



## **South-South and triangular cooperation and the Care Economy:**

***Research papers and articles compendium***

***“The Future of Work in Asia: Skills development strategies and  
social protection policies to promote employment-rich and  
equitable growth” By South-South Scholars***

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# Contents

<b>PREFACE</b> by Mr. Yanguo Liu, Director of ITCILO .....	4
<b>I. INTRODUCTION</b> .....	5
<b>II. Compilation of Articles on South-South and triangular cooperation and Care Economy.</b> .....	7
Deng, Baoshan, “Multi-bilateral cooperation in promoting the mobility of long-term care workers between China and ASEAN countries under the South-South and triangular cooperation Framework” (China).....	7
Long Thanh Giang, Thu Dai Bui, “Aging, Health and Long-term Care Needs and Human Resources for a Care Economy in Vietnam” (Vietnam) .....	10
Hamid, Tengku Aiza, Chai, Sen Tyng “The Future of the Care Economy: Ageing and Long-term Care in Malaysia” (Malaysia).....	18
Wai Mun Hong, “Demographic change and future job opportunities in ASEAN in the Care Economy” (ASEAN Secretariat).....	21
Komazawa, Osuke and Iwasaki, Fusanori, “ERIA’s commitment to the regional integration in East Asia” (ERIA) .....	26
Perez, Juan Antomio A., “Responding to the Needs of Aging Societies: The International Mobility of Filipino Health and Care Workforce” (the Philippine).....	31
Rahardjo, Tri Budi., Agustin, Dinni., and Guritno, Dian E, “Service Delivery for Older Persons by Young Generation in Indonesia” (Indonesia) .....	33
Thaworn SAKUNPHANIT, “Community Based Long Term Care Initiative” (Thailand) .....	39
Suwankitti, Wanchat, “How demographic change in Thailand will impact the world of work? ” (Thailand) .....	50
Bingzi ZHANG, “Trends of Eldercare Workforce in China and its Enlightenment to Care-economy” (China) .....	54
<b>III. Combined bibliographical references.</b> .....	60

## **PREFACE** by Mr. Yanguo Liu, Director of ITCILO

Demographic change has profound impacts on the world of work, brings about challenges, but also opens up new economic development opportunities, particularly in the care-giving service industry. Specifically, new employments are being created from the fast growing public and consumer expenditure related to population ageing and the specific needs of the population over fifty (i.e. mobility equipment, elder-friendly medicines, home-based care devices, and other services or goods). Along with the promotion of employment prospective for young job seekers, there is high risk of decent work deficit stemming from precarious employment relationship and gender stereotypes that need to be addressed. According to the data and projections from the United Nations, Asia will eventually become home to the largest number of older people in the world. A development strategy for an employment-rich and equitable growth of the care economy in Asia is thus increasingly imperative.

To address this urgent need, and under the umbrella of the established South-South and triangular cooperation (SSTC) collaboration framework with the ILO, the Chinese Ministry of Human Resources and Social Security (MOHRSS) financially supports the ITCILO Turin to organise a number of activities beginning with an expert meeting on Future of Work in Asia. The objective is to strengthening the capacity of public institutions, academia and social partners to mitigate risks and unlock opportunities in the wake of the large-scale labour market transformation processes in Asia. The expert meeting applied the SSTC modality, which gathered and facilitated knowledge and experience exchanges among public labour market research and social security research institutions from China, Europe and selected ASEAN countries. Thanks to the support of ILO's Partnership and Field Support Department (PARDEV), additional scholarships for policy-makers and practitioners working on care economy development were provided.

This compendium of articles, contributed by South-South scholars for the expert meeting, focuses on regional and national experiences on Care Economy development policies in the SSTC framework. The objective is to share and exchange good practices on SSTC and Care Economy Development, and to create a strong network of practitioners that mainstream the SSTC modality in the development of ASEAN Care Economy.

I would like to take this opportunity to express my sincere gratitude to all the experts who participated in the meeting and made excellent contribution. My thanks are also given to the Ministry of Human Resources and Social Security of China for its great support to this SSTC event.

# I. INTRODUCTION

The Government of the Peoples' Republic of China is commitment to the United Nations' 2030 Sustainable Development Agenda to support developing countries in the areas of human resources and development planning, including through South-South Development Partnerships. As part of this commitment, the Ministry of Human Resources and Social Security (MOHRSS) through its South-South triangular cooperation (SSTC) framework together with ILO combines a wide range of technical initiatives in the field of employment promotion and social protection. Under this SSTC framework, the Government has financed the project "Future of Work in Asia: Skills development strategies and social protection policies to promote employment-rich and equitable growth". It aims to contribute to employment-rich and equitable growth in ASEAN countries, by strengthening the capacity of ILO constituents to mitigate risks and unlock opportunities in the wake of the large-scale labour market transformation processes shaping the Future of Work in Asia. The project focuses on two of these mega-trends, firstly the impact of demographic change on labour demand in high-growth sectors of the economy, and secondly the implication of new forms of non-standard employment on social protection systems.

The project has two thematic pillars: (1) Skills development strategies to promote decent jobs in the care economy; and (2) Social security system reform in response to new forms of non-standard employment in the digital economy. The project intervention mix foresees a combination of policy-level advisory services and capacity building support delivered jointly by ITCILO/ILO and public labour market research and social security research institutions from China and selected ASEAN countries.

Under the first project component, an Expert meeting supported by China evidence based research took place on 17-19 September 2018 in Turin. The experts and academicians from Bulgaria, China, Italy, Japan, 6 ASEAN countries, 7 representatives from international organisations discussed the overwhelming research evidence on demographic change impacts on the world of work, created challenges, but also new economic development opportunities in the care-giving service industry. Specifically, new employments are being created from the fast growing public and consumer expenditures related to population ageing and the specific needs of the population over fifty (i.e. mobility equipment, elder-friendly medicines, home-based care devices, and other services or goods). Along with the promotion of employment prospective for young job seekers, there is a high risk of decent work deficit stemming from precarious employment relationship and gender stereotypes that need to be addressed. According to the data and projections from the United Nations, Asia will eventually become home to the largest number of older people in the world. A development strategy for an employment-rich and equitable growth of the care economy in Asia is thus increasingly

imperative if we wish to strengthen the capacity of ILO constituents to mitigate risks and unlock opportunities in the wake of the large-scale labour market transformation processes in Asia.

As designed, the meeting applied the SSTC modality, which gathered and facilitated knowledge and experience exchanges among public labour market and social security research institutions from China, ASEAN and selected European countries. The ILO's Partnership and Field Support Department (PARDEV) supported the meeting by co-funding scholarships for participating policy-makers and practitioners.

In compliance with the outputs under component one, the ITC ILO has commissioned action research from the Research Department of the Social Development, Development Research Centre of the State Council of China on future labour demand in the care economy of ASEAN countries and China. The compendium of research papers and articles contributed for the expert meeting focuses on regional and national experiences on Care Economy development policies and practices also reflecting the SSTC framework. Thus the research compendium shares results of research papers and exchange of good practices on SSTC and Care Economy Development. The publication of the research compendium creates a strong network of practitioners that mainstream the SSTC modality in the development of ASEAN Care Economy.

## **II. Compilation of Articles on South-South and triangular cooperation and Care Economy.**

Deng, Baoshan, “Multi-bilateral cooperation in promoting the mobility of long-term care workers between China and ASEAN countries under the South-South and triangular cooperation Framework” (China)

China commits to the United Nations 2030 Sustainable Development Agenda by supporting developing countries in the areas of human resources, development planning and programmes, including through South-South Development Partnerships. As part of this commitment, the Ministry of Human Resources and Social Security (MOHRSS) has established a South-South triangular cooperation (SSTC) framework with the ILO which combines a wide range of technical initiatives in the field of employment promotion and social protection. The Future of Work in Asia builds on the achievements of these SSTC initiatives. This project aims at strengthening the capacity of local ILO constituents to mitigate risks and unlock opportunities in the wake of the large-scale labour market transformation processes in Asia. One of two thematic pillars of the project is skills development strategies to promote decent jobs in the care economy in the process of demographic change.

Aging population has been bringing to more countries in the world the challenge in the shortage of care workers for elderly, in particular long term care (LTC) workers. The shortage of the LTC workers in most elderly and aging countries in East Asia, notably Japan, Korea, and China, is creating job opportunities for international migrant workers. Dealing with aging labour force, importing LTC workers is a solution. The UK, Norway and Germany in Europe, Japan and South Korea in East Asia have cooperated with ASEAN countries, for example Philippines and Indonesia, to recruit nurses and caregivers. Within the ASEAN region, efforts have been made by the member countries to promote inter-state mobility of care workers, through mutual recognition agreements on nurse qualification. The mobility of LTC workers could contribute to promote employment-rich and equitable growth in the ASEAN’s care economy and the achievement of the 2030 Agenda in this region. In this context, more efforts shall be taken jointly by ILO, China and ASEAN countries, especially under the SSTC framework, including:

Firstly, dialogue should be promoted among stakeholders, including the ILO, China, ASEAN member states, Japan, and Korea, to facilitate knowledge and experience sharing in skill

development strategies for the care economy and management of migrant care-workers. China, as both sender and receiver of care workers, has bilateral agreements to send Chinese nurses to work in the UK and Germany. ASEAN countries, in particular the Philippines, have rich experience in training and development for care workers and in the governance of care workers migration. In this context, SSTC initiatives can help China to strengthen communication and explore possible collaborations with ASEAN, Japan, and South Korea in improving LTC migrant workers mobility, through information and good practices sharing activities.

Secondly, bilateral agreements (BLAs), memorandums of understanding (MOU) and mutual recognition agreements (MRAs) are crucial instruments to successfully regulate the LTC migrant workers. BALs, MOUs and MRAs have been introduced to support the recruitment and placement of healthcare professionals (e.g. nurses, caregivers, etc.) between the UK, Japan, Germany as destination countries and Philippines, Indonesia and China as sending countries. The ASEAN has signed eight MRAs in several occupations, among which nursing services, to facilitate the mobility of migrant workers. Lessons learnt from existing practices prove that, the protection of migrant workers' rights should be sufficiently addressed in the BALs and MOUs, coupled with frequent monitoring and evaluation among participating countries, to ensure successful management of LTC migrant workers.

Thirdly, standardised training programmes and materials should be developed to enhance professional skills, and qualifications of the LTC migrant workers. . The experiences from both senders (e.g. the Philippines, Indonesia and China, etc.) and receivers (e.g. the UK, Japan and Germany, etc.) of LTC workers show that skills and language qualification are key factors for a successful migration. SSTC initiatives can thus contribute to enhance the employability of LTC workers in ASEAN countries and China by promoting standardised training programmes and materials among stakeholder countries. The technical support and training expertise from the ILO to China and ASEAN countries, therefore, would be highly appreciated.

Fourthly, bilateral and regional MRAs should be introduced to facilitate the mobility of the LTC migrant workers between ASEAN East Asia countries. Existing cases show that the absence of mutual recognition of qualification results in additional costs and complexity for both sending and receiving countries to ensure the quality of the migrant workers. In example, strict policies in labour qualification from destination countries, such as Japan and Germany, have limited the number of care workers coming from the Philippines, Indonesia, and China to a certain annual quota. Against this backdrop, SSTC could contribute by facilitating the discussion to develop a regional mutual recognition approach of LTC care workers qualification among ASEAN member states and China, based on experiences drawn from the existing MRAs



in the region.

Lastly, regional forum should be organised to discuss urgent issues on the governance of LTC migrant workers in the absence of multilateral agreement. BALs and MOUs were more common than multilateral agreements. However, existing BALs and MOUs are weak in protecting labour migrants' rights due to the differences of national laws and regulations between the countries of origin and destination. To facilitate easier mobility of regional interstate migrants and better protect the rights of labour migrants, ASEAN has developed a regional forum for member countries to discuss and achieve the policy consensus on the issue of labour migrants' rights. The SSTC projects, therefore can collaborate with ASEAN labour migrant forum to take a consideration on facilitating the mobility of the LTC migrants between ASEAN countries and East Asian Countries.

# Long Thanh Giang, Thu Dai Bui, “Aging, Health and Long-term Care Needs and Human Resources for a Care Economy in Vietnam” (Vietnam)

## **Abstract**

This note aims to examine the health status of older people in Vietnam along with their needs and current provision of healthcare and long-term care services. Among various related issues, human resource was in in-depth discussions. It was indicated that Vietnam would be rapidly aging in the coming decades, resulting in a large number of older people (defined as those aged 60 and over). The current health status with abundant non-communicable diseases (NCDs) implies great needs for healthcare and long-term care, and as such, human resource in these fields should be improved. Some possible SSTCs in training for these fields were also discussed.

**Keywords:** aging, healthcare, long-term care, older persons, care-giver training, Vietnam

## **Background and Objectives**

Vietnam has witnessed significant changes in age structure of population towards aging, resulting from lowering fertility, declining mortality, and increasing life expectancy of people during the past three decades (UNFPA, 2011). The country is now at the crossroad of young population in working age (demographic dividend) and a growing number in older persons (demographic aging).

