Policy paper

Building a cradle-to-grave care economy for Malaysia

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*Insights from Tan Sri Dato' Seri Prof Emerita Dr Sharifah Hapsah and Prof Dato' Dr Tengku Aizan Tengku Abdul Hamid, along with other panellists and delegates at the care economy roundtable and PRAXIS Conference in 2023 were invaluable in shaping this policy paper.

Executive summary

- As Malaysia's demographic transition deepens amid an aging society and a shrinking labour force, demand for care needs will surge, and its impacts will be felt most acutely by women who perform the bulk of unpaid care work. This creates an imperative for Malaysia to build a cradle-to-grave care economy that responds to care needs – encompassing child to elderly care and forms of specialised care like disabled or palliative care.
- The care economy is a potential driver of economic growth. If the unpaid care work produced in Malaysian homes every day could be valued in GDP figures, it would create about RM379 billion, accounting for a fifth of the service sector.
- By removing care constraints preventing participation in the labour force, Malaysia stands to enable 3.2 million workers to engage in paid employment and unlock 4.9 percentage points in GDP growth in 2022 alone.
- However, the formation of an equitable cradle-to-grave care economy in Malaysia is undermined by several factors, including: a heavy reliance on informal care with limited support for caregivers; an absence of social care from the country's social protection framework; a lack of social care services that meet preferences; inadequate legislation governing the care economy and workforce; and the general perception that care is predominantly a "women's issue".
- To build an inclusive and equitable cradle-to-grave care economy, Malaysia will need to realise a far more inclusive approach, by reframing and revaluing care as a public good, adopting a life cycle approach to care, while also ensuring that all income groups have access to a baseline of social care.
- At this juncture, public investment and involvement to set the foundations of a cradle-to-grave care economy are necessary. This would entail pursuing four important policy directions, such as integrating social care into the social protection framework, investing in community-based care infrastructure and services, establishing policy roadmaps and corresponding governance structures, and instituting system-wide gender-sensitive and care-centred approaches.

Glossary of definitions

- **Care work:** Spans 1) direct, personal and relational care, such as caring for children, ill partners and relatives, and 2) indirect care, such as cooking and cleaning.[1]
- **Care economy:** Consists of productive work, either in paid and unpaid labour and services that support caregiving in all its forms, primarily for dependent groups like children, elderly, the disabled and the ill.
- **Cradle-to-grave:** Refers to a life cycle approach to the care economy where care services span the spectrum – for e.g. from child to elderly care.
- **Social care:** Refers to all forms of personal care and assistance for dependents like children, young people and adults who require support. Unlike healthcare, which focuses on the improvement of health through services provided by healthcare professionals, social care aims to enhance quality of life through support in daily activities provided by a caregiver.[2]
- **Informal caregiver:** Denotes individuals, often family members or friends, who provide care on an unpaid basis without formal training or compensation.[3]

1 Introduction and the case for care as a driver of economic growth

Investing in Malaysia's care economy is among the nation's most crucial policy priorities in the coming decade. Malaysia is already undergoing rapid demographic change, with projections indicating it will become an aging nation by 2030 as fertility rates decline.[4] This demographic shift is set to increase the old-age dependency ratio while reducing the proportion of the population that is of working age.[5] Concurrently, evolving family structures and a decline in multi-generational households are leading to more people living apart from their families.[6]

These socioeconomic and demographic shifts highlight a surge in care needs – which are set to grow in the coming decade as Malaysia navigates the transition into high-income economy.[7] However, the current care infrastructure, both formal and informal, is inadequate in terms of affordability, accessibility and quality to meet this growing demand for care – creating a growing "care gap" that has far-reaching implications for the socioeconomic fabric.

If this growing care gap grows unchecked, it will be families, particularly women, who will bear the brunt of its consequences.[8] Without greater investment in the care economy, care responsibilities will continue to fall largely on families and informal caregivers. This situation will exacerbate the already high unpaid care and domestic work burdens for women in Malaysia.[9]

In the short term, this means women reallocating time from formal employment to caregiving, leading to reduced work participation and intensity.[10] Over the long term, it risks hindering human capital accumulation and labour productivity growth, while setting back years of progress on improving women's economic outcomes. As such, care is a strategic issue, central to the question of nation-building, economic development and social inclusion.

Indeed, most care work is currently provided informally by families, primarily women. In a week, women spend at least 10 more hours on care work than men.[11] This care and domestic work is typically not remunerated, excluded from GDP calculations and does not come with the attendant social and labour protections afforded to a full-time worker in paid employment.

Using standard methods of approximating the market value of domestic work,[12] our analysis indicates that if the unpaid care work produced in Malaysian homes every day were valued in national GDP figures, this would create about RM379 billion in economic value.[13] In fact, unpaid care and domestic work would account for about a fifth of the service sector alongside market services (Figure 1). As a standalone services subsector, it would form the largest sector after manufacturing if valued in GDP (Figure 2).

Fig. 1: Valuing unpaid care and domestic work would contribute RM379 billion to Malaysia's GDP

Unpaid care and domestic work v GDP by sector, in RM billions

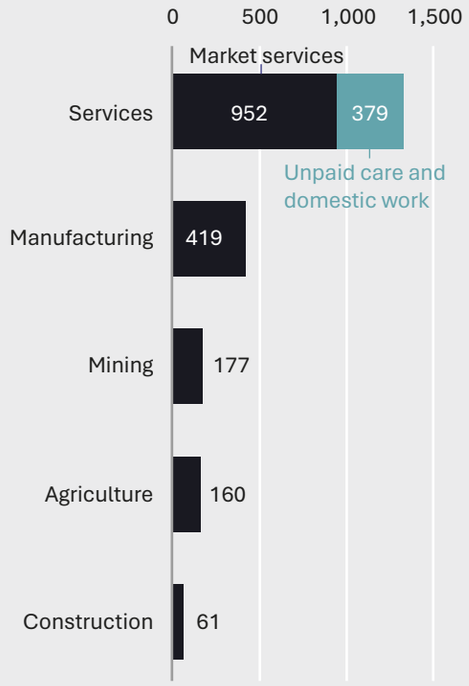
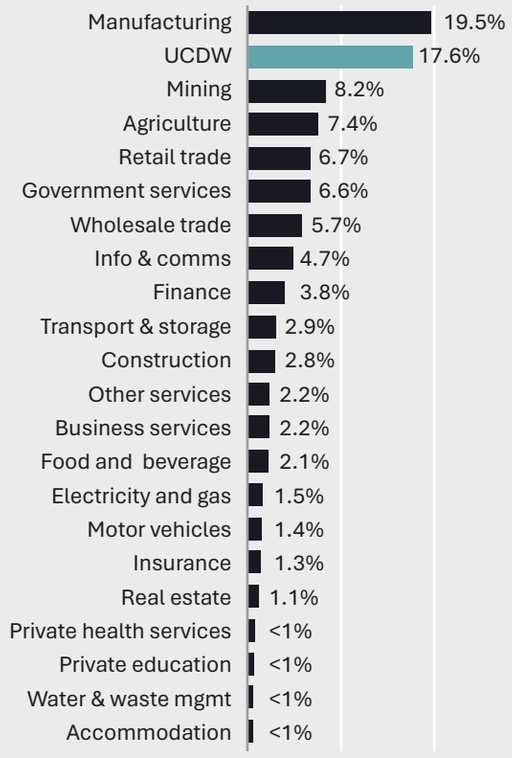


Fig. 2: Unpaid care and domestic work is the second largest economic sector after manufacturing

Unpaid care and domestic work as a standalone subsector (percentage share of GDP)



Source: Authors' estimates using data from Indeed[14], Department of Statistics Malaysia,[15] Khazanah Research Institute[16]
Note: UCDW = Unpaid care and domestic work. GDP figures are in current price local currency units. See Technical Appendix A for details on these estimates.

