alone and in isolation. 3. Difficult to find someone to take care of the patient if they want to go back home. 4. Some relatives are unappreciative, and some relatives have different opinions5s.Some houses have CCTV cameras, making them uncomfortable. 6. Loneliness. 7. Need to make decisions about caring by themselves. 8. Range and breadth of knowledge can become limited if caring for only one patient for a year.

Table 5. Pros and cons of for caring older people in the hospital.

Pros	Cons
1. Carers gained a lot of knowledge due to the number and range of patients they cared for.2. The main responsibility is to support the older person's activity of daily living. Nurses will give nursing care to patients and observe the older person's clinical status.3. Carers were able to make friends, especially in the general ward.4. They have a break time after older people are discharged.5. It is easy to come back home from work.6. If the older people had health problems or problems with care, they are able to ask nurses or doctors.7. Nurses and doctors help to make decisions about caring for the older people.8. They can work independently.	1. It is crowded, especially in the general ward; there are many patients and many relatives come to visit patients. 2. Carers have a little rest, particularly in the general ward. Sometimes the ventilation sounds all the time or the new patients are admitted in the nighttime. 3. They have to pay for their accommodation. 4. A greater risk of infection in hospital environment. 5. They have to wake up early to assist with personal hygiene before day shift nurses start their shift at 6.00 a.m. 6. General ward environment not conducive to rest and sleep.

Participants reported specific benefits of providing care in the home environment, including the continuity of care to the same patient in a private and quiet environment which in turn facilitated periods of rest for the caregiver. They also reported being able to manage their own time and that spent with the person in their care and had control over the range of caring and social activities undertaken with their patient. Financial implications included job stability and security along with the added benefit of making savings on rental income elsewhere, when they lived on site. They appreciated having direct one-to-one contact with their patient and also that the home environment felt protected from the higher risk of infection to the patient that might have been encountered in a hospital setting.

On the downside, participants reported that they sometimes felt lonely or isolated, having to provide all patient care on their own and struggled to find a replacement carer should they wish to take a break from the role for holiday or to visit their own families. They also recognized the investment needed each time they embarked on a new caring relationship, having to get to know the patient and their family anew. They also reported that relations were

sometimes difficult with the relatives of their patient, particularly when opinions differed on the best way to provide care, or where they felt undervalued. They also worried about losing their broader clinical knowledge and skills when their sole focus was on one specific patient for extended time periods.

Participants reported specific benefits of caring in a hospital environment, including the potential to increase and diversify their knowledge due to the number of patients in their care, with a great variety of health conditions and caring needs. They described the main focus of their role being with the assistance with the activities of daily living, rather than specialized clinical care, which fell within the remit of qualified nursing staff. They appreciated having nurses and doctors on hand should they ever need to ask any questions or seek guidance about any elements of care and valued being involved I this joint decision making. Carers enjoyed the social aspects of the hospital environment. Allowing them to forge new acquaintances and friendships and valued the time in between patients following a discharge home.

Less positively, participants reported how the hospital environment could be very busy and over-crowded, especially when relatives came to visit and this, along with constant noises from medical equipment, including through the night did not make for a restful environment. Shifts could be very busy and posed a greater risk of infection compared with the home environment. They also felt restrained by having to work within the confines of existing ward routines. Carers also reported having to pay for their accommodation in the hospital which was not well received.

Discussion

Although conducted in a single province in Thailand, the findings of this study resonate with the wider international literature in this growing field. Most of our participants were female. This is in line with the results of previous international studies (Dimakopoulou, Vamvakari, & Sakka, 2020; Feinberg & Skufca, 2020; Kelly, Morgan, & Jason, 2014; Osterman, 2018). The average age was 52.33 years old (range 26–70) which is not dissimilar to other country-contexts. Sims-Gould and Martin-Matthews (2015) reported that the average age of paid caregivers in British Columbia, Canada is 50 years old (Range 27–65). Most of the participants were married or divorced (37.25% in each group), again similar to other settings for example in the USA where Kelly, Morgan, and Jason (2014) found that one in four paid caregivers was divorced and possibly, therefore, needing financial independence. 56.86% of participants had finished primary school and this has also been seen previously in the context of the Global North: Hussein and Manthorpe (2005) found that most paid caregivers come from poor families and have relatively low levels of formal education. The majority of the older people being cared for were female (60.78%) and the average time of caring was 22.75 hours per day, with 94%