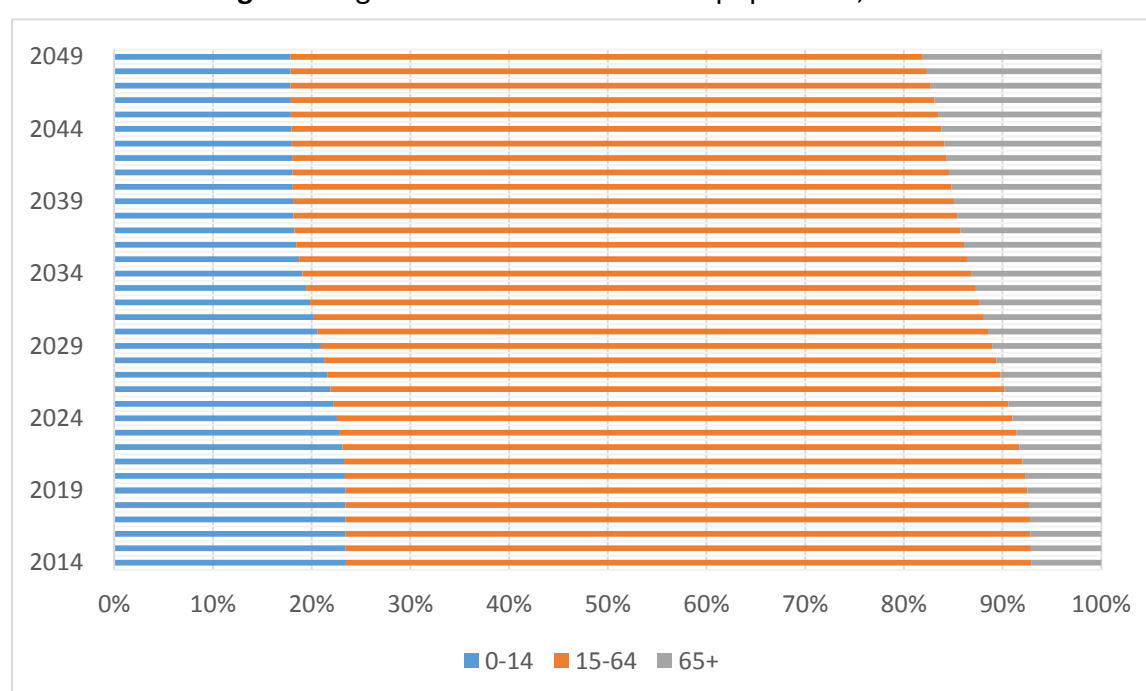
The process of individual aging is significantly associated with deterioration of health status and higher rates of morbidity (Haseen, Adhikari, & Soonthornthada, 2010; Hoang, Dao, & Kim, 2008). In particular, a study found that the more advanced age, the higher proportion of older persons with illness (Evan et al., 2007). As one of the fastest ageing societies in the Association of South East Asian Nations (ASEAN), Vietnam is facing the challenges of epidemiological transition in term of shifting in disease patterns, which in turn poses greater demands and higher expenditures on healthcare (Dam et al., 2010; Evans et al., 2007; Nguyen, 2010). Moreover, older persons in Vietnam are now facing with ‘double disease burden’ (United Nations Population Fund, 2011), and most of them are suffering from at least one disease, including chronic diseases (Dam et al., 2010). At the same time, older people are also facing a high incidence of ADLs or IADLs which all require great needs of care. Therefore, understanding the challenges of the healthcare and long-term care system, in which human

resource is a key factor, would be crucial to build adaptive strategies to a rapidly aging population.

### Demographic Profile – A Snapshot

Figure 1 presents the age structure of the Vietnamese population in 2014-2049, which clearly illustrates the aging issue in the coming decades. As projected by GSO (2016), people aged 65 and over will account for more than 20 percent of the total population by 2049, placing Vietnam in the group of aged countries. Along with this, the feminisation of aging will be persistent (GSO, 2016).

**Figure 1:** Age structure of Vietnamese population, 2014-2049



Source: GSO (2016)

### Health Profile and Care Needs of Older People

Using Vietnam Aging Survey (2011), Le and Giang (2016) showed that about 72% of older people in Vietnam had at least a chronic disease, in particular those with multi-morbidities accounted for about 44% (Table 1).

**Table 1:** Distribution of older population by the number of diseases

Variable	Weighted percent
Having no disease	27.88
Having one chronic disease	28.21

Having multi-morbidities	43.91
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Source: Le and Giang (2017), using VNAS 2011

Table 2 presents further details about the health complaints by older people. It indicates that older people face various non-communicable diseases (NCDs).

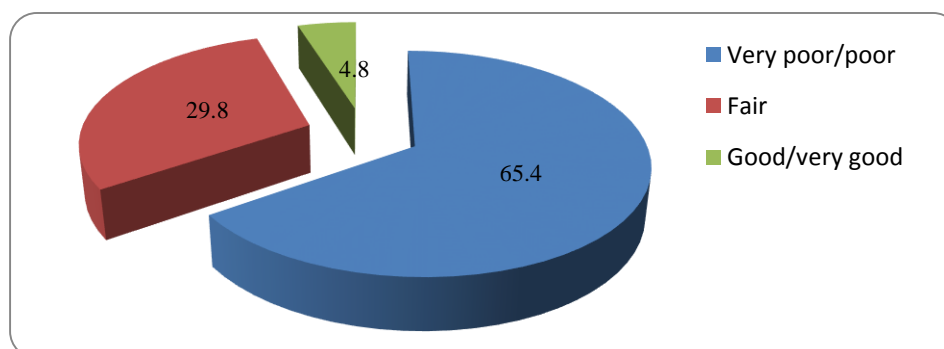
**Table 2.** Health complaints of the older people in the last 30 days

Health complaints	N	% (weighted)	Health complaints	N	% (weighted)
Back pain (n=2,786)			Trembling hands (n=2,785)		
Yes	2,017	72.4	Yes	768	27.6
Headache (n=2,788)			Constipation (n=2,786)		
Yes	1,967	70.6	Yes	755	27.1
Dizziness (n=2,788)			Stomachache (n=2,785)		
Yes	1,925	69.0	Yes	691	24.8
Joints pain (n=2,788)			Vomiting (n=2,788)		
Yes	1,920	68.9	Yes	684	24.5
Feeling Weak (n=2,787)			Skin problem (n=2,786)		
Yes	1,707	61.2	Yes	622	22.3
Coughing (n=2,788)			Fever (n=2,783)		
Yes	1,470	52.7	Yes	563	20.2
Breathing problem (n=2,787)			Diarrhea (n=2,788)		
Yes	1,019	36.6	Yes	399	14.3
Chest pain (n=2,784)			Loss of bladder control (n=2,788)		
Yes	1,011	36.3	Yes	270	9.7

Source: Giang et al., (2018), using VNAS 2011

Figure 2 shows self-rated health of older population. About two-thirds assessed that they had poor or very poor health status.

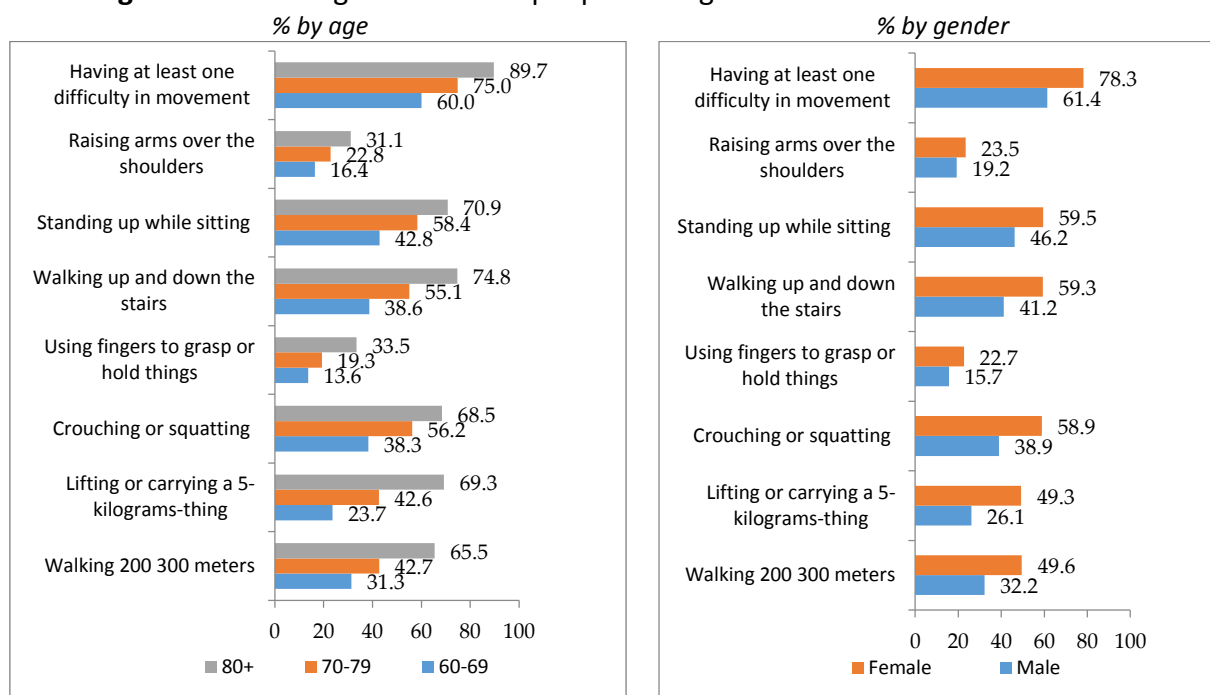
**Figure 2:** Self-rated health of older people



Source: VWU (2012)

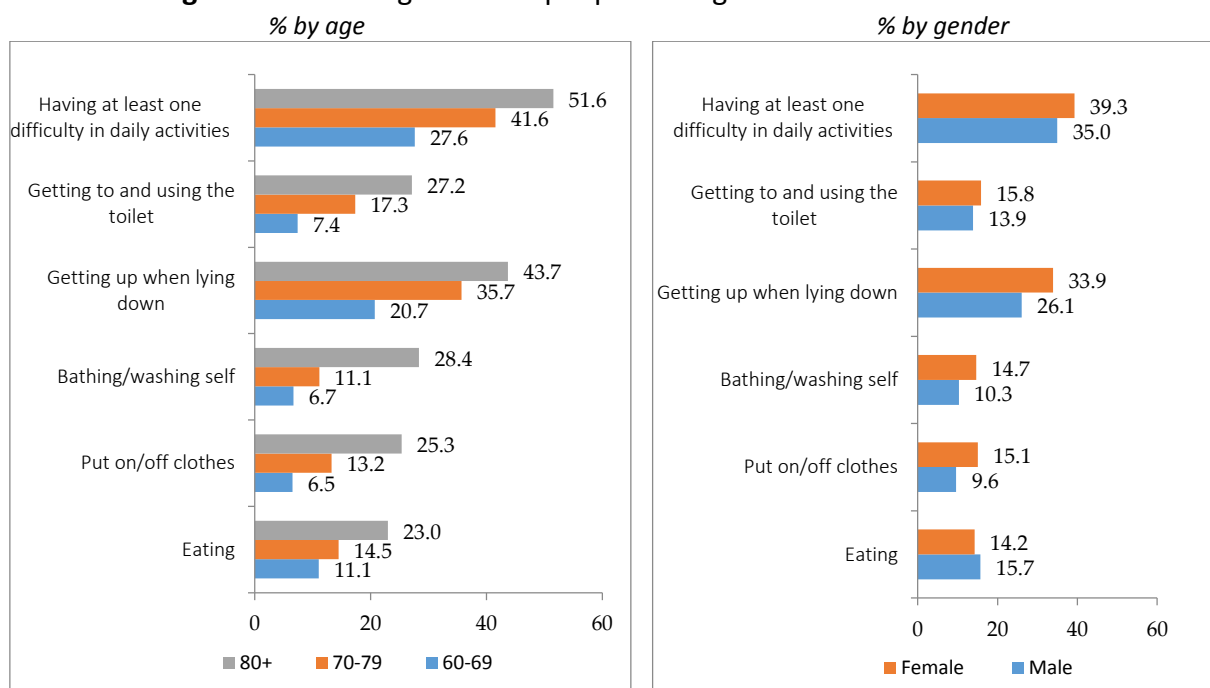
Figure 3 presents the percentage of older people who had difficulties with movement, while Figure 4 shows the percentage of those having difficulties in ADLs. The results from both figures indicate various differences in both terms of sex and age among older people. Long-term care needs are in place.

**Figure 3: Percentage of the older people having difficulties with movement**



Source: VWU (2012)

**Figure 4. Percentage of older people having difficulties with ADLs**



Source: VWU (2012)

Projections by MOH and Health Partnership Group-HPG (2018) indicate that, by 2019, approximately one million older people would need long-term care due to the difficulties or inability to perform at least one basic function of vision, hearing, mobility, and concentration/memory. By 2049, if there are no changes in the disability prevalence by age group, this figure would increase to 2.5 million. Projections for the long-term care needs – using difficulties in ADL as basis – show that, by 2019, approximately 4 million older people would need long-term care, and this figure would increase to up to nearly 10 million by 2049.

### **Care System for Older Persons with a Focus on Human Resources**

MOH is responsible for training and re-training of physicians and health workers specialised in geriatrics (as in the Law on the Elderly in 2009) and in rehabilitation (as in the Law on Persons with Disabilities in 2010), and for improving the capacity of social workers counselling and caring for older persons (as in the Vietnam National Action Program for the Elderly in 2012).

The National Geriatric Hospital is mainly responsible for training in geriatrics and developing geriatric training materials and practice guidelines. As indicated in the Health Care for the Elderly Project in 2017-2025, the National Geriatric Hospital is also responsible for direction, support and technical transfers related to healthcare for older persons to lower technical level health facilities across the country, as well as for developing geriatric training materials and practice guidelines in collaboration with training institutions. The Vietnam National Action Program for the Elderly stipulates the integration of contents relating to healthcare for older persons into training and capacity building programs for social workers, collaborators and volunteers who provide counselling and care for older persons (MOH and HPG, 2018).

However, up to date, there have been no standards for the geriatric medicine specialisation to help in determining the scope of practice of geriatric specialists. In particular, there have not been any geriatric competency standards for general doctors, family doctors, internal medicine physicians, and geriatric physicians (MOH and HPG, 2018). In terms of professional training institutions, there are only three schools providing geriatric medicine specialty training. There have been no framework curriculum or standard geriatric curriculum to be used in training programs of general doctors, family doctors or internal medicine physicians. And even the national education system does not yet have a code for geriatric medicine in the list of postgraduate education specialties.

Since most of elderly patients with specific diseases are likely to be treated in a specialty departments rather than in a geriatric department, there is a great demand for training to

improve the general knowledge of health workers on the special needs of older patients (such as drug interactions, risk of falls, and self-management of diseases). However, such trainings have not been put in practice.

In regard to long-term care, as stipulated in the Law on the Elderly 2009, MOLISA – in collaboration with MOH – is in charge of developing professional standards for and training of caregivers of older persons. For the main caregivers (including relatives, volunteers and personal caregivers), there have been no training plans, documents on ethical and professional standards, or relevant state management for these people. For health workers, MOH issued regulations on training, practice certificates and professional standards in line with the Law on Medical Examination and Treatment. For social workers, MOLISA issued Project 32 in 2010 with professional criteria for public employees working in the field of social work, professional standards for commune/ward/township social workers, undergraduate framework curricula on social work, and ethical and professional standards for social workers. Table 3 provides information on some training programs for care-givers of older people in Vietnam.