These figures underscore the potential gains from valuing care work, not least for Malaysians who want to work but are unable to because of family and care duties. In 2022, more than 3.1 million people remained outside the labour force due to family obligations and housework and a further 21,100 remained in part-time employment for the same reason.[17] Together, this represents about 3.2 million Malaysians who were forced to reduce work hours or drop out of the labour force because of domestic work obligations, of whom 98% are women (Figure 3).

We estimate that the direct effect of potential market gains from fully enabling 3.2 million workers, both on the margins to participate in paid employment or go from part-time to full-time, is about RM77.2 billion in economic value per year.[18] This adds about 4.9 percentage points in GDP terms for 2022 alone (Figure 4). Additionally, as most of these 3.2 million workers are women, this is projected to increase women's labour force participation from 56% in 2022 to about 83% – effectively closing the gaps in workforce participation between women and men, and beyond Malaysia's current target of 60%. These estimates represent the potential of removing the constraints to work because of care and domestic obligations, restoring freedom and choice for millions of workers to engage in market employment.

Fig. 3: About 3.2 million people remain outside the labour force or in part-time work because of care obligations

Number of people outside the labour force or in part-time due to care obligations

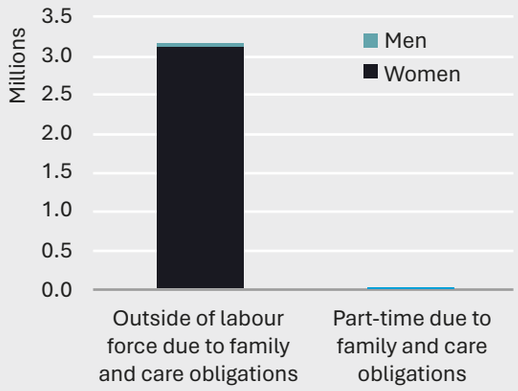
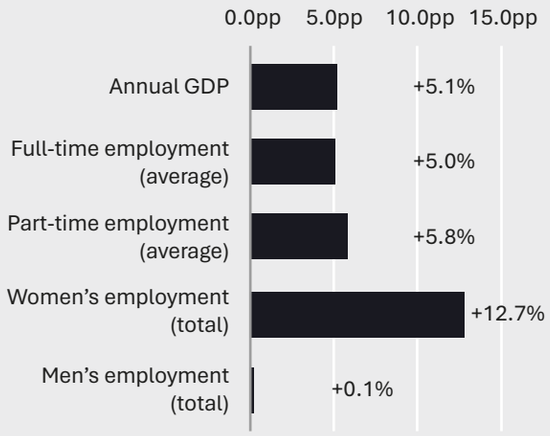


Fig. 4: Large potential gains to growth and employment from reducing labour supply constraints

Projected gain in percentage change from 2022 figures



Source: Authors' projections using data from Department of Statistics Malaysia[19]
Note: Part-time defined as working less than 30 hours. See Technical Appendix B for more details on these estimates.

These estimates do not factor in short-term labour market frictions and/or changes to labour force structure, nor do they model the welfare impacts that could arise from shifting home production to market services. Additionally, it also focuses solely on direct impacts and excludes the knock-on benefits of stronger labour market attachment and potential human capital development.

Yet, these preliminary estimates paint a conclusive picture: in the absence of any policy change in public investment in care, Malaysia stands to lose out on significant gains in both economic growth and gender equality. Furthermore, Malaysia will continue to contend with a growing care gap, in turn perpetuating barriers to self-determination and limiting choices for millions of Malaysians who are forced to make their labour supply decisions based on their care responsibilities.

At this juncture, the imperative for greater public investment in Malaysia's care economy has never been clearer, not least because care work, both paid and unpaid, enables all other forms of work in modern society.[20] Care work creates benefits that accrue not just to the direct users of care, such as households, families and dependents, but also creates wide-ranging positive externalities that benefit the broader economy and society. Greater provision of care, thus, increases growth and productivity while promoting greater equity.[21] Expanding public investment in closing care gaps would enable millions of Malaysians and their families to make the choice of shaping their desired socioeconomic outcomes. As such, Malaysia stands to benefit from building a cradle-to-grave care economy, recognising and responding to care needs across the spectrum, from child to elderly care.

2 Policy gaps

Care must be recognised as a strategic issue central not only to daily life but to social wellbeing and national development. To do so, various policy gaps must be addressed to ensure solutions respond directly to the realities faced by women and families. This section presents an assessment of existing policy gaps in the current approach to social care, especially as it relates to the two primary care needs – child and elderly care.

2.1 Heavy reliance on informal care arrangements

Care work is primarily undertaken informally in Malaysia, often going unpaid or underpaid, and is carried out primarily by women family members. This is true for both elderly and childcare.

When it comes to elderly care, the high costs of engaging formal care services coupled with normative views on filial piety leave families and communities almost entirely responsible for the care.[22] Malaysia's strategies for elderly care provision emphasise the role of familial care through encouraging adult children to care for elderly family members. Public investment in social care in Malaysia focuses primarily on direct service provision through institutional care, restricted to those who are poverty-stricken, alongside grants for civil society.[23]

Elderly care is, thus, propped up by informal caregivers, with some reliance on formal care for healthcare needs.[24] Looking closer, most informal caregivers were women aged 36-59.[25] This indicates that informal caregivers continue to provide care well into old age. Despite intergenerational support in Malaysia remaining strong,[26] this model is increasingly being strained by urban migration, financial challenges and inadequate housing.[27]

As Malaysia ages, care needs will not only grow but also become more complex, because of the elderly requiring more specialised forms of care in line with their health status. The majority of elderly carers in the National Health and Morbidity Survey suffer from at least one illness and have little to no adequate training to cater to complex care needs.[28]

Similarly, for childcare, close to 99% of children aged three and under were cared for informally by family members, including grandparents, unregistered childcare centres, and/or other informal care arrangements in 2018.[29] The percentage of children in the formal care sector remains relatively small, with 2019 data indicating that enrolment rates for children aged 0-3 and 4-6 years old in formal childcare centres and preschools falling short of government targets.[30]

This reliance on informal caregiving may prove unsustainable over the long run, with Malaysia's care burden across the spectrum set to increase.[31] This is especially the case as caregivers age while the number of family members that can be relied on for care decrease, and as urbanisation and housing circumstances erode multi-family living. If Malaysia is to continue relying on informal caregivers as the backbone of the care economy, this will require more targeted public support, especially because the costs of care are borne by informal caregivers through lost earnings, pensions and diminished career progression.[32]

Box article 1: Wellbeing of older persons in Malaysia – evidence from the Malaysia Aging and Retirement Survey (MARS)[33]

By Prof Datuk Dr Norma Mansor

The wellbeing of older persons in Malaysia is significantly influenced by support provided by both family and community. The Malaysia Aging and Retirement Survey (MARS) was conducted nationwide to track their overall wellbeing and understand diverse aspects of aging, retirement and related challenges in the Malaysian context.

Overall, older respondents in Malaysia reported positive wellbeing. Among the 2,137 respondents aged 60 and older, more than 70% reported feeling satisfied and happy with their lives, indicating a generally positive emotional state. Further, an overwhelming majority reported leading meaningful and purposeful lives. Upon closer examination, there are significant factors that determine elderly wellbeing in Malaysia, which necessitate considerations in care economy policies. These include:

Intergenerational living arrangements and family support: strong family and community connections are an important factor to elderly wellbeing. The survey found that a key factor to social connection is that many elderly respondents live in three-generation households, which include the respondents themselves, adult children, grandchildren and/or parents. About 17% lived with their spouse only, while a small percentage (6%) lived alone. About 57% of respondents were looked after by adult children while 32% saw spouses as their primary caregivers in old age. At the same time, elderly respondents indicated that their adult children were relied on to accompany them for outpatient treatment (39%) and hospitalisation (44%). Overall, Malaysians have a strong preference (89%) for family care and support. This evidence underscores the importance of empowering families as a key policy option.