taking care of older people 24 hours a day, similar to findings from other country contexts including Greece (Dimakopoulou, Vamvakari, & Sakka, 2020) and the USA (Feinberg & Skufca, 2020). The main motivation for the decision to become paid caregivers was based on economic stability. The results of the study are similar to the study of paid caregivers in Bangkok, Thailand (Singtuen, Monkong, & Sirapo-Ngam, 2018), Canada where research has shown that one financial considerations are a key factor which attracts people to become home support workers (Sims-Gould, Byrne, Craven, Martin-Matthews, & Keefe, 2010). Other reasons included the inability to find alternative employment. Because 47.06% of participants started this job at the age of 41 or older, they felt that it would be difficult to find a job based on their age. A similar finding has been reported elsewhere: 37.1% of participants who chose to become caregivers were unable to obtain other jobs (Lindquist et al., 2012). 35.39% of participants love caregiving and reflected how the job comes with a degree of independence. Singtuen, Monkong, and Sirapo-Ngam (2018) note how the love of caregiving leads participants to understand and sympathize with older people.

Participants knew that they were hired as a substitute for caring for older people's relatives. Therefore, the participants were in in a good position to closely observe and note any changes in condition of the people in their care. Reckery, et al., (2021) showed in the USA the contribution that paid caregivers made to the well-being of relatives, and the recognition that paid care may be beneficial for relatives. This study also found that participants play the role of an intermediary of care between medical personnel and relatives. Carers communicated with doctors about patient symptoms during follow-up consultations or when the relatives were not present, during hospitalization. As Stone and Bryant (2019) argued: paid caregivers are the eyes and ears of the health system.

The factors that motivated participants to become paid caregivers could be categorized according to Herzberg's two-factor theory: motivation factors are intrinsic factors such as recognition from older relatives, attitudes, the opportunity to present their potential in this challenging work, and work conditions. Hygiene factors are extrinsic factors such as flexible scheduling and independent job, wage, benefits, job security, and working conditions. This is consistent with Sims-Gould et al.,'s (2010) findings that home health workers had both intrinsic and extrinsic that attract employment as home support workers.

54.90% of our participants did not recognize their own training needs, because they thought that their experiences were sufficient. Some participants wanted training needs to include the topics CPR, caring for an unconscious person, dressing pressure ulcers, lung percussion, using an oxygen concentrator, sterilization techniques, suction, and blood glucose test. These are interesting areas for debate as it raises the discussion around appropriate scope of practice and the intersection of

skills across the qualified and unqualified health care sector. Sims-Gould et al. (2010) found, paid caregivers' tasks had four categories: acute care, management of chronic conditions, promote general health, and promote mental health and well-being but half of their tasks were not included in the basic training. Therefore, paid caregivers should be given clarification around their tasks and competence which will guide the scope of training for paid caregivers (Reckery et al., 2019).

Strengths and limitations

The strength of this study is that it has gained a significant amount of insight into the participants' views about their caring role. However, a limitation of this study was that all of the participants were freelance and found employment through their networks. They were controlled by the hospital's rules if they cared for older people during hospitalization and undertook the annual training review within one day each year. Future studies with paid caregivers working with employment agencies or in the nursing home sector would contribute further evidence and insights.

Conclusion

We aimed to explore paid caregivers' motivation factors, attitudes toward the job, care management strategies and training needs and undertook 51 in-depth interviews with paid caregivers who constitute a growing workforce in caring for older people with functional impairment both in Thailand and internationally. This study uncovered important views around decisions to become paid caregivers who provide care directly to older people. They perform many health-related tasks and they may face challenging work conditions. Training and skills for caring for older people are important for the quality of care but levels of experience may vary greatly amongst those providing care and training needs to be developed according to need but with a careful review of scope of practice for this unregistered workforce.

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IRB approval

IRB protocol/human subjects approval numbers: Phuket Rajabhat University Research Ethic Board No. PKPH 2564/018.

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