**Table 3:** Some training programs for caregivers of older persons in Vietnam

Training provider	Position	Training duration	Contents of training
Nhan Ai International Stock Company	Nurses and caregivers for older persons	3 months/course	Communication, nutrition, psychophysiology, techniques for caring and nurturing older persons.
Viet education and technology stock company	Nurse for sick people	2 months basic and 2 months advanced	Health care for older persons, maintaining hygiene in the home, living environment, know how to recognize some common diseases and provide emergency first aid.
Hong Doan center for helpers	Paid home caregivers for older people	Not clear	Skills to care for older persons and do housework
Pham Ngoc Thach Medical University	Paid caregivers for sick people and older people	6 weeks	Knowledge and skills to care for sick people and older people. Primarily practical training.
Hue Medical and Pharmaceutical University	Nurses to care for older persons (Japanese standards)	1 year (3 terms)	Strengthen skills to care for older persons among people who already have secondary or higher nursing degrees.
Mekong secondary medical and pharmaceutical school	Profession to care for older persons (elementary level)	3 months	Prevention and treatment of common diseases in the family, skills to care for health of older persons, practice of skills to care for older persons in the home.
Institute of Formation and	Paid caregivers for older persons and	3 months	Communication, ethics, monitoring of vital signs, nutrition, patient hygiene, taking blood

Promotion (IFP) HCMC	people with chronic disease		sample for rapid tests, preventing bedsores, etc.
Dong Duong secondary school	Technicians to care for older persons (German standards)	6 months to one year	Implement technical procedures and plan basic care of older persons. Advise, education on health of older persons, provide emergency first aid, ensure safety for older persons. Take care of older persons at home and at medical facilities

Source: MOH and HPG (2018)

In Vietnam, the primary caregivers for older persons are mostly family members since people usually cannot afford to hire personal and/or professional care-givers. Due to lack of knowledge and skills, such primary source of caregivers fails to provide sufficient and adequate care to older people. Moreover, long-term caregivers of older persons in the community and mass organisations are not considered as professionals since they do not belong to any job category, and in fact many of them have not been trained with basic knowledge and skills of care. For home caregivers, there has been no elementary level training curriculum. In the social protection centres, staff are usually insufficient in both quantity and quality of care due to lack of professional social work and skills.

### **South-South Cooperation on human resource development for the Care Economy.**

Albeit not fully developed, Vietnamese government started benefiting from the South-South cooperation with ASEAN member states and other development partners in developing human resources for its Care Economy. Since 2016, under the Economic Partnership Agreement (EPA), Vietnam has despatched hundreds of people to Japan for training courses to care for older people. This will be important human resources for both countries in the coming years. In addition, a number of international donors (e.g. ADB, UN, WHO, the World Bank, etc.) are now working with line ministries, particular MOH and MOLISA, to establish training series for health and social workers, as well as care policy dialogues for policy makers. SSTC will be the crucial modality to facilitate Vietnam's collaboration with other countries in achieving greater and higher quality human resources for the care economy.

### **Concluding Remarks**

Vietnam's health and long-term care system have not been developed sufficiently to adapt with increasing needs and demands of care workers for the elderly. In response to this problem, several policies and strategies should be taken into consideration (MoH and HPG, 2018), including: (1) Developing geriatrics competencies as the basis for modifying the training of general doctors, specialists related to older persons and nurses caring for elderly patients; (2) reviewing, updating, revising and amending undergraduate, junior college and



secondary training curricula in the health sciences towards meeting health care needs of older persons; (3) enhancing the contingent of geriatric specialists in localities through postgraduate training in geriatrics and supplementation of geriatric contents to the training general physicians, internal medicine physicians, cardiologists and physicians of other specialties with a high proportion of elderly patients; (4) continuing to provide training in geriatrics for health workers involved in medical care for older persons; (5) developing technical guidelines on preventive medicine, health promotion, diagnosis and treatment, health care, rehabilitation and palliative treatment in geriatrics; and (6) developing the contingent of professionals involved in health care for older persons (including doctors, nurses, rehabilitation technicians, social workers and caregivers).

In order to better design and implement development policies for the Care Economy, Vietnam could benefit from the SSTC modality, in which the lesson learnt from other countries, especially in the ASEAN region, will be shared. The compatibilities among ASEAN member states, in term of demography, institutional setting, and human resources, would make the experiences from other countries more applicable and replicable in the national context of Vietnam. The development process will thus be shorten and more efficient.

# Hamid, Tengku Aiza, Chai, Sen Tyng “The Future of the Care Economy: Ageing and Long-term Care in Malaysia” (Malaysia)

## Introduction

Malaysia is a middle-income country with a GDP per capita of \$10,745 (constant 2010 USD) in 2015<sup>1</sup>. Total health expenditure for the 31 million population of Malaysia was RM52.6 billion<sup>2</sup> or 4.55% of the GDP in 2015. Out of that figure, 51.5% of the health financing is borne by the Government. Estimating the true value of the care economy is often difficult. The total health expenditure covers only formal care provided through public and private health sectors, as other forms of paid and unpaid care (informal care) for children, the sick and older persons performed by the family and community at large remain unquantifiable.

With an increasing female labour force participation rate at 54.1% in 2015, the role of women as traditional caregivers is gradually being replaced by paid carers, thus commodifying care work in Malaysia. Between 2005 and 2015, the number of older persons aged 60 years or over grew from 1.78 million to 2.25 million, making up about 7.9% of the total population. As the society ages rapidly, demands for long term care services for the elderly are expected to increase significantly.

## Employment in the Care Sector

According to the Labour Force Survey Report<sup>3</sup>, about 573,100 or 4.1% of the 14 million employed persons in 2015 are working in human health and social work activities. This number does not include the employed persons in professional, scientific and technical activities (2.6%). A majority of people employed in the industry are women (80.79%) and most of the jobs are found in urban areas (83.9%). The mean age of workers in the human health and social work industry was 38.4 years old, two (2) years higher than average. The median and mean monthly wages of workers<sup>4</sup> in the human health and social work industry in 2015 were RM2,550 and RM2,999, respectively. Survey<sup>5</sup> by the Department of Statistics in 2015 also showed that the proportion of informal employment was the highest for human health and social work activities, where 34.3% of the total employment in this industry fall under the

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1 World Bank Databank, <https://data.worldbank.org/indicator/NY.GDP.PCAP.KD?end=2015&start=1990>

2 Ministry of Health (2017). Malaysia National Health Accounts (MNHA), Health Expenditure Report, 1997 - 2015.

3 Department of Statistics, Malaysia (2016). Labour Force Survey Report, 2015.

4 Department of Statistics, Malaysia (2016). Salaries and Wages Survey Report, 2015.

5 Department of Statistics, Malaysia (2016). Informal Sector Workforce Survey Report, 2015.

informal<sup>6</sup> sector.

### **Skills Development for Care Workers**

The National Occupational Skills Standard (NOSS), established under Part IV of the National Skills Development Act 2006 (Act 652), specifies the competencies expected of a skilled worker for an occupation, its levels, as well as pathways to achieve the required capabilities. In 2012, a panel was convened by the Department of Skills Development and the Department of Social Welfare to develop a NOSS on the Care of Older Persons. Subsequently, three (3) levels of the Malaysian Skills Certification System (MSCS) on Aged Care (Sub-sector 27.4) was developed, namely MSC-3: Elderly Care Centre Operation, MSD-4: Elderly Care Centre Administration, and MSAD-5: Elderly Care Centre Management. The Malaysian Skills Certificate (SKM) is a formal, nationally recognised certificate but many schemes have yet to be made mandatory or required, especially for caregiving jobs. Under the Sector for Care and Community Services (Sector 27), the NOSS registry also included other sub-sectors for Domestic Worker (27.1), Child Care (27.2), Care for the Disabled (27.3), Community Services (27.5), After School Carer (27.6) and Counselling Services (27.7). Malaysia's experiences with NOSS, transferred through South-South Cooperation, would be of great value to countries in the ASEAN region and also other development partners.

### **Long-term Care for the Elderly**

According to the United Nations (2017), it was estimated that 0.8% of older Malaysians aged 60 years or over in 2010 are residing in institutions. A previous study by the Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia in 2016 found that an estimated 13,730 older persons reside in 392 old folks homes, shelters, care centres for the elderly or nursing homes. These facilities employ about 2,775 workers, of which about 11% are non-Malaysians or foreign workers. Charitable homes are usually only open to single or childless, able-bodied elderly, while paid care facilities are available for a flat, monthly fee that range in thousands of Ringgit. Residential aged care facilities in Malaysia are rarely purpose-built and are mostly retrofitted double-storey terrace, semi-detached or bungalow units. Most of the facilities are registered under the Care Centres Act 1993 (Act 506) under the Department of Social Welfare. Nursing homes, on the other hand, are regulated via the Private

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6 The informal sector comprises of informal enterprise that meet the following criteria:

- i. all or at least one goods or services produced are meant for sale or barter transactions;
- ii. the enterprise is not registered with the Companies Commission of Malaysia (CCM) or any other professional bodies, including the Local Authority (LA); and
- iii. The size in terms of employment is less than 10 persons & is not registered under specific form of national legislation.

Healthcare Facilities and Services Act 2006 (Act 586) under the Ministry of Health. At the end of 2017, a Private Aged Healthcare Facilities and Services Act was passed in Parliament to address the governance gaps between the two laws. There are 10 federal-funded old folks homes for the destitute elderly known as Rumah Seri Kenangan and they are governed separately (*Kaedah-kaedah Pengurusan Rumah Orang Tua 1983*).

In recent years, senior living is touted as a new business opportunity and retirement villages began popping up in the country. Unfortunately, Malaysia does not have a public-funded long-term system and family members (usually the adult children) will have to pay for such services out-of-pocket. Both private medical and life insurance also do not provide coverage for long-term care needs. As such, the aged care industry is underdeveloped and services, whether residential or non-residential, are costly for the average family in Malaysia. Jobs in private aged care facilities are poorly paid and a lack of career pathways mean that staff turnover is high. One of the most common issues identified by operators<sup>7</sup> of residential aged care facilities in Malaysia is manpower problems relating to skills training and staff retention.

### **South-South Cooperation: Way forward.**

Malaysia has a national skills development framework but many certification schemes have yet to be made compulsory by law or mandated as an industry requirement. As care work becomes increasingly commodified, there is a need to address gaps in legal regulations as well as diversity in financing options. Official statistics have shown that most of the care sector workers are women and one-third of the industry's employment is informal. This has significant implications on job security and pay equity in the long run. The demand for health and social care will grow rapidly, especially care services for older persons. However, the absence of an affordable long-term care solution for the population means that families will have to continue to manage an increasing burden with fewer resources.

Against this backdrop, the South-South and triangular cooperation with other ASEAN member states and with East Asia countries, especially through experiences and lesson sharing, would help to foster innovative solutions for an aging ASEAN region, yet applicable to the local context of Malaysia.

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<sup>7</sup> Focus Group Discussions, National Convention of Residential Aged Care Service Providers 2016, 1-2 September 2017, Vistana KL Titiwangsa organized by MyAgeing, UPM.

## Wai Mun Hong<sup>8</sup>, “Demographic change and future job opportunities in ASEAN in the Care Economy” (ASEAN Secretariat)

### Introduction

Ageing population is not a phenomenon unique to developed countries or regions. Many have overlooked the challenges developing regions are facing as a compound effect of declining birth rates and increasing life-expectancy as middle-income class grows. The ASEAN region is one such interesting region that is experiencing an exciting period to reap the demographic dividends that is driving economic growth, and facing a fast growing ageing population at the same time. In approximately 15 years' time, the economically inactive population (catergorised by persons aged between 0 and 15) would shrink, and the middle-bulge that is identified with the working-age group would expand. Although ASEAN's population is expected to remain youthful within the next two decades, signs of ageing has emerged in several countries in the region.<sup>9</sup>

The different demographic dynamics in ASEAN would inevitably play a key role in helping policy-makers to understand, predict, plan and strategise policies to ensure steady and sustainable economic growth and development in the long-term. Countries with a fast ageing population normally experience a shrinking pool of working-age population, a population typically aged between 15 and 64 years old. This would likely have implications on a country's economic output if adequate policies are not put in place to increase labour productivity to produce more with less resources. From a statistical perspective, the different demographic dynamics in ASEAN appears to complement and balance out one another.

ASEAN countries like Singapore and Thailand are indeed experiencing fast ageing population, and may soon be or are already confronting the economic challenges of a shrinking workforce. The shrinking workforce is likely to have direct impacts on the levels of output of the industries or sectors driving the economy of the country. However, as the demand for healthcare services in countries with ageing population increases, it also creates a sensible socio-economic case to expand and invest in the technology and skills development in the healthcare industry.

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<sup>8</sup> Views expressed by the author in the article are her own personal views and should not in any way attributed to the institutions with which she is associated.

<sup>9</sup> Author's own calculations based on U.S. U.S. Census Bureau, International Programs, International Data Base, Revised: December 22, 2017, Version: Data:17.0810 Code:12.0321

## Migration Trend in ASEAN

Primarily, what ASEAN countries with ageing population most urgently need are healthcare workers to take care of ailing elderly. A Shrinking workforce means less workers are available, and the consequence is a shortage of healthcare workers. One of the most direct responses to shortage of local healthcare workers is to hire foreign healthcare workers. This approach is certainly not new to ASEAN. Despite the lack of relevant statistics, a casual observation supports the reality that some ASEAN countries are indeed host to a significant number of foreign healthcare workers from within ASEAN.

As a rough approximation, based on the International Labour Organization's (ILO) International Labour Migration Statistics Database in ASEAN<sup>10</sup>, as host country, 88 percent of Cambodia's total migrant workers came from within ASEAN in 2008; Thailand 68 percent in 2010; Brunei Darussalam 69 percent in 2014; and Indonesia 44 percent in 2016. As sending country, however, only 10 percent of Philippine and Thai nationals reside in another country within ASEAN in 2013 and 2012, respectively; and interestingly, 89 percent of Myanmar nationals were reportedly living abroad in Malaysia, Singapore and Thailand is an outlier.