Aging-in-place: older respondents indicated a strong preference for spending their golden years in their own home. Only a small percentage (16%) were prepared to live in assisted living facilities. A high proportion (87%) reported that they were prepared to look after their own health. However, they still required support within their own homes to ensure safety and assistance in daily activities as indicated by 69% of respondents who expressed worries about falling. A smaller percentage (15%) expressed feelings of helplessness and challenges in problem solving. About 64% agreed that they would need long-term care. Among those living with non-communicable diseases (NCDs) that limited their daily activities, this number was slightly higher, coming up to about 71%. As such, external help provided by trained social workers, alongside home-based social care workers, is an important solution to assisting elderly living in their own homes with personal care, domestic chores and emotional support.

Health conditions: in terms of self-reported health, 40% of the respondents considered themselves to be in good health. However, the proportion diagnosed with at least one NCD is high (72%). Of this number, at least 32% admitted having NCDs that limited their daily activities. Less than half of the respondents (49%) participated in physical exercise while about 14% have difficulty in the activities of daily living (ADL). Altogether, these health risks pose multifaceted longevity concerns that shape the experience of aging. Malaysia will need to better consider the intersections between health and social care to address elderly wellbeing in a holistic manner.

To put the MARS findings into perspective, it is in Malaysia's best interest to incorporate aging as a development agenda. This is in line with the Madani Economy framework where national development and productivity must be premised on the new parameters set by the twin challenges of an aging population and a shrinking workforce.

About MARS: MARS was conducted nationwide to understand and track the overall wellbeing of older persons. Wave 1 was conducted in 2018/19 and a large portion of them were interviewed again in 2021/2022 – 5,613 and 4,821 respondents of 40 years and older respectively took part in this longitudinal study.

2.2 Absence of social care from social protection framework

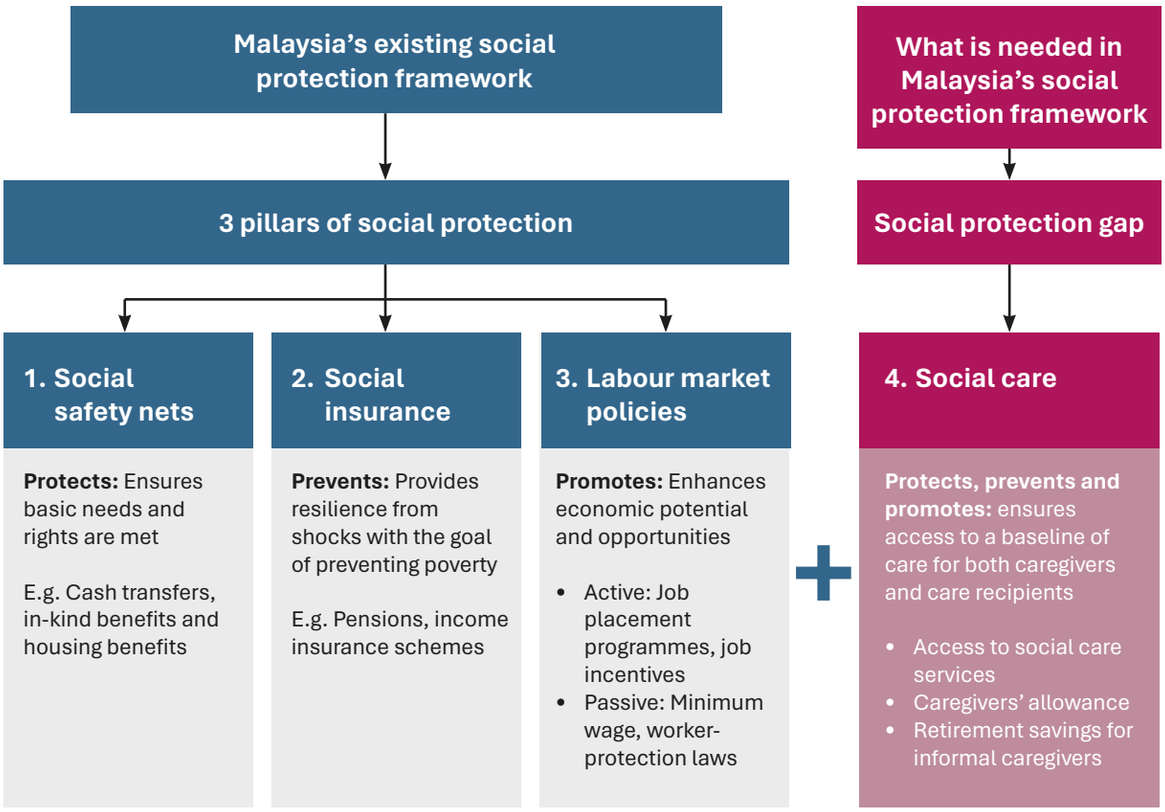
There exists a social care gap in Malaysia's social protection framework. Currently, the framework can be organised into three pillars: (1) social safety nets aimed at poverty eradication; (2) social insurance for income replacement; and (3) labour market policies (Figure 5).[34]

Respectively, these serve protective, preventive and promotive functions. The current framework revolves around formal employment, with both transfer and social insurance mechanisms tailored around an income-tested, needs-based model that determines who does and does not receive support, including non-financial healthcare support for the elderly through the public health system.[35] However, while the tax-funded healthcare system provides relatively affordable and efficient medical care for the elderly, it notably lacks coverage for social care.[36] This absence of social care means that low-income women and families will often not have access to a baseline of care, as even public social care services are low in coverage.

Malaysia has since made headway in recognising unpaid care work by extending social safety nets to housewives through the i-Suri and i-Sayang under the Employees Provident Fund (EPF) and the Housewives' Social Security Scheme under the Social Security Organisation (Socso). The i-Suri and i-Sayang initiatives offer housewives and women heads of household monetary incentives based on their contributions and allows husbands to transfer a portion of EPF contributions to their wife's account respectively. Meanwhile, the Housewives' Social Security Scheme insures housewives from injury or invalidity. However, these initiatives do not fully compensate informal caregivers for losses incurred from unemployment and reduced income – with the exception of the i-Sayang, which was recently expanded to include househusbands – targets only women, limiting the possibility of men taking on the role of informal caregivers.[37]

Moving forward, integrating social care as a fourth pillar in the social protection framework is important to meet the growing demand for care services in Malaysia equitably (Figure 5). In fact, factoring social care into social protection could serve all three functions of being protective, preventive and promotive. By bridging social protection with access to expanded social care services, it could ensure basic care needs are met and, if effective, could eventually promote the economic opportunities of informal caregivers by facilitating their entry or re-entry into the labour market.

Fig. 5: The social care gap in Malaysia's social protection framework



Source: Adapted from Social Wellbeing Research Centre's National Social Wellbeing Blueprint[38] and Bank Negara Malaysia's Economic and Monetary Review 2020[39]

2.3 Lack of diversity and depth of social care services to meet care preferences

There is a need for broader configurations of social care for children and the elderly in Malaysia that are in line with the care preferences and working arrangements of different families.

Malaysia's elderly indicate a strong cultural preference for aging-in-place, in their own homes and communities. This is at odds with the public social care services that are available – currently, elderly public care services in Malaysia are focused on institutional care designed to serve only extremely vulnerable elderly individuals who lack family support or financial resources.[40] There are also public support services and temporary respite care available for when family caregivers are unavailable[41] but the number of beneficiaries of these programmes is small. Overall, public social care services are focused on providing care to the elderly, on an individual basis, and is less focused on addressing long-term caregiving systematically.[42] As such, there is a mismatch between care preferences of the elderly and available public social care services.