From the statistics, we can say that as host country, ASEAN countries appear to have preference for migrant workers from another country within the region. As a destination, ASEAN countries tend to appear less attractive to migrant workers from other ASEAN countries. Indeed, ASEAN countries with ageing population would face tight competition against other countries in the Asia-Pacific, such as Japan, Korea, Australia and soon China, for foreign healthcare workers from ASEAN countries.

## Challenges facing ASEAN in Care Economy

There are two plausible explanations to the difficulties ASEAN countries might face in attracting foreign healthcare workers. First, to begin with, apart from professionals practicing as medical doctors and specialists, the care sector is generally perceived as a low-skilled occupational sector that is labour-intensive and demands more of manual or physical labour than mental skills. On top of that, the typical salary a healthcare worker commands are perceivably low considering the nature of the job requires long and irregular working hours. In a country with an expanding middle-income class and increasing affluent society, the career choices of young people tend to be driven more by aspirations. The low perception of healthcare work in general hardly matches up to those aspirations.

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<sup>10</sup> International Labour Migration Statistics Database in ASEAN, Version V (June 2017). <http://apmigration.ilo.org/2016ILMSDatabaseinASEAN.xlsx>

This perception issue requires a multifaceted approach to address. First, the profile of healthcare workers can be raised by enhancing the type, level and quality assurance of their skills. As technology takes over the routine manual, physical and mechanical processes, healthcare workers would be expected to get more involved in and focused on interactions with those receiving care. To ensure the quality of care services, the future healthcare workers would require stronger cognitive skills and emotional quotient (EQ), as well as analytical and diagnostic competences to detect early symptoms of health conditions. These skills would not only increase significantly the value-add to care services of healthcare workers provide, but also allows building a career path that would open to opportunities to pathways to diversify their skills into counseling, psychology and social work. Such job prospects for healthcare workers are likely to increase the perception of the occupation itself.

Second, theoretically one of the main factors affecting the decision of a migrant worker to look for jobs abroad is income difference between the home and host countries. When presented with choices, it is more likely that a migrant worker chooses to seek job opportunities in a foreign country where he or she could fetch a higher income than another one. Other pull factors of labour migration include job or career opportunities, work and employment conditions, to name a few. Competition to seek after the same pool of resources of care would only intensify as more countries, within ASEAN and outside the region, face ageing population.

### **ASEAN's Initiatives to the Challenges in the Care Economy**

To address the challenges related to human resource and skills development of healthcare workers, there are a number of ASEAN initiatives worth noting. In 2006, the ASEAN Economic Ministers signed the Mutual Recognition Arrangement (MRA) on Nursing Services to support the mobility of nursing professionals within ASEAN. A platform was created to convene regular meetings for the ASEAN Joint Coordinating Committee on Nursing (AJCCN) to exchange information and expertise on standards and qualifications, to promote adoption of best practices, and capacity building opportunities for nurses.<sup>11</sup>

The ASEAN Qualifications Reference Framework (AQRF) was developed as a common regional reference framework to compare and link education qualifications across participating ASEAN Member States (AMS), was developed. The framework has eight-level descriptors covering all levels of education qualifications and sectors. Some of the objectives of the AQRF are (i)

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<sup>11</sup> ASEAN (2006) ASEAN Mutual Recognition Arrangement on Nursing Services. [http://www.asean.org/wp-content/uploads/images/2015/april/mra\\_nursing/MRA%20Nursing%20signed.pdf](http://www.asean.org/wp-content/uploads/images/2015/april/mra_nursing/MRA%20Nursing%20signed.pdf)

support recognition of qualifications, (ii) promote lifelong learning, and (iii) promote higher quality qualifications systems. It also complements the eight MRA initiatives<sup>12</sup> to support the workers and learners' mobility.<sup>13</sup> The endorsement of the framework by the ASEAN Economic Ministers, ASEAN Education Ministers and ASEAN Labour Ministers was completed in 2015.

In 2016, the ASEAN Labour Ministers endorsed the ASEAN Guiding Principles for Quality Assurance and Recognition of Competency Certification Systems that aims to provide principles and protocols for developing trust, mutual understanding and recognition of TVET quality assurance processes and competency certification systems.<sup>14</sup>

Finally, in 2017, the ASEAN leaders signed the ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers at the 31st ASEAN Summit.<sup>15</sup> The Consensus aims to establish a framework for closer cooperation among AMS on addressing migrant workers' issues in the region.<sup>16</sup>

To prepare the challenges fast advancing technologies to replace routine manual, physical and mechanical care processes, ASEAN is focusing on improving Science, Technology, Engineering and Mathematics (STEM) education, including teaching and training quality, developing regional standards on STEM and capacity-building. ASEAN currently has youth exchange programmes focused on STEM in support of the ASEAN Work Plan on Education.

### **Scope for South-South Cooperation**

The on-going initiatives of ASEAN are some demonstrable efforts of south-south cooperation to develop solutions to address common challenges of different nature. However, more needs to be done to ensure the effectiveness of the existing and new ASEAN's initiatives to promote and tackle challenges in the care economy. These needs are diverse in nature and to pursue

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<sup>12</sup> The eight MRAs are: (i) Engineering Services, (ii) Architectural Services, (iii) Accountancy Services, (iv) Surveying Qualifications, (v) Nursing Services, (vi) Medical Practitioners, (vii) Dental Practitioners, and (viii) Tourism Professionals.

<sup>13</sup> ASEAN (2018) ASEAN Qualifications Reference Framework. <http://asean.org/asean-economic-community/sectoral-bodies-under-the-purview-of-aem/services/asean-qualifications-reference-framework/>

<sup>14</sup> ASEAN (2018) ASEAN Guiding Principles for Quality Assurance and Recognition of Competency Certification Systems. <http://asean.org/storage/2018/03/Guiding-Principles-for-Quality-Assurance-and-Recognition-of-Competency-C....pdf>

<sup>15</sup> ASEAN (2017) ASEAN Consensus on the Protection and Promotion of the rights of Migrant Workers. <http://asean.org/storage/2017/11/ASEAN-Consensus-on-the-Protection-and-Promotion-of-the-Rights-of-Migrant-Workers.pdf>

<sup>16</sup> ASEAN (2017) ASEAN Leaders commit to safeguard the rights of migrant workers. <http://asean.org/asean-leaders-commit-safeguard-rights-migrant-workers/>



activities and programmes to address the challenges would require different approaches, from types to level of engagement.

The first is to develop tools to assess and estimate the supply and demand equation to ensure the balance of the job and labour markets in the care economy in the medium- to long-term. This, in part, has been covered by studies conducted by international organisations, such as the ILO, and other research institutes.

The second is to strengthen engagement with healthcare services suppliers to better understand the type and level of skills needed to ensure healthcare workers are adequately trained and gainfully employed. The third is to raise the occupational profile of healthcare workers by focusing on developing and strengthen cognitive skills to apply knowledge in different care settings to execute specific task more effectively. Last but not least, is to create conducive working and living conditions to make healthcare sector a more attractive industry to pursue a career or pathways to diversify skills. These are strategic areas where closer and deeper south-south cooperation could be fostered among ASEAN countries and other potential countries with expanding care economy sector to share best practices and understanding needs and gaps to develop capacity building programmes and skills development of healthcare workers in a sustainable manner.

## Komazawa, Osuke and Iwasaki, Fusanori, “ERIA’s commitment to the regional integration in East Asia” (ERIA)

### About ERIA

Southeast Asia is the region with a rich diversity in a variety of aspects, such as political systems, security issues, economic status, social institutions, culture, languages, etc. It is also the region that has been heavily influenced by great surrounding powers. Association of Southeast Asian Nations (ASEAN) has been playing a crucial role to promote the solidarity, cooperation and development of the region since its establishment in 1967 and its expansion to current members in 1990s. The Association adopted fundamental principles of mutual respects, non-interference, and settlement of disputes by a peaceful manner.

The Economic Research Institute for ASEAN and East Asia (ERIA) is a Jakarta-based international organisation that was established in 2008 with the agreement of the leaders of 16 East Asia Summit member states, which consisted of ten ASEAN countries, along with Australia, China, India, Japan, Republic of Korea and New Zealand. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community (AEC) building and to support wider regional development and community building. ERIA was encouraged in the Chairman’s statement of the 12th East Asia Summit in 2017 to continue its supports for the Chair of the ASEAN Summit and East Asia Summit, and actionable policy recommendations for EAS Economic Ministers.

ERIA’s research activities fall into three pillars; (1) Deepening economic integration, (2) Narrowing development gaps, and (3) Achieving sustainable economic development. Research projects cover a wide range of policy areas, including trade and investment, globalization, small and medium-size enterprise promotion, human resources and infrastructure development, as well as energy and the environment. Beside research activities, ERIA also has the Outreach Department and the Policy Design Department. Specifically, the Outreach Department provides capacity building programs, aiming at increasing the policy research capability of government officials from Cambodia, Lao PDR, Myanmar and Viet Nam (CLMV). The Policy Design Department responds to the growing demand to bridge the gap between research and policy activities. For example, it supports the chair countries of regional summits in developing agenda, with particular focus on ERIA’s research achievements.

In this paper, ERIA’s research achievements related to SSTC are described in Section 2. Section

3 presents ERIA's new research findings on population ageing and long-term care, which covers the discussion about care workforce in Southeast Asia.

### **ERIA's achievements in the context of South-South Cooperation**

ASEAN and East Asia region is expected to be the next centre for global growth. In order for ASEAN to reap great success, ERIA has conducted a number of economic development studies. One important research subject, among others, is infrastructure strategy. Notably in 2010, by the request from the leaders of EAS, ERIA published the Comprehensive Asia Development Plan (CADP) to help member states cope with the global financial crisis in 2008 (ERIA, 2010; and updated version, ERIA, 2015). The CADP illustrated a grand spatial design of economic infrastructure and industrial placement in ASEAN and East Asia based on the new geographic economic theory. The mechanics of dispersion and agglomeration have been applied to expand international production networks for deeper economic integration and narrower development gaps. Furthermore, to mobilise the resources and investment from private actors, ERIA has implemented several research projects and created the guidelines of PPP scheme for infrastructure development (Zen and Regan, 2014 and 2015).

Cross-border movements of technicians and experts have been made easier with the promotion of regional economic integration and infrastructure development among ASEAN and East Asia States. The development process benefits significantly from both physical connectivity, and institutional/people-to-people connectivity (ASEAN, 2010). Infrastructure development is expected to enhance the South-South technology transfers or technology cooperation among countries. Based on ERIA projects, Norasingh et al. (2015) showed that firms in Lao PDR obtained technologies through face-to-face contacts with partners from the neighbouring countries, in particular China, Thailand, and Vietnam. The re-locations of the production sites, resulting from activities of Multi-national Corporations (MNCs), from China to Cambodia, Lao PDR, Myanmar and Vietnam (CLMV) (China plus One) or from Thailand to CLMV (Thailand plus One), have also encouraged the South-South transfers and technological cooperation in the region. Furthermore, rapid industrial development across East Asia increases the access to frontier technology and knowledge for firms in Vietnam and other less-developed ASEAN member states, which in turn improve their local quality, cost and delivery (QCD) (Machikita and Ueki, 2013). Iwasaki and Ueki (2018) depicted the cases of Thailand-plus-one relocation as the prime example of technology transfer from Thailand's small and medium enterprises (SMEs) to manufacturing factories in Lao PDR.

Innovations are important drivers of the economic growth. Ambashi (2018) surveyed the innovation policies among ASEAN member states and formulate initiatives to promote policies

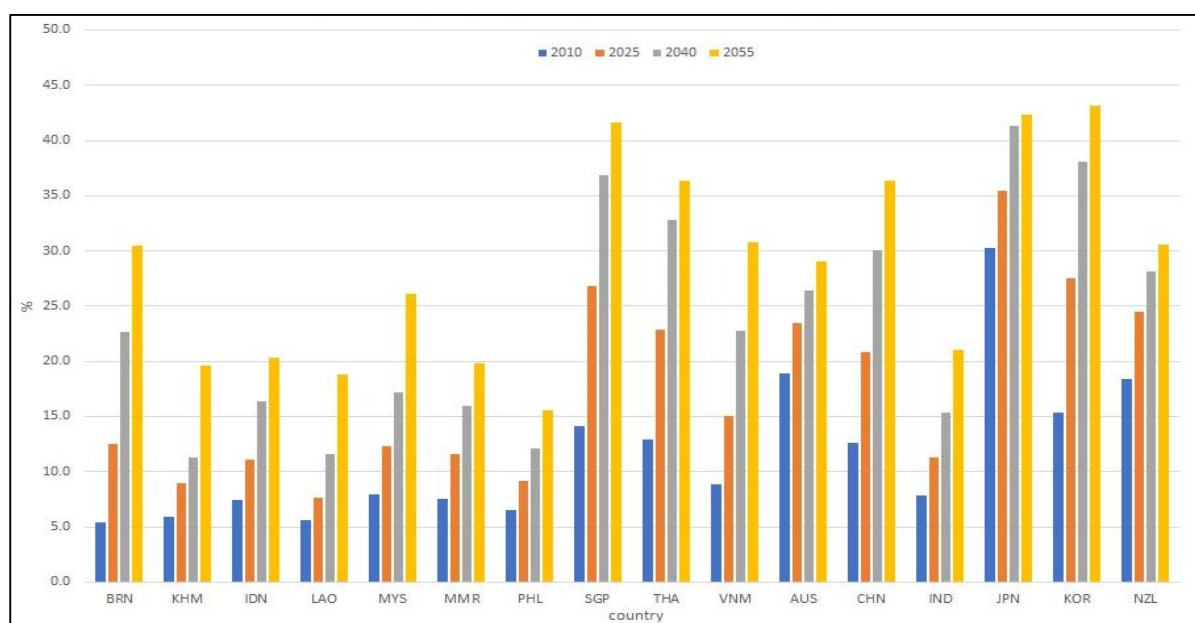
that create and entail more synergies across countries. A region-wide innovation system ensures a robust economic growth and avoids the “middle income trap.” In this context, ERIA contributes the policy implications to the innovation policies, such as the university-industry linkage and developing local government policy centres.

### **ERIA’s new challenge to promote regional cooperation in population ageing.**

The ASEAN Economic Community (AEC) is one the three pillars comprising the ASEAN Community. ERIA has been making efforts to expand its role to two other pillars, which are critical for regional integration and development as well as narrowing development gaps. One of them is health and long-term care.

ERIA established the Healthcare Unit in August 2017, in response to the Asia Health and Wellbeing Initiative (AHWIN), which was launched by the Government of Japan in 2016. AHWIN aims to promote bilateral and regional cooperation that fosters sustainable and self-reliant healthcare systems in Asian region. The goal of this initiative is to create vibrant and healthy societies where people can enjoy long and productive lives, and to contribute to the region’s sustainable and equitable development as well as economic growth. The population of ERIA member states will be, or has already been, ageing quickly (Figure 1).

**Figure 1:** Proportion of people aged 60 or above to the total population



Source: United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, custom data acquired via website.

Drawing on the lessons learnt in Japan, the most aged country in the world, this initiative focuses on the ageing-related challenges with the following four pillars: (1) to review and

share Japan's experience that could benefit other countries in the region, (2) to provide training for long-term care workers in the region and to facilitate their smooth and region-wide movements (3) to promote and develop the long-term care industry in the region, (4) to conduct policy research and dialogues on healthy ageing, elderly care, and other relevant issues that benefit from regional approach.

ERIA, as an international research institute, has already started several research projects on population ageing and long-term care. One example is the longitudinal survey of older people. This study is designed to track individuals aged 60 years or above for multiple years to analyse factors which contribute to longer and healthy lives. In Southeast Asia, few such studies have been put in place. We will first implement this survey in the Philippines and Viet Nam, where about six thousand older people aged 60 or above will be selected randomly from each country.

ERIA also implements some studies focusing on care workforce in Southeast Asia, in collaboration with the experts of local research institutions. Through these research projects, ERIA would like to promote the standardisation of care provision and the harmonization of certification system of caregivers, so that caregivers could attain reputable social status as the profession with professional knowledge and skills rather than just as physical workers. ERIA expects that this effort could work for attracting potential care workers, and it would lead to enough supply of well-trained caregivers, the crucial component for vibrant and healthy ageing societies.

ERIA's studies on care workforce will be developed on the foundation of two main outcomes of the preceding researches conducted by local experts, who have been working closely with the organisation. The first outcome suggests that most of the care workers who worked in aged societies abroad and went back to home countries are no longer engaged in the local care industry. This implies that their skills and knowledge of long-term care are not well mobilised in their home countries, where rapid ageing is expected in the near future. The second outcome shows that there is a considerable number of nurses who are registered nurses in their home countries but work as domestic workers in destination countries. Domestic workers are often ordered by their employers to take care of older people, so in such cases, the difference between domestic workers and caregivers is ambiguous. Such migrant nurses are often preferred to ordinary domestic workers who have not received any structured training of care, especially when the families who have older family members look for domestic workers to be employed. This kind of job mismatch could be derived by the payment level gap between their home countries and receiving countries, but it can be considered as waste of skills and knowledge from the view of their home countries.

Cross-border movement of care workforce is unavoidable, as long as some countries have labour shortage while other countries have abundant human resources. ERIA would like to contribute to the international cooperation, through its researches and policy recommendations, to raise the awareness on the importance of care workers and their mobilisation for a more vibrant and prosperous ageing ASEAN.

## **Conclusion**

ERIA is characterised by the followings; (1) it is an independent international research institute, (2) it consists of 16 member states which cover East Asia, South Asia and Oceania together with ASEAN member states as the core, (3) it has strong communication ties with ASEAN policy making process. ERIA is currently in the process of editing 'ASEAN Vision 2040' which will be published in 2019 and will be shared with ASEAN Secretariat and member states. We believe our activities like this project are one of the models of SSTC.

ERIA celebrates its 10th anniversary in 2018. We are a still young organization and more than willing to cooperate more closely with the member states, international organizations and other relevant institutions in the development of the policies which contribute to fulfil ASEAN's mutual vision.

## Perez, Juan Antomio A., “Responding to the Needs of Aging Societies: The International Mobility of Filipino Health and Care Workforce” (the Philippine)

### **The Rising Demand for Health and Care Workers in Developed Countries**

With the rapid aging of population in developed countries, the Philippines has become one of the major sources of “care workers”, mainly domestic care and health care workers. To wit, in the last three years, the Philippines has regularly supplied health and care workers to the Middle East, America, Asia, and European countries. Data provided by the Philippine Overseas Employment Administration (POEA) showed that in 2010-2015, health and care workers (professional nurses and caregivers) are among the top skills deployed by the Philippines.

### **The Filipino Health and Care Workforce and South-South Cooperation: Towards Competitiveness and Regional Integration**

The Philippine Government is indeed committed to hone technically competitive and dedicated health and care workforce by giving attention to:

- Education and training
- Core competency standards
- Quality assurance
- Remuneration prospects
- Personal attributes (i.e. language skills)

With the continued globalisation and emerging regionalism, Filipino health and care workers are poised for regional integration. For instance, under the framework of South-South Cooperation, the Philippine Government has been working on technical cooperation (TC) towards signing and implementation of mutual recognition agreements (MRAs) that will facilitate the recognition of qualifications of Filipino professional nurses in the country of destination.

### **Cross-border Movement of Filipino Health and Care Workers: Challenges and Opportunities**

The Philippine population still remains relatively young marked by a high and slowly declining fertility and a declining mortality. Such demographic shifts have led to a gradual change in the age structure with a slowly increasing proportion of people in the older ages. Though the proportionate share of older persons is still low, there is an apparent steady increase in absolute terms. In 2015, the census count showed there were 7.5 million people 60 years and above or 7 percent of the total population of 100.98 million. By 2030, the number of

older persons is expected to reach 15 million or 14 percent of the country's projected population of 110 million. The increase in the proportion and number of Filipino older persons is coherent with its rapid growth rate of 3.2 percent per annum from 2000-2010 which makes it to be the fastest growing segment of the Philippine population.

Indeed, the seeming paradox between the rapid growth of the older segment of population and the increase in out-migration of health and care workers poses a big challenge that requires sound policy initiatives. Even though the tradition of caring for the old still lingers in Filipino families, adequate quantity and good quality of health and care workers are vital necessities at the community level particularly by older persons who are abandoned and with no significant others to give care.

Inevitably, the exodus of health and care workers among others is seen as “brain drain” for labour-sending countries like the Philippines and “brain gain” for the receiving countries. The challenge now is how to tap the benefits from the phenomenon of losing and gaining of skills and experiences through “brain circulation” as the Filipino migrants return to the Philippines. Often, “remittances” appear to be the most popular “counter-weight” of brain drain. Yet, only few tells of “social remittances” which may be in the form of superior confidence and more competent skills that migrant workers may take with them upon their return to the country.

Nevertheless, return of Filipino overseas workers such as care workers requires improvement in prospects in the domestic front such as competitive salary, adequate incentives and opportunities for continued education and training. Moreover, the foregoing window of opportunity from “brain circulation” requires strengthening of current measures on reintegration for return overseas Filipino workers that includes health and care workers. It should be ensured that the current government reintegration programs address economic, social and psychosocial concerns of the return migrant workers to make their return meaningful to them, their families and their communities.

### **Caring for the Carers: Advancing the Career Growth and Welfare of Filipino Health and Care Workforce**

Finally, the Philippine Government through the leadership of the Department of Labor and Employment (DOLE) has been working on the following measures for the advancement of career and welfare of Filipino health and care workforce:

- Benchmarking of course curriculum and comparability studies and technical cooperation (TC) towards signing and implementation of mutual recognition agreements (MRAs);
- Promotion of welfare, social security and protection of rights through bilateral dialogues with countries of destination; and
- Implementation of ASEAN Qualifications Reference Framework (AQRF) and MRAs on 7 priority professions including nursing.



# Rahardjo, Tri Budi., Agustin, Dinni., and Guritno, Dian E, "Service Delivery for Older Persons by Young Generation in Indonesia" (Indonesia)

## Abstract

Indonesia's elderly population is growing at an unprecedented rate throughout the period of 1990 - 2020, as well as experiencing an increase in life expectancy from 66.7 years to 70.5 years. The number of older persons in Indonesia is expected to increase to 28.8 million (11% of the total population) in 2020, and 80 million (28.68%) in 2050. The longer the life of a person, the more the person is prone to experience physical, mental, spiritual, economic and social problems. Based on *RISKESDAS* (Basic Health Research 2013), the diseases found amongst the older persons in Indonesia include hypertension, osteoarthritis, dental-oral problems, chronic obstructive pulmonary disease (COPD) and diabetes mellitus (DM) (Ministry of Health of the Republic of Indonesia, 2014). The emergence of various diseases and disorders can lead to functional disabilities in older persons, with more severe conditions requiring the help of others, hence the need for long-term care (LTC). Disability as measured by the ability to perform activities of everyday life or Activity of Daily Living (ADL) affects approximately 51%, and around 10% of them are suffering from severe disability with increase in age. To cope with this situation the *Service Delivery Model on the Promotion of Older Persons' Quality of Life through the role of young generation, and the need of formal care givers in the near future*". In this regard, *BKKBN* (*Badan Kependudukan dan Keluarga Berencana*/National Board of Population and Family Planning) through family based care, and two community development established by young generation in Central Sulawesi and Yogyakarta have implemented the services for older persons. As most of older persons prefer to stay at home and being cared by the family, appropriate training to the family should be conducted. On the other hand formal care giver would be very highly needed, hence training and education for formal care giver should be conducted properly.

Keywords: older persons, ability, quality of life, young generation, care giver training

## Background and Objectives

Population ageing is mainly the result of decrease in fertility rates and increase in life expectancy. The total fertility rate started to decline and, by the turn of the century, had dropped to less than half. At the same time, measures were introduced to improve access to quality health care that resulted in significant declines in mortality: life expectancy increased

from 45 years in 1971 to over 65 years by the turn of the century. Indonesians were, on average, enjoying a longer life span. As a result of declining fertility and mortality rates, the age structure began to shift towards the higher age groups and the latest 2010 Census has shown that Indonesian policy makers need to prepare for a rapid increase in the country's older population during the coming years. On the other hand, these conditions will be more severe if the aging of the population is accompanied by pathological conditions. The aging process is affected by the risk of various diseases, especially chronic/degenerative.

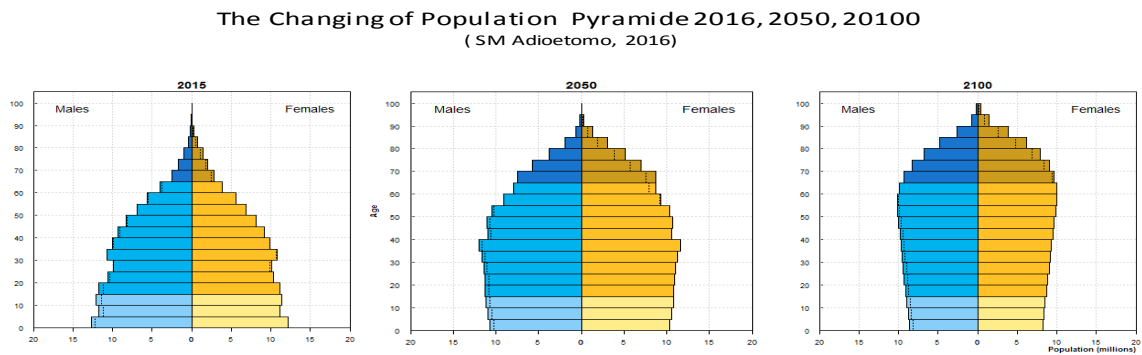
The conditions above require health service delivery. Therefore health service delivery for the older persons will be conducted in a comprehensive manner, starting from families and communities (integrated health service delivery post for the older persons and home care), first level health service facility (*Pusat Kesehatan Masyarakat/Puskesmas* or Community Health Center) and referral health service facility (Hospital). Meanwhile, there are only 14 referral hospitals in Indonesia, considering the complexity found in handling a geriatric patient, Comprehensive Geriatric Health Services are required (promotive, preventive, curative, rehabilitative and palliative) with a holistic approach lead by an integrated team. The services are conducted in stages starting from the community, community health centers to hospitals/ *Geriatric Health Continuum Care*.

In the community, caring for older persons are conducted by the family and volunteers, supervised by health professionals from primary health centers. Hence the majority of older persons prefer to be cared by family, particularly children, but on the other hand the number of young generation as informal caregiver is decreasing. It means the professional care givers are highly needed. Therefore, this paper would discuss the "Service Delivery Model on the Promotion of Older Persons' Quality of Life through the role of young generation, and the need of formal care givers in the near future"

## **Demographic Profile**

Indonesia's age structure has been gradually shifting towards higher age groups. The process of change in the age structure is illustrated in Figure 1 through the presentation of population pyramids at various stages of the demographic transition. The changing shape of the population pyramid through time provides a visual depiction of the changes in the age structure.

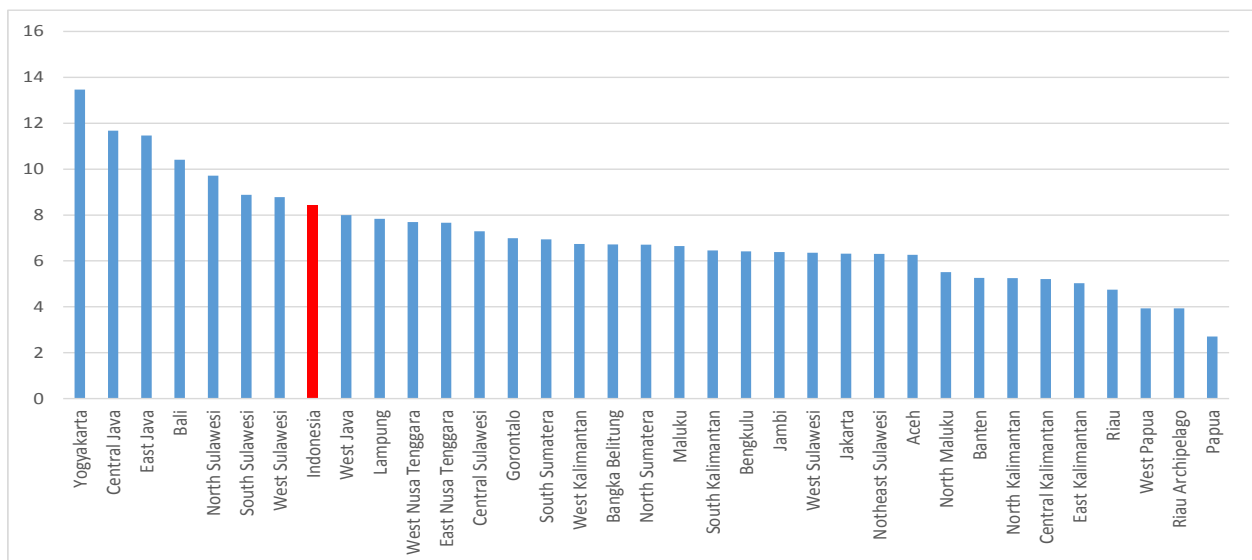
**Figure 1: The changing of Population Pyramid 2016, 2050, 2100**



Source: SM Adioetomo, 2018

Comparing the pyramids, it can be seen that over time the base of the pyramid becomes narrower. There is a gradual narrowing of the bottom three layers (depicting ages 0-14 years) which reflects the declining fertility as a result of Indonesia's successful family planning programme. At the same time there is a broadening of the top four layers (depicting ages 60 and over) which results from improving life expectancy (SM Adioetomo, 2013). Population ageing will also occur in Indonesia, as shown below:

**Figure 2. Proportion of Older Persons by Province, Indonesia, 2015**



Sources: BPS-Statistics Indonesia, 2015

Among 34 provinces in Indonesia, only 9 out of 34 provinces (26.5%) have an older population below 6% and the national figure is slightly above 8%.