Private care services offer a wider configuration of care services beyond institutional care that can certainly respond to this demand. However, given that elderly care is resource-intensive in nature, private social care services are accessible only to those who can afford them, making coverage both low and uneven.[43] Establishing a wide range of care infrastructure that not only responds to care needs but is also affordable and accessible is of crucial importance.

Meanwhile, for childcare, there is also a mismatch between the demands of parents with available services. Only one in 10 registered childcare centres is listed as "workplace childcare centre",[44] despite parents continuously ranking workplace childcare centres as their most preferred childcare arrangement.[45] The majority of workplace childcare centres are placed in public sector institutions and multinational corporations,[46] which render them inaccessible to nearly half of all Malaysian workers.[47] While the government has made many attempts to encourage the establishment of workplace childcare arrangements by providing incentives like tax reliefs, this has not led to a significant increase in the number of workplace childcare centres. Employers cite resources and cost as main barriers, making it a difficult commitment for SMEs.[48]

2.4 Gaps in legislation governing care and professionalisation of care workforce

Malaysia lacks consolidated legislation and policy on the care economy as well as regulatory frameworks to sustain a highly qualified social care workforce in the long term. These gaps in legislation and policy need to be addressed to build the necessary foundations of a care economy and ensure a well-trained workforce to meet care needs.

For one, there are existing legislations relevant to the care economy – but they are distributed and fragmented across various acts and policies. The three most relevant legislations regulating the provision of care services are the Childcare Centre Act 1984, Care Centres Act 1993 and Private Aged Healthcare Facilities and Services 2018. These are regulatory frameworks that posit minimum standards of care covering issues, such as registration, licensing, control as well as inspection of care centres – which are essential in governing the quality of formal care centres.

Malaysia has also outlined policy roadmaps, specifically for the elderly through national-level blueprints like the National Policy for Older Persons 2011 under KPWKM and the National Health Policy for Older Persons 2008 under the Ministry of Health (KKM). These contain strategies towards addressing elderly wellbeing. The Senior Citizens Bill and the Social Work Profession Bill, which are currently being drafted, will also be relevant.

Meanwhile, when it comes to childcare, regulatory standards are primarily guided by international principles stemming from the Convention on the Rights of Child (CRC). Taken together, the existing legislations and policies in place lack a cradle-to-grave approach that recognises care needs across the life cycle. To formalise Malaysia's commitment to building a cradle-to-grave care economy, the country needs streamlined legislations and strategies to address the care economy in the aggregate, outlining strategies for state involvement and investment, as well as regulatory frameworks that are applicable across public and private social care services.

Further, legislation or policies to professionalise social care work are inconsistent. Childcare policies that support care workers through building networks, facilitating skills training and peer support are also notably missing.[49] This is particularly important because social care workers are generally seen as engaging in low-skilled work. They report being underpaid, overworked, with limited options for career progression[50] – which undermine labour supply for the care workforce.

Professionalising social care work means regulating and registering social care workers, raising and streamlining formal qualifications, providing opportunities for training, and outlining the terms and conditions of social care work clearly under the Skills Development Department (JPK) in the Department of Social Welfare (JKM).[51] This would go a long way towards valuing social care work and recognising it as a profession in its own right. In this regard, the Social Work Profession Bill, aimed at professionalising social work, is a good example of legislative action and a first step that should also be adopted for social care workers.[52]

Box article 2: Social worker perspective: what the Social Work Profession Bill means for the care economy

By Dr Teoh Ai Hua

Social workers are among the professional occupation groups central to the functioning of a care economy. As care is a core pillar of social services, social workers play a key role in its delivery. In fact, social workers play a complementary role to care workers and need to be considered as a key component of the care ecosystem. Where care workers typically engage directly with clients in daily activities and personal care, social workers engage with the welfare system to effect broader changes.

Not only are social workers trained to work with vulnerable individuals, families and marginalised groups, they also bridge government agencies, civil society and business entities with the goal of enhancing social wellbeing. Qualified social workers are thus equipped to address complex situations like child abuse and neglect, domestic violence, health and mental health crises. They also conduct needs and risk assessments for older persons and people with long-term dependency issues and formulate corresponding care plans.

As such, there have been movements to professionalise social work in Malaysia since the 2010s, culminating in the Social Work Profession Bill. However, the bill, which is aimed at recognising and regulating social work, has yet to be tabled in Parliament, following successive delays since its drafting. If the bill is passed, it stands to be a foundational legislation that could contribute to a viable care economy in Malaysia.

This bill is important as the social welfare sector, including social care, remains the least regulated in Malaysia, in comparison to other sectors like healthcare and education. This is especially true where the qualifications and training of the social welfare workforce are concerned. Legislations like the Child Care Centre Act 1984 and the Care Centre Act 1993 stop short of setting qualification standards for the workforce – with the exception being for childcare providers *(pengasuh)* whose qualifications require a certificate of Kursus Asuhan dan Didikan Awal Kanak-kanak PERMATA (KAP). In fact, JKM as the primary authority has yet to enforce these qualifications strictly as there remains many unregistered childcare centres and providers without minimum qualifications. Even so, these requirements fall behind in comparison to the professional standards for workers in the health and education sectors.

More alarmingly, the qualifications of social care workers for elderly, people with disabilities and vulnerable children are not regulated. This means there are no standards or minimum qualifications – which pose major concerns for the quality of care, running the risk of unqualified workers being hired to reduce costs.

In contrast, social work is the most advanced in terms of tertiary education. There are 10 institutions of higher learning that provide social work education at diploma and degree level. For postgraduate education, at least three public and/or private universities offer social work at the master's level and PhDs in social work are offered at seven public universities. Given this, regulating social work through the Social Work Profession Bill would be much simpler and more straightforward, as compared to other occupational groups within the social welfare system which often have lower qualifications or do not yet have relevant courses offered by institutions of higher learning or training.

The bill would represent an important first step towards streamlining and raising standards of care. A similar form of legislation focused on social care workers is equally important for establishing a care economy that is peopled by a highly qualified workforce.

2.5 Perception of social care as a predominantly 'women's issue'

While the government recognises social care as an issue of national interest, this has been typically approached from a narrowly defined gendered outlook, with KPWKM as the sole ministry to implement care-related policies.[53] Here, care is tied up with pervasive gender and filial norms, resulting in relatively modest levels of public investment because social care is seen as first and foremost, the responsibility of the individual and family.[54] However, approaching social care primarily as a women's issue undermines the fact that to build a viable cradle-to-grave care economy that is a source of growth for Malaysia, it needs to be addressed from a multisectoral approach that spans various ministries.[55]

3 Establishing a vision of a cradle-to-grave care economy for Malaysia

At this juncture when Malaysia is designing policies to build its care economy, it is of critical importance that the country determines how comprehensive or expansive its care economy should be. This section maps out a vision for the care economy, by making aspirational comparisons with other countries, and highlighting key guiding principles for the formulation of an equitable cradle-to-grave care economy.