## Health Profile, Disability and Quality of Life

With the decline in physiological functions due to degenerative processes, the immune system also decreases, resulting in non-communicable diseases and infectious diseases. This condition will reduce the ability to perform daily activities that have an impact on the decline in quality of life. Based on the distribution of diseases, Basic Health Research in 2013 showed rates of hypertension (57.6%), arthritis (51.9%), stroke (46.1%), dental and mouth problems (19.1%) chronic obstructive pulmonary disease 8.6%) and DM (4.8%) Approximately 34.6% of older persons suffer from one type of disease, about 28% with two diseases, approximately 14.6% with three diseases, about 6.2% with four diseases, approximately 2.3% with five diseases, approximately 0.8% with six diseases, and the rest with seven or more types of diseases (Research of the Ministry of Health of the Republic of Indonesia, 2013). The Centre for Ageing Studies Universitas Indonesia study in Depok 2014 showed data on vision impairment with a fairly high proportion especially in elderly men 90%, and advanced women age 75%; followed by memory impairment, joint disorders, hearing loss, osteoporosis and easily fall. In addition, geriatric syndromes appear, with the following findings: nutritional deficiencies (41.6%), followed by cognitive impairment (38.4%), impaired urination/urinary incontinence (27.8%), immobilization (21.3%) and depression 17.3% (Setiati, 2014), while frailty was found around 25.10% compared to other countries only around 10.70% (Siti Setiati et al, 2013). Furthermore Adioetomo (2018) found that there is increasing prevalence of disability by age. From 4.8% (male) and 5.2% (female) among 60 – 64 years old ; 7.9 % (male) and 10.4 % (female) among 65 – 70 years old; 32.0 % (male) and 37.7% (female) at 80 – 84 years old. It seemed that female tends to be more disable than male.

Rahardjo et al, 2016 showed that the quality of life of older persons in the community was higher (93.2%), compared to those in institutional home (66.7%). Factors that correlate with the quality of life of the elderly: 1)Self-care and activity daily living; 2)Education; 3)Economic status; 4) Participation and quality of life; 5)Physical dimension: Health examination; 6)Emotional dimension Meet-up each other; 7)Intellectual dimension: reading holy book; 8) Social dimension: family gathering, support each other; 9)Vocational dimension: keep working; 10)Spiritual dimension: Be grateful; and 11) Environmental dimension: falls prevention life. Recently, there are 31000 Family Based Care for Older Persons (*Bina Keluarga Lansia*) that conduct health and social services in which the role of family and younger generation are significant. Those approaches would be appropriate manner to promote quality of life of older persons.

## Caring for Older Persons by Young Generation

According Indonesia Family Life Survey, 2014 most of older persons are cared by the family particularly children around 63%, and by whom older persons want to be cared in the future would tend to be children as the majority, around 73%. This kind of situation found in 11000 Family Based Care conducted by *BKKBN (Badan Kependudukan dan Keluarga Berencana/* National Board of Population and Family Planning) where the family particularly children take care for older person in maintaining their wellbeing including spiritual, emotional, intellectual, social, physical, vocational and enabling environment. In addition there two NGOs/Foundations established by young generation in Yogyakarta and Palu Central Sulawesi who take care of older persons through community services, home care and education to the family as well as empowering older persons based on their condition and interest. However there are not professional caregivers. Therefore capacity building such training and education on care giving are highly needed.

### **South-South Cooperation: standard of Training and Education for Caregivers**

Since 2016, Ministry of Health with other ministries have been developing a standard of caring and education for caregivers particularly on Long Term Care for older persons. Rahardjo et al 2018 presented the draft of those in ACAP (Active Aging Consortium Asia Pacific Conference) and being discussed whether the standard would be appropriate for national and international market. It seemed that in general the items have been comprehensive, and would be implemented according to the level of dependency and the value of country where the caregivers would be working. The level of care givers would be informal care givers (50 hours training), and formal care givers from 300 hours training to 3 years education.

Under the framework of South-South Cooperation, Indonesia government possesses the opportunity to share its experiences and learn from the Training System for care workers of other ASEAN member states and also from East Asia countries. Furthermore, there are possibilities of signing Mutual Recognition Agreements and of skills and educations of care workers, which in turn increase the competitiveness of the local care workforce and encourage the their mobility in the region.

### **Conclusion**

We conclude that Indonesia tends to face population ageing, and the need of care among older persons increase accordingly. Most of older persons prefer to be cared by the family particularly children however the competency as caregivers is still limited. Family based long term care by BKKBN and caring by young generation would be potential in the near future that should be trained and or educated properly.



# Thaworn SAKUNPHANIT, “Community Based Long Term Care Initiative” (Thailand)

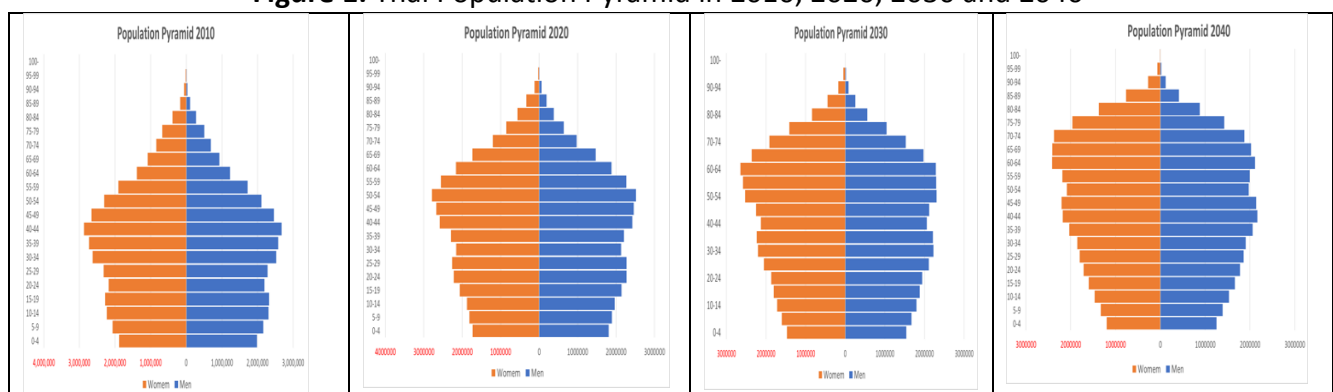
## Background and context

The Kingdom of Thailand is located in continental Southeast Asia. Ministerial functions are delegated to local administration at provincial level, under the supervision of provincial governors.

### *Demography*

Thailand is an aging society with the population of around 66 million in 2017. The population age structure pyramids are changing shape due to decreased total fertility rate and increased life expectancy. The total fertility rate was 1.62 in 2010; and could decrease to 1.3 by 2040 (NESDB, 2013). Life expectancy at birth was 70.39 for males and 77.47 years for females in 2010. The National Economic and Social Development Board (NESDB) forecasts that, by 2040, life expectancy at birth will increase to 75.25 (male) and 81.86 (female).

**Figure 1: Thai Population Pyramid in 2010, 2020, 2030 and 2040**



Source: Population Census 2010 (National Statistical Office, 2011) and Population Projection by the National Economic and Social Development Board (NESDB, 2013).

The number of older people will increase from 8.4 million (13% of the population) in 2010 to 20.5 million (32% of the population) in 2040. The total dependency ratio will increase from 0.41 in 2010 to 0.61 in 2040. Old people in Thailand usually live with one or more adult children. Even though the number of older people living alone or living only with a spouse increased steadily from 1986 (John Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015), there is trend of a continuing decline of co-residence with children. 85% of older people receives monetary and non-monetary supports from their children. However, older people's direct income from other sources is increasing, such as from work (main source of income for 34% of older population)

### *Economic*

Thailand is an Upper Middle-Income country, which enjoyed high growth from an economy based on exports, manufacturing and an abundant labour force. However, current economic growth is slow down. Future growth is projected to remain low (3-5%) due to structural challenges, low productivity and the aging society (Jitsuchon, 2014). Although Poverty rate based on the absolute poverty line is not high, inequality remains a challenge for Thailand. However, in 2013, 7.3 million Thais were considered poor <sup>17</sup>and another 6.7 million lived within 20 percent of the national poverty line and remained vulnerable to falling back into poverty. (World Bank, 2016).

### *Policy and Regulatory Framework*

Regarding to legal framework, the Constitution of Thailand (B.E. 2560 (2017)) provides the right to public health services for all citizens, including the rights of older people. There are many acts relevant to the care of older people, among which the most important are the Elderly Act B.E. 2546 (2003), the National Health Security Act B.E. 2552 (2002), and the Determining Plans and Process of Decentralization to Local Government Act B.E. 2542 (1999). The Elderly Act B.E. 2546 assures older people the right to health services, employment opportunities, social participation, waiving fees for public services, appropriate accommodation and a monthly allowance (pension) for older people. The National Committee on the Elderly (NCE) chaired by Prime Minister is established under this act. The National Health Security Act B.E. 2552 (2009) established universal health coverage. The Determining Plans and Process of Decentralization to Local Government Act B.E. 2542 (1999) determined the process of decentralization of the central government activities including health care and social care to local authorities, and between local authorities.

The Thai Government has adopted several policies for older person and works closely with civil society on aging issues. The First National Older People's Plan (1986-2001) was influenced by the First World Assembly on Aging in Vienna in 1982. However, the first plan did not include policies to prepare people for old age, improve self-care, boost social participation, strengthen family values and integrate relationships, nor strategies to sustain family support for older people (Jitapunkul, Chayovan, & Kespichayawattana, 2002). The Second National Older People Plan (2001- 2021), using a life-course planning approach, was designed on the principle that security in old age means security for society. Despite the well-designed plan, performance evaluation for the first five years (2001-2006) found that the implementations were unsatisfactory, especially in preparing people for high-quality old age and providing social protection for older people (Prachuabmoh, 2008). Currently, there is no legal framework that specifies standards for management, nor any comprehensive regulations for Long term care in Thailand.

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<sup>17</sup> In 2013, Poverty rate using national poverty line was 10.9, and Poverty rate (US\$3.10 a day, PPP terms) was 1.1%



Governance structure for older people care, including Long term care in Thailand, is fragmented. There are various central government agencies cover different topics of older people. The Ministry of Public Health is responsible for health care and health care providers. For instance, regulations for Long term care institutions under the Health Establishment Act is the responsibility of the Department of Health Service Support (DHSS) at the MOPH. The Ministry of Social Development and Human Security (MSDHS) is responsible for regulating social care including residential home. The Ministry of Finance (MOF) is responsible for fiscal policy including financing policies for aging society. The MOF has already prepared a range of measures to address the aging society. The Ministry of Interior (MOI) is responsible for overseeing local authorities. The Office of Insurance Commission (OIC) is responsible for regulating private insurance including Long term care insurance, however, private LTC insurance is, currently, a research agenda. The National Health Security Office (NHSO) is responsible for providing universal health coverage for Thai people, which has worked closely with local authorities in pilot areas for community-based long term care. However, the legal framework of local authorities - which are expected to provide social and environment modifications for older people - does not clearly specify whether long term care services are included in their authority under the Determining Plans and Process of Decentralization to Local Government Act.

Thai civil society has been involved in policy design and policy formulation regarding older people issues. Elderly clubs, other NGOs e.g. the Thai Red Cross Society, the Foundation for Older People's Development and HelpAge International, the Duangprateep Foundation, some religious organisations have played significant role to shape the design and partners for implementation of many initiatives for older persons, especially those in poor and remote areas. Older people are encouraged to form elderly clubs. The Association of Senior Citizens Council of Thailand is a not-for-profit organization under the patronage of Her Royal Highness the Queen Mother that was established in 1989. This association plays a role in coordinating elderly clubs and contributing to policies, such as the Elderly Persons Act of 2003. The chairman of the association also acts as deputy chairman of the NCE. The association also plays an active role in encouraging people to form elderly clubs in every province, managed by older people themselves.

Thai government is keen on encouraging people volunteer for public activities. The MOPH has recognised people's participation working as health volunteers as a critical factor for the effective coverage of health services. There are around 1 million MOPH-registered health volunteers, to cover the 67 million Thai population in 2016. The Home Care Service Volunteers for Older People, some of whom are also health volunteers, were initiated by the MSDHS in 2002. The scheme was piloted in four provinces and expanded nationwide in 2013. Currently,

this cadre numbers 51,000 trained volunteers who care for almost 800,000 people.

### **Demand for Care**

According to the Survey of Older People in Thailand, Self-assessed health status for those 60+ was very good, good or fair for 84%. The remaining 16% reported their health status as poor or very poor. Self-reporting of poor or very poor health increases with age. 53% of older Thai people self-reported that they had at least one chronic disease. The 5th National Health Examination Survey (NHES V) demonstrated a higher prevalence of obesity ( $\text{BMI} \geq 25 \text{ kg/m}^2$ ), and increase prevalence of chronic diseases e.g. Diabetic Meletus, and Hypertension (Aekplakorn, 2016).