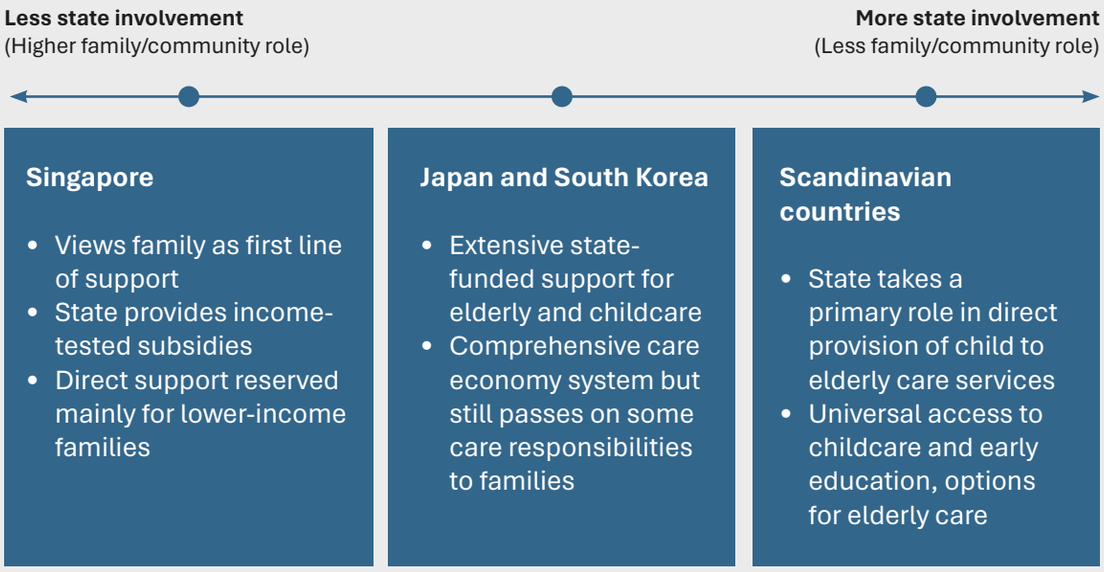
First off, benchmarking against countries that have similar cultural and societal norms is an important step as it allows us to take stock of the mix of policy tools available. Countries like Japan, South Korea and Singapore have placed similar cultural emphasis on the role of families in providing care. Despite that, these countries have built robust care economies with various levels of state involvement.

Both Japan and South Korea's approach combines several policy tools to ensure care: social protection schemes to support the elderly coupled with either public or subsidised services, while maintaining emphasis on family support and community involvement.[56] Both have in place comprehensive social safety nets for the elderly and public care services,[57] alongside a thriving private care industry.[58] Meanwhile, Singapore continues to maintain family as the first line of support, especially for elderly care,[59] where benefits are primarily targeted at low-income groups. These care models employ a range of policy tools like subsidies, direct provision of services and social protection through long-term care insurance (LTCI).

The Scandinavian care models are based on the principles of universalism. Here, social care services are widely available and accessible, designed to be gender-sensitive, are utilised by all socioeconomic classes and run by municipalities.[60] This model represents the most comprehensive provision of a baseline of care.

As such, these care models serve as useful points of reference for Malaysia in designing the accessibility and equitability of its care economy. Figure 6 outlines where these three countries stand in terms of state involvement in social care vis-à-vis family/community with Scandinavian countries representing the highest level of state involvement as direct service providers, and Singapore at the other end with higher involvement by family and community. While these represent high-income countries whose care models remain largely aspirational for a middle-income country like Malaysia, policy lessons from these countries indicate the need for less developed countries to scale up such benefits over time, starting with less generous and means-tested benefit packages and expanding them as financing becomes more accessible.[61]

Fig. 6: Care models of other countries



Source: Author's own

3.1 Approaching care as public good

As Malaysia ages, it is crucial that the approach to the care economy involves reframing social care as a public good to ensure affordability and accessibility by all income groups.

Malaysia's care gaps are largely indicative of a longstanding public under-involvement and underinvestment in social care. These low levels of state involvement and investment in social care underline Malaysia's approach to social welfare – with the government taking up what can largely be seen as a "residual role".[62] When compared to domains like healthcare and education, care-related social welfare services stand as one of the nation's most inadequate support systems.[63] Spending on health and education in Malaysia is already low for its level of development[64] but it is still 1.5 times and twice higher than share of expenditure allocated for social care.

Social care has thus been relegated to three realms: privatised to the family through emphasis on informal caregiving, supported by the voluntary sector (i.e. civil society organisations), and increasingly, to the market. This low level of state involvement aligns with the government's intended shift from playing a role as a "supplier and provider" to a "purchaser and regulator".[65]

As a result, the care economy is developing more efficiently in the private sector, as evidenced by the general range of services available. However, while the private social care sector is a crucial pillar of the care economy, this alone will be insufficient to meet Malaysia's growing care needs – nor is it widely accessible to low-income and vulnerable groups.[66] The nature of care as an inherent public good means that market forces tend to underinvest and underprovide care in equilibrium. A total reliance on the monetisation of social care is far from a comprehensive or equitable solution towards addressing care gaps.

To approach care as a public good, stronger public involvement and investment is crucial. This also does not imply that the private sector would be crowded out – but rather that public investment could present opportunities as it could set the foundations for greater private investment while growing different target markets for private care services.

3.2 Applying a life cycle approach to care economy

A life cycle approach recognises the various risks and vulnerabilities that individuals face throughout their life span.[67] Applying the life cycle approach to care allows for the consideration of diverse social care needs as existing on a spectrum, spanning child to elderly care – and not excluding specialised care like disabled or palliative care required throughout or during specific periods of a person's lifetime. This is what is meant by building a cradle-to-grave care economy.

The life cycle approach facilitates a more inclusive conception of social care needs. Child and elderly care are often considered separately in policy and practice because of the marked differences in needs: childcare requires an educational component, while elderly care brings with it healthcare requirements. Further, disabled care needs are commonly seen as separate from the mainstream spectrum of care, given the specialised skills it requires.

However, integrating all care needs under the umbrella of the care economy allows for a holistic approach responsive to dependents' needs across their lifetime. For example, children require care well into adolescence, beyond the age groups of 0-3 (care centres) and 4-6 years (preschool), as outlined in Malaysia's early childcare and education model. When it comes to the elderly, they will often require care on a day-to-day basis, beyond the point of illness or hospitalisation. Disabled care needs intersect across childhood and adulthood, with risks increasing with old age. As such, a life cycle approach recognises these needs and aims to offer a spectrum of services or support.

3.3 Offering all Malaysians accessible baseline of care

To ensure the care economy is equitable across all groups, there needs to be an accessible minimum baseline of care. However, the primary targets should be low-income groups who often face several unmet social needs simultaneously.[68] What this ensures is that even in times of crisis, social care needs are still met, without which would expose vulnerable families to further risk. In practice, this should represent a social protection floor that enables all families to access social care when they require it.

4 Policy recommendations

The vision of an equitable cradle-to-grave care economy requires setting important policy reforms – spanning social protection, legislation and governance, and gender-sensitive policymaking. To that end, Malaysia's approach to the care economy should follow four policy directions:

1. Integrating social care into the social protection framework
2. Investing in community-based care infrastructure and services
3. Establishing policy and governance for social care
4. Instituting system-wide gender-sensitive and care-centred approaches

POLICY DIRECTION 1: Integrating social care into Malaysia's social protection framework

4.1 Establishing primary caregiver support through social protection

Given that care is largely performed informally, an important public investment in social care involves providing protection for primary caregivers, especially those with long-term care responsibilities. Informal caregivers can be supported through a range of social assistance measures, including cash transfers, cash-for-care benefits, family allowance or pension credits targeted specifically at informal caregivers. This is crucial as most caregivers are unpaid and accrue health and socioeconomic costs, while potentially having more than one dependent to care for or other mitigating circumstances like disability or being the sole caregiver. Using transfers to offset the loss of income from engaging in caregiving activities instead of paid work will prevent further deprivation of low-income caregivers and tangibly recognise the value of care in society as a productive activity.[69] Refocusing policy on caregivers instead of only care recipients represents a person-centred approach that recognises the costs of caregiving and seeks to redress it.

A policy example of compensating caregivers includes Singapore's monthly Home Caregiving Grant (HCG), which ensures financial support for households with the elderly, especially those with moderate to severe disabilities.[70] Singapore's care model provides direct support for low-income families, be it social care services or financial assistance, while encouraging voluntary contributions through the Central Provident Fund (CPF). Singapore also allocated in 2019 a top-up through the CPF to enhance the retirement savings of low-income individuals.[71] Altogether, the HCG and CPF top-up initiatives are important measures that could also be considered by Malaysia's Employees Provident Fund (EPF).

More broadly, supporting Malaysia's primary caregivers through social protection could encompass a two-pronged strategy, including:

- **Instituting caregivers' allowance:** this allowance could be means-tested and provided depending on the intensity of care needs (i.e. disability), serving to compensate partially or fully informal caregivers who provide full-time care. In practice, this could be similar to cash-for-care benefits, helping to improve the welfare of caregivers while reducing the disparities between those performing paid and unpaid work. It could also enable them to afford care, allowing them to seek paid employment.
- **Enhancing retirement savings:** extend EPF coverage for those who are full-time caregivers, or who are forced to leave work for caregiving responsibilities. Similar to programmes like i-Saraan, the government could incentivise voluntary contributions by offering matching contributions or top-ups to caregivers' EPF.[72]

4.2 Bridge social protection with access to social services

In the long run, social protection measures like cash transfers and social insurance cannot replace affordable, accessible and quality social care services, especially when it comes to elderly care.[73] The healthcare system, as it stands, is also neither adequate nor suitable to cater to everyday social care needs.[74] In this regard, the government plays a crucial role in financing, regulating and, to an extent, providing social care services for low-income groups to prevent the reproduction of further inequalities. On this, Malaysia's social protection framework must be expanded by

bridging it with access to social services. This could form a social protection floor or baseline of care for all Malaysians.

A viable mechanism that can help achieve this is long-term care insurance (LTCI) – a key health agenda that countries with aging populations have established. Taking the example of Japan and South Korea, their LTCI programmes bridge the link between social transfers and social services by allowing access to different types of care, such as home, visiting, institutional and community care, with eligibility for all citizens over 65.[75] These LTCI programmes are cross-subsidised, funded by taxes, social insurance and co-payments – with subsidies for low-income groups.[76]

For Malaysia, early financing is necessary because it allows the service-delivery system a buffer period to adapt and build up before demand for resources grows, especially as the current care infrastructure is lacking.[77] While Japan's and South Korea's care models are largely aspirational, policy lessons from these countries indicate that it would be better to start with less-generous benefits and restricted schemes before scaling up over time.[78] This may be useful for the case of childcare as well, taking on a tripartite funding model that spreads the cost across employers, parents and government.

POLICY DIRECTION 2: Investing in community-based care infrastructure and services

4.3 Diversifying social care support services to be more flexible and respond to different needs

For Malaysia's care economy to respond effectively to social care needs, it will require a wider and more accessible range and depth of services than are currently available. The care economy should essentially allow recipients to choose the type of care they want to receive. To fill this gap, community-based and home-based models are an important care configuration as they provide care and support within the communities that they live and interact in – places that "people call home" – which could serve to be more affordable and accessible in the long run.[79]

For the elderly, community-based and home-based care promotes aging-in-place and independence in ways that institutional care lacks. Diversifying how these social care services are provided is key, hence services should include arrangements like adult daycare, home visits, community activities and programmes, and respite care. This is important as primary caregivers can only work and flourish if they have access to adequate formal care support that are flexible and tailored to their needs.

Malaysia already has a community-and home-based care model in place for persons with disabilities (PWDs) under the purview of the Disabled Development Department (JPPWD) placed in JKM.[80] The next step would be to expand this existing model to the elderly while facilitating uptake and support within vulnerable communities.

At the same time, Malaysia will have to consider integrating its social and health care systems. The latest Health White Paper offers key opportunities for such a move as it outlines a transition towards "person-centred care and bringing care nearer to the community" and moving services like transitional care out of the hospital to the community level.[81] This offers the opportunity to move beyond medically-oriented care to include social care services required beyond the point of illness.

Community-based care may also be feasible and attractive options for working parents in the absence of workplace childcare. These can connect and integrate parents to a wider network of relatives, friends and neighbours. At the same time, employers also play an important role in recognising and supporting the care responsibilities of their employees. Companies within a common area should be incentivised to pool resources and funding to set up childcare centres as another mode of community-based care. Providing corporate guidance, training and skills to empower companies to do this will be key. Childcare centres also need to have extended hours to cover the full workday and be flexible enough to accommodate irregular work shifts.

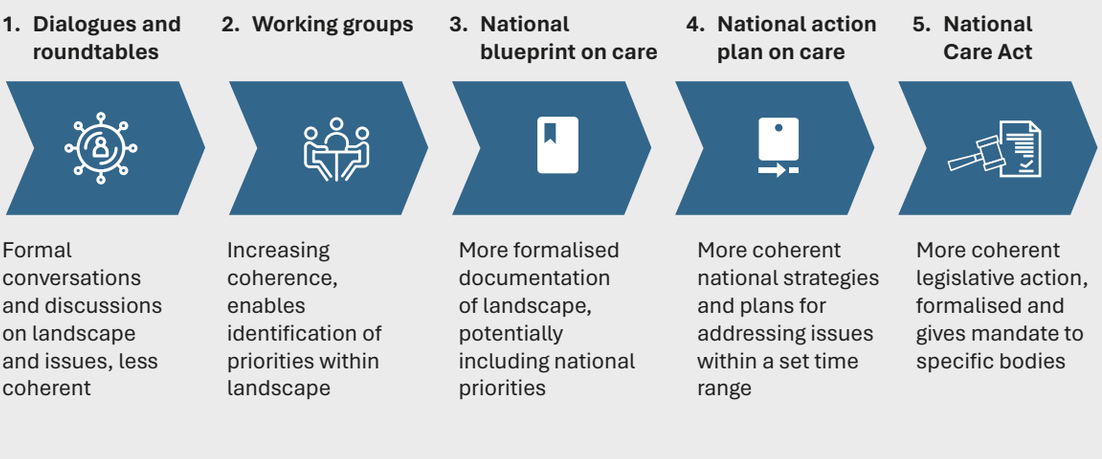
Community and home-based social care centres will ultimately require more collaboration across all government levels, from federal to state to local government. Implementation, monitoring and regulation must be decentralised to the district level. Improving implementation and governance structures should go hand in hand with diversifying the services provided in the care economy in ways that are flexible and convenient to the communities it aims to serve.

POLICY DIRECTION 3: Establishing policy and governance for social care

4.4 Outlining legislation, policies and roadmaps for the care economy

While the concept of a care economy is featured in the Madani Economy framework, Malaysia has yet to outline tangible steps towards developing it. Legislation, policies and governance frameworks that outline a more systemic approach to the care economy are necessary. Figure 7 identifies a five-point road map to set the legislative and policy foundations for a cradle-to-grave care economy.

Fig. 7: Roadmap for care economy legislation and policy



Based on Figure 7, the preliminary steps would be to strengthen institutional coordination and collaboration through multi-stakeholder dialogues, roundtables and working groups. In other countries, formalising structures for collaboration and engagement across stakeholders has led towards the identification of priorities and ultimately, more concrete outcomes, such as those illustrated from steps 3 through 5. For example, in Argentina, the creation of an inter-ministerial commission on care in 2020 brought together 12 agencies to plan and formulate social care policies.[82] Similarly, in Nepal, an inter-ministerial National Steering Committee on Decent Employment and Care Economy (NSC), situated under the National Planning Commission, was established to develop policies and grow investments in the care economy.[83]

Malaysia's care economy would benefit from developing a national care blueprint and a formal policy document, such as those outlined in steps 3 through 5. These, however, are incremental changes that are built over time, demonstrating a strengthening commitment to developing the care economy.