There is an increasing trend of disability among older people. The overall disability rate in Thailand is 2.2% of which more than 57% are over the age of 60. Of those people over 60, 16.8% have a disability (ESCAP, 2011). The 4th National Health Examination Survey (NHES V), showed a higher prevalence of dependency among older people in Thailand compared to the previous survey of 2007-2008. Limitations in one ADL, two ADLs and three ADLs in Thai population were 11.4, 10.4 and 4.1 percent respectively. The prevalence rate of older people was higher than general population and also higher than the previous survey. Older people who need help with two or more ADLs or who were unable to perform continence-related tasks was 20.7% compared to earlier prevalence rates of 15.5%.

Older Thai people do not want to stay in LTC institutions; they prefer to stay at home. Housing survey found that 99% of older Thais preferred to stay at home with their community than to move to new places when they need additional support for daily activities. A survey on demand for LTC in Bangkok found that the main reasons were trust in family, lack of trust in institutional care, and financial capability. Those who willing to stay in LTC institutions cited the lack of a caregiver at home, the need for skilled assistance, and a desire to lessen the burden on family (Suwanrada, Sasat, & Kumrungrit, 2010).

### **Supply of Care**

The majority of care for older people in Thailand is provided by their families. Children account for 55% of caregivers, of which a large majority are daughters. Spouses are the second most common main caregivers (30%). However, the traditional role of adult children as caregivers for older people is declining. This can be partly attributed to shrinking household sizes, which decreased from 4.4 to 3.1 people per household between 1990 and 2010, and internal migration. There is also a growing low-skilled labour from neighbouring countries working as

caregivers for many Thai families. On the other hand, formal care is provided by a variety of trained volunteers, professionals and non-professionals both public and private. Government sponsored volunteer groups e.g. Health volunteers play a significant role in responding to the care needs of older people.

The number of private residential care facilities is increasing. In 2016, the Department of Business Development at the Ministry of Commerce (MOC) reported that there were 442 private facilities providing care for older people, of which two-thirds were private businesses and one-third was corporations. The number of private facilities reported was probably lower than the actual number, as there is no legal requirement for LTC facilities to register their service. These facilities can register their business with the MOC under other categories. Business owners also gathered together forming the 'Thai Older People's Promotion and Health Care Association' with 110 members in 2016. Although there are no public nursing homes in Thailand, public residential homes for vulnerable, active older people also provide care for frail and bedridden residents who have no specialised staff or facilities to assist them. Up to date, there are only 12 public residential homes provided by the MSDHS and 13 residential homes provided by local authorities.

### **Development of Community-based long term care and South-South Cooperation**

Diminishing of traditional care for dependent older person by families has been recognised by Thai government for decades. However, many initiatives to find alternative mitigating measures from the MSDHS and the MoPH, relied mainly on volunteers to support family role and have limited success. One prime example is the Home Care Volunteers for the Elderly (HCVE), whose amount and quality of services provided by volunteers varies across communities. Evaluation showed that only one third of local authorities reported that services provided by HCVE, such as home visits, assistance in preparing meal and eating, taking medicine and exercise, had met the needs of older people in their communities. The Health Volunteers from the MOPH who provide basic health care for older people share the same problems. It is difficult for existing volunteers to provide regular or routine care, especially for highly dependent older people, as they have other roles and activities in the community (Lakbenjakul, 2013).

In this context, South-South and triangular cooperation has proved to be an effective modality that offered innovative solutions, especially through technical cooperation collaborations such as:

- Technical cooperation between Thai and international experts for designing of the long term care service since 2008, which finally become a pilot for community-based long

term care. The first technical cooperation occurred in the Health Care Reform Project Phase II, which aimed to strengthening implementation of Universal Health Coverage in Thailand focusing on primary care, hospital management, financial management and social marketing including capacity building through formal training in EU countries, short courses, consultant and model developments. During project implementations, the need for long term care system was identified. Attempt to forecast long term care needs and expenditure was conducted in 2008 (S. Srithamrongsawat, Bundhamcharoen, & Sasat, 2009b). Three modelling approaches were used to project institutional LTC needs among older Thai people; a multiple state model, a linear model, and a modified multiple state model. The first model used Australian disability rates, while the third model modified Australian rates to fit to the Thai context. The second model assumed that all the rates were constant over time. However, there was no action following the study.

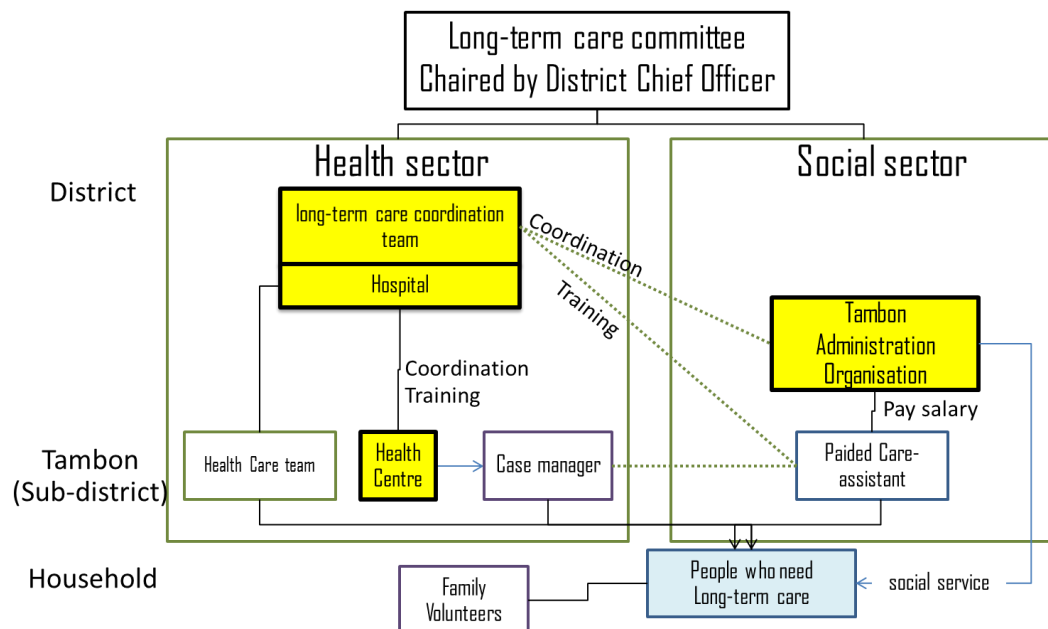
- The Collaboration among Japanese International Cooperation Agency (JICA), the MOPH and the MSDHS to support the development of community-based LTC in Thailand. The first phase (2007-2011) of the project Development of a Community-Based, Integrated Health Care and Social Welfare Services Model (CTOP), assessed the situation of aging, policies, welfare and social support systems in Thailand and piloted LTC models in selected sites. The second phase (2013-2017) focused on the Long-Term Care Service Development for Frail Older People and Other Vulnerable People (LTOP), which aimed to develop evidence-based policy recommendations for LTC targeting frail older people (Okumoto, 2015). Results were adapted and integrated into assessment tool to categorised dependent staging, training curriculum for care givers and case managers.

Local initiatives for community based long term care were inaugurated in many areas in Thailand. One prime example for community-based long term care policy is “Lamsothi Model”. This model was developed since 2006 for older people and the disabled, with the slogan, “People in Lamsothi will not ignore others”. This model comprises of 3 main initiatives - system governance and coordination initiative, integrated care initiative and appropriate technology initiative. The stakeholders involved in these initiatives were families, volunteers, paid care-givers, local governments, health care facilities and a chief district officer, appointed by Ministry of Interior.

System governance and coordination initiative has come from learning by doing since 2006 using bottom approach. It links people, health facilities, local and central governance together using both informal (local value, altruism, norm and culture) and formal institutions (legal framework) at district level. This governance structure (Figure 2) leads to friendly coordination for planning, deployment and monitoring long term care activities among stake holders

through a district committee, which is chaired by District Chief Office. Members of the committee comprise Representatives from health care facilities and representative from local governments.

**Figure 2** System governance structure and coordination



Source: (Lakbenjakul, 2013)

People-centre is a core value of the integrated care initiative. Family members are expected to be the “first hand” providing support to people with disability in their families. Volunteers are encouraged to support disability people in their community. Health facilities will take responsibility on health care services and local government are responsible for social service include housing and environment, along with paid caregivers for work in every village. Morning conferences between paid caregivers and health care professional team foster the integrated care. Individual plan for LTC is tailor-made for each person according to specific context of family. Appropriate technology initiative reduces the cost of community-based long term care. Equipment and changing environment for improvement of mobility and activity daily living for older people with disability were developed using local product and local wisdom, which appropriate for the context of Lamsonthi.

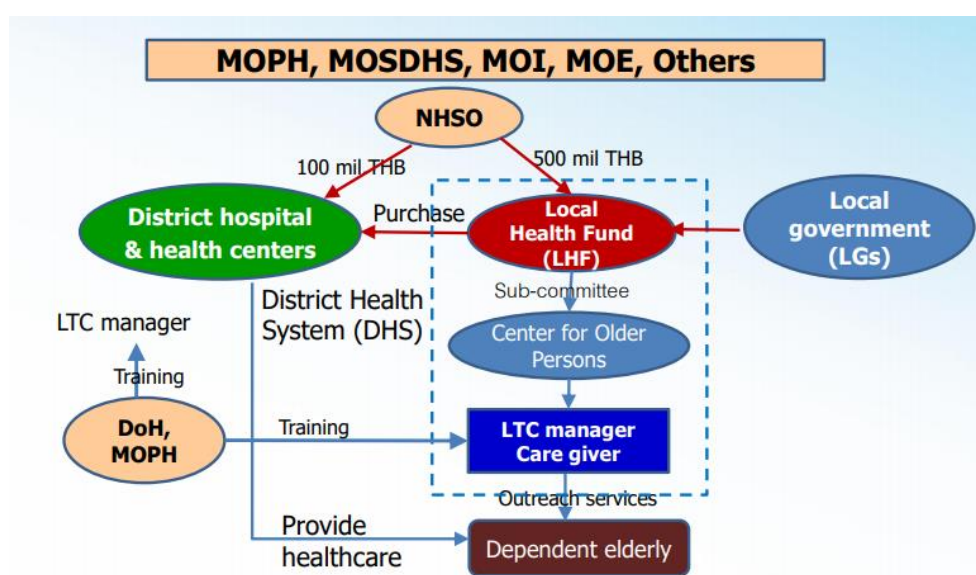
The ILO provided technical support for the Long term care development with the project “Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Thailand”. The ILO together with the Sante Protection Sociale International (GIP SPSI) providing French experts from the Caisse Nationale d’Assurance Vieillesse (CNAV) to collaborate with a group of Thai experts along with short-term consultants to assess situation in Thailand and providing workshop for design, researches to provide evident-based

for development policy, Unit cost for long term care services and Costing Model for Long-term care system in Thailand. A simple LTC actuarial projection, based on the Rapid Assessment Protocol (RAP), was developed in 2013 (Prasitsiriphon et al., 2014). The numbers of dependent people in each cohort was calculated using the prevalence rate of disability. Then the dependents in each cohort were disaggregated into 4 groups based on the level of disability. Management model was synthesis according to real practice especially from Lamsonthi district.

Result of technical cooperation with the JICA, the ILO and Thai experts were synthesized to prepare a pilot project for a Community-Based Long-term Care Program of the National Health Security Office, which started in 2016.

### *Design*

**Figure 3:** Governance and Coordination of the community based long term care



This current project aims to establish a case management system for community-based LTC and is managed by the NHSO and local authorities. A care manager, usually a nurse from health centres, assesses the care needs of a dependent older person, which leads to the development of an individual care plan developed through a multi-disciplinary team meeting. The care manager then assigns and supervises a volunteer caregiver to provide care according to the individual's care plan.

The caregivers provide home-care services, mainly to bed-bound and house-bound older people, with a relatively comprehensive package of services including health and social care elements. With a ratio of one caregiver to 7-10 dependent older people, 130,000-185,714 caregivers would be needed to cover 1.3 million dependent older people.

### *Benefit Package*

Long-term Care Benefits Package for Dependent Older People include medical services such as screening examinations, assessing the need of care, home visits, health promotion and preventive services, physiotherapy, occupational therapy, and the provision of rehabilitative and assistive devices as defined either by the Sub-Committee for the Development of a Long-Term Care System for Dependent Older People or by the NSHO are included in the benefits package. Similarly, social services such as assistance with housework or activities of daily living, the provision of social assistance equipment, assistance in performing activities outside the house, and so on, are included.

**Table 1:** Categories of groups and budget for each category

Group 1: Being able to partially move, having some eating or elimination disorder, no cognitive disorder	Group 2: Having cognitive disorder	Group 3: Not able to move, having some eating or elimination disorder or severe diseases	Group 4: Serious illness or palliative condition
Budget < 4,000 THB	Budget 3,000-6,000 THB	Budget 4,000-8,000 THB	Budget 5,000-10,000 THB

### *Financing*

In its first year, the central government provided 600 million THB through the National Health Security Office to support this project. Of this amount, 500 million THB went to the Local Health Fund for supporting care provision at home and 100 million THB went to the Primary Care Unit for human capacity building, including care management and volunteer caregiver training (NHSO, 2016). The pilot project aimed to reach 100,000 older people with a high degree of frailty (13 or higher on the Barthel Index) and provided assessment, case management and provision of in-home visits by home caregivers 2-8 hours a week depending on the need and availability of care support. In 2017 and 2018, the program expanded to a budget of 900 million THB for 150,000 people and then to 1.159 billion THB for 193,200 people. In 2018, there are 44,000 trained caregivers.