A blueprint, as outlined in step 3, offers the simplest way of formalising this commitment. While the Ministry of Economy is currently working on a National Aging Blueprint,[84] Malaysia's care economy landscape would benefit from a blueprint for the overall care economy that encompasses aspects of both paid and unpaid care from a life cycle perspective. With a national care blueprint, a better understanding of the current landscape and existing gaps could be mapped out while also prescribing the overarching perspectives of how the care economy should be shaped.

Step 4, a national action plan (NAP), would build off this foundation. A NAP for care would articulate strategies to approach the care economy. A NAP would be more concrete than a blueprint and is often used to articulate priorities and actions that countries have committed to.[85] An example from Indonesia is relevant here: the country's Ministry of Women's Empowerment and Children Protection (KPPA) is currently leading the development of a National Action Plan on the Care Economy, which will be included in its Long-Term National Development Plan 2025-2045.[86] Malaysia could benefit from this type of policy document in the medium term and it would go a long way towards formally recognising social care as a strategic issue, and integrating it into wider development plans.

Finally, step 5 is a National Care Act, the most coherent legislative action where a mandate can be assigned to a particular ministry or group of ministries, with clearly outlined definitions, minimum standards, and regulatory and monitoring responsibilities. A key example is Uruguay's Care Act, adopted in 2015 to avert what was feared to be a care crisis.[87] Under the act, all children, persons with disabilities and elderly persons were given the right to access care.[88] Ideally, this is what Malaysia should aspire to.

4.5 Recognise, professionalise and regulate the social care workforce

Concurrent to a national strategy, legislative action will also need to address the professionalisation of social care workers to sustain and streamline the quality of care. There is already legislation in motion that could serve as an example: the Social Work Profession Bill aimed at professionalising social work in Malaysia, which has yet to be tabled in Parliament. However, even if passed, the bill is likely to benefit only social workers and it will not impact all forms of social care workers across the public and private sector.

As such, social care workers will require separate legislation aimed at professionalising the workforce. Professionalisation of social care workers needs to be formalised in national policy documents – such as through blueprints, plans and acts related to care. This is crucial to systematically enable the growth of the formal care sector – which would be hampered if it is otherwise unable to attract and build a qualified workforce in sufficient numbers. Once the Social Work Profession Bill is passed, this should pave the way for a similar act targeted at social care workers to raise formal and paid care work to a professional level.

At the baseline, legislations to professionalise social care work must include the following components, including: (1) standardising and improving education and training to grow the skills needed for a qualified care workforce, (2) outlining the terms and conditions of social care work, (3) professionalising care workers in line with the status of professional workers i.e. healthcare workers (for elderly or disabled carers) and/or school teachers (for childcare workers), (4) offering employment protections to social care workers through social protection, and (5), instituting regular monitoring and evaluation mechanisms for quality.

Box article 3: Mapping TVET programmes to upskill Malaysia's social care workforce

By Sofea Azahar

Technical and vocational education and training (TVET) programmes play a defining role in training and upskilling the social care workforce. Already, social care skills are in high demand globally: the World Economic Forum predicts a 37% rise in emerging jobs within the care economy over the next three years. Despite this growing demand, Malaysia faces a labour shortage of social care workers. Home-based personal care work was listed as among the critical occupations that are facing a shortage, according to a 2022/23 list released by TalentCorp and the Institute of Labour Market Information and Analysis (ILMIA).[89]

The TVET system could plug some of these gaps by equipping social care workers with practical skills and providing focused and adaptive training that can be used to swiftly upskill social care workers and reskill potential workers. Harnessing Malaysia's TVET programmes to provide skills-based training for the social care workforce is critical given its emphasis on hands-on experience, which accounts for up to 80% of its structure.[90]

In Malaysia, various efforts related to TVET have been undertaken to address skills-related issues of care workers. Figure 8 maps out existing and future initiatives.

Currently, Malaysia's approach to training social care workers is fragmented and undertaken on a piecemeal basis, rather than in a streamlined and structured manner. To maximise the potential of the TVET system to plug labour shortages in care work, Malaysia should first improve skills training and certification for social care workers by enforcing a minimum entry standard through compulsory participation in pre-service training hours for all social care workers.[91] A key example is the mandating for all childcare providers to be certified through the Early Childhood Care and Education Course (KAP) but such requirements are notably missing for aged care workers. The announcement regarding upcoming childcare and elderly care courses under the purview of ISM is a move in the right direction.[92]

Second, given that community-based care centres are more accessible and affordable, there is a need to facilitate partnerships between TVET providers and community-based care centres providers. TVET programmes can be harnessed to provide relevant skills training and courses to community-based social care workers. One such example of collaboration is that between the UOA Academy, Yayasan Peneraju and Komune Care to provide professional certificates in elderly care through the TVET system.[93]

Fig. 8: Malaysia's initiatives to upskill and streamline qualifications for social care workers

Driving organisation for industries
The Industry Lead Body under MOHR facilitates collaboration between TVET providers and industries. The body regularly updates the National Occupational Skills Standard (NOSS) to include emerging skills in early childhood care & education, elderly care, and care for persons with disabilities (PWDs).

Accrediting body for professional development of care workers
The Social Institute of Malaysia (ISM) under KPWKM offers postgraduate diplomas on social work, workshops, seminars and conferences related to childcare and disabled care.

Social care qualifications framework under NIOSH
The National Institute of Occupational Safety and Health (NIOSH) regularly develops a qualification framework for care workers, particularly in the healthcare sector. However, progress on this framework has reportedly stalled and requires updating.

Private sector courses
The My Flex Health training programme is an example of an accredited course authorised to provide Australian nationally recognised qualifications in Malaysia. The programme offers vocational training and short courses covering aged care and community care like nursing and physiotherapy. This offers international expertise to Malaysia's social care workforce which can be harnessed to attain high-quality care.

Cross-collaboration across ministries
KPKWM and MOHR are poised to collaborate in running TVET training programmes for social care workers. This cross-collaboration allows for a comprehensive array of training opportunities for care workers. It can also ensure greater efficiency as ministries can streamline efforts and minimise redudancy.

Source: Department of Skills Development, Institut Sosial Malaysia, The Star, My Flex Health and stakeholder engagements

4.6 Instituting a multisectoral approach to the care economy

Currently, progress on the care economy is spearheaded by KPWKM, given that care is seen primarily as a women's and welfare issue. However, the task of building a robust cradle-to-grave care economy is best-served by multisectoral collaboration, with involvement of various ministries, agencies and levels of government. This is critical as coordination across sectors could remove barriers to implementation, promote scale-up and maximise the impact that a single entity would not have the capacity to perform.[94]

As such, the care economy needs to be the shared responsibility of multiple other ministries, as key stakeholders whose active participation and response are integral. This includes: the Ministry of Economy to recognise and value the contribution of care to national GDP and facilitate the growth of an industry of social care services; Ministry of Human Resources to oversee the skills training and employment conditions of social care workers; Ministry of Health to better integrate the health and social care towards playing a preventative health role; and Ministry of Education where early childcare and education is concerned.

To this end, an inter-ministerial committee is needed to coordinate cross-cutting responsibilities and streamline action towards the common goal of building a cradle-to-grave care economy that responds to Malaysians' social care needs.

POLICY DIRECTION 3: Instituting system-wide gender-sensitive and care-centred approaches

4.7 Collect, publish and integrate data on unpaid care work and the care economy

Building the foundations of a care economy requires recognising care work more formally and "making visible" what is normally conducted in the private realm of the home. To do this, data and statistics on unpaid home production and care work must be collected and made publicly available. Not only will this outline the urgent need for policy attention, but it will also be useful to drive evidence-based policymaking – an important task needed to justify significant public investments in the care economy. In this regard, Malaysia stands to benefit from taking on a nationwide time-use survey (TUS) to measure unpaid care work.[95] However, a TUS may be costly and resource-intensive. As such, it may be more feasible for Malaysia to start by harnessing the household and labour force survey under the Department of Statistics Malaysia (DOSM) to collect data on unpaid care work and make this publicly accessible,[96] although this would not be a perfect substitute for a TUS.

4.8 Mainstreaming gender-sensitive policymaking

Malaysia's policies related to social care will need to be more gender-sensitive. At the baseline, being gender-sensitive in the context of care means recognising and responding to the underlying reality that men and women experience the need for care and its attendant policies differently. For example, women tend to live on average 4.5 years longer than men.[97] They are also far more likely to be responsible for providing care for other family members well into old age[98] and tend to have less savings. Their care needs and ability to access care differ from men's and, as such, long-term care policies need to respond to these differences.

Additionally, it is often women who are overrepresented in the social care workforce – not only do they work in a context where care is undervalued, they are also concentrated in lower status, poorly paid or unpaid roles, which increase their socioeconomic vulnerability.[99] As such, policies must recognise the inherently gendered elements of social care work and create conditions that value care. This approach should also be intersectional to respond effectively to diverse situations.

Gender-sensitivity needs to be complemented by a recognition that these experiences are further shaped by concrete circumstances like socioeconomic status, disability, migrant status, or race, for example. To make policymaking more gender-sensitive, intersectional considerations need to be systematically mainstreamed across all levels of government and in policy design.

Malaysia has made headway on this front, by disseminating the responsibility for gender equality across ministries through the establishment of gender focal teams (GFTs). Moving forward, building on the GFTs to mainstream gender and care considerations will be a key first step. However, establishing key priorities and success indicators for GFTs centred on care is key, while also training GFT experts and reporting on this progress across ministries – without which it would be difficult to measure effectiveness. Once these are in place, KPWKM should consider instituting mechanisms for accountability to ensure gender-sensitive goals are met.

5 Conclusion

The care economy is, at its core, an issue strategic to Malaysia's development, not only because it stands to drive economic growth but also because it is critical to both the wellbeing and welfare of everyday Malaysians. It would play a key role in improving gender equality outcomes by providing concrete support to families and enable women to pursue economic opportunities. In total, Malaysia stands to benefit by investing in the care economy.

But the challenge lies in building a cradle-to-grave care economy that responds to the care needs of all groups amid rapid demographic change – while also ensuring that it is equitable and widely accessible. As such, it is of crucial importance that Malaysia shapes a vision of the care economy that is inclusive and comprehensive by reframing care as a public good, adopting a life cycle approach to social care and ensuring all Malaysians can access a minimum baseline of care.

Unlike most policy areas, social care is a domain that is particularly complex because it is closely associated with gendered and cultural norms. As of yet, Malaysia also does not have the foundations to ensure a thriving care economy, let alone one that spans from cradle-to-grave. This is where the country will have to pursue wide-ranging policy reforms, covering social protection, legislation and governance, community-based care infrastructure and services, as well as centring a gender-sensitive approach to policymaking. In all, these would be important policy directions, promising gains that would impact not only the care economy but the nation as a whole.

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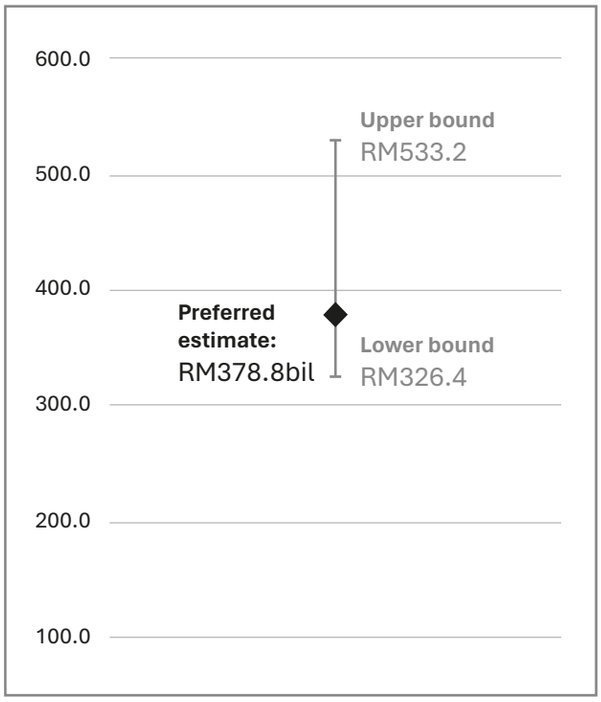
Appendices

Appendix A: Valuing unpaid care and domestic work

In deriving the estimates of the market value of unpaid care and domestic work in Malaysia, we use a standard simple substitution approach using generalist wages.[100] This entails using a measure of market domestic service wages multiplied by the number of average hours dedicated to home production (using KRI's pilot time-use survey, which provides a non-representative but illustrative picture of home production hours). The resulting number is then scaled by the estimated number of people who produce unpaid care and domestic work – which we estimate as the total number of persons aged 15 and above in Malaysia as per population projections for 2022.[101] Value comparisons are then done with regard to 2022 real GDP (current price in local currency units).



In deriving this estimate, we use three different wage measures as a substitute for domestic wages, converted to full-time equivalent hourly wages. The first and lowest is the monthly minimum wage of RM1,500, the second is the average "housekeeper" wage from Indeed[102] of RM1,741per month, and the third is the entry level (1-3 years' experience) domestic maid average salary in Kuala Lumpur from Salary Expert of RM2,453 per month.[103] We subjectively use the second (middle) estimate resulting from the Indeed housekeeper wages as our preferred estimate, and this is the figure we refer to in the main text of the policy brief.

Appendix B: Estimate the potential market extensive and intensive margins gains from reducing care barriers to market employment

To derive the estimate of the potential gains from removing barriers to paid employment participation, we use Labour Force Survey 2022 Report data on the number and socio-demographic characteristics of persons outside the labour force because of family and care obligations (across gender, educational attainment and sector), as well as the data on persons remaining part-time (working less than 30 hours) because of the same reason. Then, we roughly simulated the direct value created and employment gains from both extensive margin changes (persons outside the labour force entering into both full-time and part-time employment based on 2022 full-time/part-time shares) and intensive margin changes (from people in part-time moving to full-time employment).

Subsequently, estimates of market value created are based on simulating the aggregate wages received by the additional workers induced to supply labour hours based on their socio-demographic characteristics. This hinges on the assumption that workers get paid median wages for their reported level of educational attainment – i.e. degree holders get paid 2022 median wages for degree holders, SPM graduates get paid 2022 median wages for SPM graduates. For part-time workers, due to data limitations we simulate paid wages based on sector instead (e.g. agriculture/manufacturing/services median wages), with the assumption of part-time pay being half of full-time pay. The direct value created (wages paid) is then aggregated across educational attainment, sector and full-/part-time workers induced to change their labour supply decisions.

These estimates and projections are meant to be illustrative, and they have several shortfalls. On the one hand, these estimates are conservative in the sense that they only consider the direct impacts in terms of the value of the wages received, excluding potentially large knock-on effects on consumption and human capital accumulation. On the other hand, these projections abstract away from real-world considerations like labour market frictions (and absorptive capacity), compensating differentials, and potential general equilibrium effects on price inflation and wages from an increase in labour supply.

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