### *Challenges*

- Financing for care: Currently, main financing sources for care of dependent older people are their families and volunteers. While these are not paid, recognising their unpaid contributions to the care economy is important. The financing of Universal Community based LTC is debated as LTC is financed through both health and social services. Financing of LTC for health is a part of the financing of Universal Coverage Scheme (UCS), which is itself a hotly debated topic as the scheme is 100% tax finance

without a cost sharing mechanism. Measures for increasing UCS efficiency and cost containment as well as identifying new financing sources and tax increases are under consideration. In relation to financing of LTC for social support, this focuses on the amendment of regulations for local authorities to finance these activities. However, projections show clearly that new financing sources, local taxes or tax transfers are needed. Public financing or provision of institutional LTC is not on the current policy agenda. Instead, the main focus is on housing for active older people using private finance. Public support for housing is only for vulnerable groups. However, there is need for provision of care services for those who live in public residential homes. Demand for residential nursing care homes is like to rise particularly for those with 24-hour care requirements and complex health and care concerns. Those living alone and/or without much informal support are likely to have demand of residential LTC at lower rates of care support unless home and community-based care provision increases in scope significantly. Older people and families also need financial mechanisms to smooth their income and to risk share to avoid catastrophic LTC expenditure. A Government subsidy is another potential source of finance for older people's LTC support, but this option requires further discussion. There is no private LTC insurance scheme in Thailand. The OIC plans to initiate this product for the aging society. However, product design and capacity building are needed for both the OIC and for private insurers.

- Integration between health care and social care: Only a few pilot areas have success the integration of health care and social care especially coordinated for people-centered care.
- Management: A national mechanism should be established for the coordination and integration LTC planning and monitoring, involving ministries, the auditor general, local authorities and civil society. Local authorities should be empowered to manage care for older people, including LTC and age-friendly modifications. The MOPH still preferred care to be provided by volunteers, while the NHSO recommended paid caregivers. The majority of local areas used volunteer caregivers. However, evaluation found that paid caregivers performed to a higher standard in all main areas of care service provision. Among the various community-based LTC initiatives, there was inconsistent application of services required by older people with LTC support needs. The home-care service from the MSDHS focused on social care, while services from the MOPH focused on health care. Although the JICA-supported, LTOP project tried to integrate health and social care, the challenges of different departments with different budget lines and mandates indicate insufficient emphasis on social care in this



community-based long term care project.

## **Conclusions**

Thailand has been relatively proactive in progressing with LTC system development based on available evidence and informed by international best practice guidelines. A pilot project for Community-based Long term care should be expanded to be a National program, which has concrete legal framework and adequate budget. Person-centered care should be promoted and care planning should encourage full engagement of the individual receiving care. Further developing community-based care services such as community day care, respite care and specialist services would be encouraged together with institution care for some needed dependent people.

To improve the long-term care for the elderly, under the framework of South-South and triangular cooperation, Thailand can extend its collaboration beyond technical cooperation with traditional partners (i.e. Japan, France, ILO, etc) to other ASEAN member states. ASEAN is aging and its countries are facing the same problem of shrinking labour force and increased needs for care workers. Thailand's experience and lesson learnt from designing, implementing and managing the community-based long-term care services for the elderly would appear to be of great value to other countries in the region. On the other hand, working closely with other neighbours might offer innovative solutions for the local problems. South-South Cooperation therefore would play an important role in maintaining prosperity in the aging ASEAN, and Thailand in particular.

## Suwankitti, Wanchat, “How demographic change in Thailand will impact the world of work? “ (Thailand)

### **Current Demographic Situations**

Given the current demographic profile, Thailand is expected to become an aged society in 2021. The total population in 2017 was recorded at 66.19 million people, of which 14.69 percent elderly people. The Total Fertility Rate (TFR) in 2017 was about 1.59, below the replacement rate of 2.1 and was expected to decline to only 1.35 in 2036. Such decline in the working age population will have potential impacts on the country's future economic growth and other development aspects.

This demographic transition toward an aging society will hinder economic development, both directly and indirectly. Firstly, if labour productivity cannot increase at a rate that compensates for the effects of a shrinking labour force, it will adversely affect economic growth. Secondly, slower population growth rates will cause domestic demand to grow at a slower rate. This means that economic growth will have to rely more on external demand, particularly if the increase in income per capita does not compensate for a fall in the size of the population. Thirdly, an increase in the proportion of elderly population, while that of the working age population decreases, is likely to limit competencies in technological and innovation development - an important factor for upgrading the economy. Finally, an increase in the number of elderly populations will tend to bring a larger fiscal burden while reducing revenue collection capacity in the public sector. Additionally, data from the National Transfer Account (NTA) showed that working age population is the only population group with income surplus, and thus the declining size of this group will inevitably impact the government's tax revenues, which are needed for the country's development and welfare allocation.

Apart from the demographic changes in Thailand, several conditions also affect to the country development. In the economic context, the economic structure has yet to be fully driven by innovative technology, while productivity in both the agricultural and service sectors remains relatively low and the Thai workforces do not yet meet expected requirements and demands of the recent changes in labour market. On social issues, many obstacles urgently need to be tackled in order to raise people's income levels, address poverty and income inequality, and enhance public service quality and accessibility. Regarding the country's environment and natural resource, preservation and restoration of natural resources and the environment continue to be key factors for ensuring sustainable development. With respect to administrative efficiency, the public sector's efficiency, continuity and flexibility in response to

civic problems still need to be improved. In addition, Thailand has been facing with other rapid changes, be it disruptive technology, changes in international relations in terms of security and the national economy, more complex connectivity due to regional integration and liberalization in different sectors as well as climate change and ecological degradation.

### **Thailand National Strategy for elderly care system.**

Thus, for Thailand to compete in the world economy and to raise people's living standard, the Royal Thai Government (RTG) has announced a 20-year national strategy with a vision that "Thailand becomes a developed country with security, prosperity and sustainability in accordance with the Sufficiency Economy Philosophy<sup>18</sup>". The goals of the National Strategy were to maintain national security and ensure people's welfare; boost multidimensional national competitiveness to ensure consistent economic growth; empower human capital at each and every stage of life to manifest competent and moral citizenry; broaden opportunities to improve social equality; promote environmentally-friendly growth with improved quality of life; and develop governmental administrative efficiency for greater public benefits.

Thailand's strategies to improve the elderly care system and create adequate environments suitable for an aging society include: (1) pushing forward long-term care legislation to cover quality and accessible services provided by the public sector, private sector, and civil society, as well as a sustainable financing system; (2) developing a medium-term aftercare system, designed to provide essential support to recovering patients, that is seamlessly connected with the long-term care system, and promoting long-term care service businesses whose standards are up to par to what is required, for dependent elderly people in urban areas, as well as studying suitable financing models for long-term care insurance; (3) conducting research and development on the necessary facilities required by elderly people to sustain quality living on a daily basis, and developing medical technology and innovations to be used in improving the health and well-being of elderly people, as well as injury prevention technology and a treatment monitoring system; and (4) promoting elderly-friendly urbanization with universal designs, including public transportation, buildings, public areas, and accommodation that is suitable for the quality living of elderly people and everyone in society.

### **From Strategies to Practices: Community-Based Long-Term Care**

In implementing these strategies, the RTG, has proposed a long-term care programme in order to uplift living quality for older people. However, government's sole effort is not enough. One solution is partnership with local stakeholders to create the community-based long-term care.

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<sup>18</sup> Sufficiency Economy Philosophy is a Thai philosophy for development based on five principles: knowledge, morality, reasonableness, self-immunity, and moderation.

In this context, local volunteers will be trained by the Ministry of Public Health to become professional caregivers. The caregivers will be in charge of the elderly and the disabled people, who suffer from chronic diseases. Their responsibilities extend to managing medications or discussing with doctors and nurses, etc. This mechanism has succeeded in generating jobs and incomes for many local females. Local governments also emphasised on living conditions for the elderly. Efforts were made to foster innovations such as easy to access toilet, local low-cost bed for older people, etc.

Indicators in SDGs have been incorporated to the monitor and evaluation of the country development. Thai development strategies deploy a set of indicators for monitoring and evaluating progress and outcomes of country development, including: (1) well-being of Thai people and society; (2) national competitiveness, economic growth and income distribution; (3) development of human capital; (4) social equality and equity; (5) sustainability of national biodiversity, environmental quality and natural resources; (6) government efficiency and better access to public services. These indicators help to measure comprehensively the development progress of Thailand in the era of demographic change.

### **Development Partnership**

Thailand's Partnership Development Strategy comprises of developing both internal and external partnership. Internal partnership refers to the integration of different local stakeholders including public, private, academic, civil society, etc. In Thailand's experience, development partnership in implementing community-based long-term care has resulted in solutions for higher living standard for the elderly. On the other hand, external partnership refers to collaboration with other countries/development partners. Specifically for the South-South cooperation, Thailand emphasises on the importance of pushing forward institutional connectivity at the sub-regional and regional level to facilitate the implementation and evaluation of care policies, solidify the linkages and cooperation frameworks with member states, including through international organizations and other kinds of platform. Furthermore, new and mutual set of indicators and database to measure development outcomes among member countries and international organisation are promising areas of South-South collaboration.

### **The Way Forward: South-South Cooperation**

In the context of South-South cooperation, Thailand has been playing an active role in ASEAN and with other development partners. Specifically, the RTG have been offering training fellowships and postgraduate scholarships to developing partners through bilateral and triangular development cooperation projects, under the overview of Thailand International Cooperation Agency (TICA) - Ministry of Foreign Affairs of Thailand. Thailand's development

foundation lies on improving quality and inclusive healthcare, targeting all sectors of the society, including the promotion of primary health care, community health care system and health protection from diseases. TICA offers over 700 training fellowships and 70 postgraduate scholarships for government officials from developing countries around the world through Annual International Training Course (AITC) and Thailand International Postgraduate Programme (TIPP).

The AITC courses under the theme “Public Health” offer training experience on current and future health challenges such as universal health coverage, community health management, as Thailand aims to contribute to global effort in achieving Goal 3 as well as other health-related targets of the SDGs. AITC offers not only training experience, but also a platform for the exchange of ideas and establishment of professional network among participants from all over the world. In addition, TIPP provides postgraduate scholarships for developing partners. Believing that knowledge sharing is an important pillar of South-South Cooperation, Thailand offers opportunities for partners to exchange their experiences and best practices that would contribute to long-term and sustainable development for all, particularly to achieve the desired goal of a sustained human development at all ages and for all groups.

## Bingzi ZHANG, “Trends of Eldercare Workforce in China and its Enlightenment to Care-economy” (China)

### **Population ageing and growing needs of care**

In terms of the total elderly population, the number of people aged 65<sup>19</sup> and above in China increased from 25 million in 1953 to 135 million in 2015, with an increase of 110 million in more than six decades. In the next 20 years, China's elderly population will continue to grow rapidly. By 2035, China's elderly population will double to nearly 300 million and approach a peak of 400 million around 2060. In the world, China will rank first in terms of the number of elderly population. In 1960, China's total population accounted for 23% of the world's population, while China's elderly population only accounted for 15% of the world's population. In 2015, China's elderly population accounted for 22% of the world's elderly population and 40% of the total elderly population in Asia. By 2035, China's elderly population will account for 26% of the world's elderly population and 43% of the total elderly population in Asia.

With the rapid growth of elderly population, the need for eldercare will also increase accordingly. First, the number of elderly with disease and disability is increasing. According to the Fourth Sampling Survey on Living Conditions of the Elderly in Urban and Rural Areas in China, the number of disabled and partially-disabled elderly people in China reached 40.63 million in 2015, accounting for 18.3% of the total elderly population. According to the data from the *1% national population sample survey* in 2015, 16.8% of the elderly are “unhealthy but able to take care of themselves in life” and “unable to take care of themselves in life”. In general, all those surveys show that the rate of disability among the elderly tends to increase with age. The situation of disability in rural areas is more serious than that in urban areas, and the rate of disability among women is higher than that among men. Chronic diseases are also important factors affecting care needs. According to the *Report on the Status of Nutrition and Chronic Diseases among Chinese Residents (2015)*, the prevalence of hypertension and diabetes among the people aged 60 and above in China reached 52% and 20% respectively.

Secondly, family size continues to shrink, and the family care function is weakening. After the 1980s, Chinese household size decreased significantly from 4.41 persons in 1982 to 3.10 persons in 2015. Besides, the type of family has also experienced significant changes; the

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<sup>19</sup> At present, the definition of the elderly population in China usually uses two kinds of statistical caliber: “60 years old and above” and “65 years old and above”. More developed economies usually use only the statistical caliber of “65 years old and above”. In order to facilitate international comparison, the statistical caliber of “65 years old and above” is used here, and the statistical caliber of “60 years old and above” is used for most of the data in China later in the paper.

traditional phenomenon of “three generations under one roof” has decreased significantly, and the proportion of elderly people living alone has increased obviously. According to the result data of the *Fourth Sampling Survey on Living Conditions of the Elderly in Urban and Rural Areas in China*, the proportion of empty-nest elderly reaches 51.3% now. Along with large-scale population migrations and the reduction of number of children per family, the spatial distance between children and parents is increasing, which is one of the direct reasons for the scale expansion of empty-nest elderly and lonely old people. Meanwhile, along with the rapid development of economy and the rapid pace of urban life, young people generally work under heavy pressure. Even if they were still living with the elderly, it could be difficult for them to assume responsibility for taking care of old people. The widespread emergence of the “4-2-1” family pattern brought about by the one-child policy has further intensified the pressure of taking care of their parents on young people.

### **Projections of the needs on elderly care workers**

The demand for elderly care workers is highly related to the increase in the number of older people in the future and also to the model and goals of the entire senior-care service system. In order to better reflect the demand for elderly care workers in the future, this paper adopts two prediction methods:

*Method One:* The low-demand plan, which is based on the development goals of the existing senior-care service system. According to *the 13<sup>th</sup> Five-Year Plan for the Development of Civil Affairs*, by 2020, the number of beds provided for the aged for every thousand old people in China will reach 35-40 ones. According to *the 13<sup>th</sup> Five-Year Plan for National Development of Old Age Undertaking and the Construction of a Senior-care System*, the proportion of nursing beds provided for the aged shall not be less than 30%. In the next 30 years, if we still maintain a standard of 35 beds per 1,000 senior citizens, of which 70% will be non-nursing beds for those able to look after themselves, and 30% will be nursing-type beds, and nursing-type beds will be able to serve both the disabled elderly and the semi-disabled elderly. The proportion of beds is consistent with the proportion of disabled and semi-disabled elderly people in that year<sup>20</sup>. The number of elderly care workers is consistent with the requirements of the Code of Conduct for Life Care of Senior-care Institutions, which is, the ratio of the elderly care workers to senior citizens able to take care of themselves is 1:20;

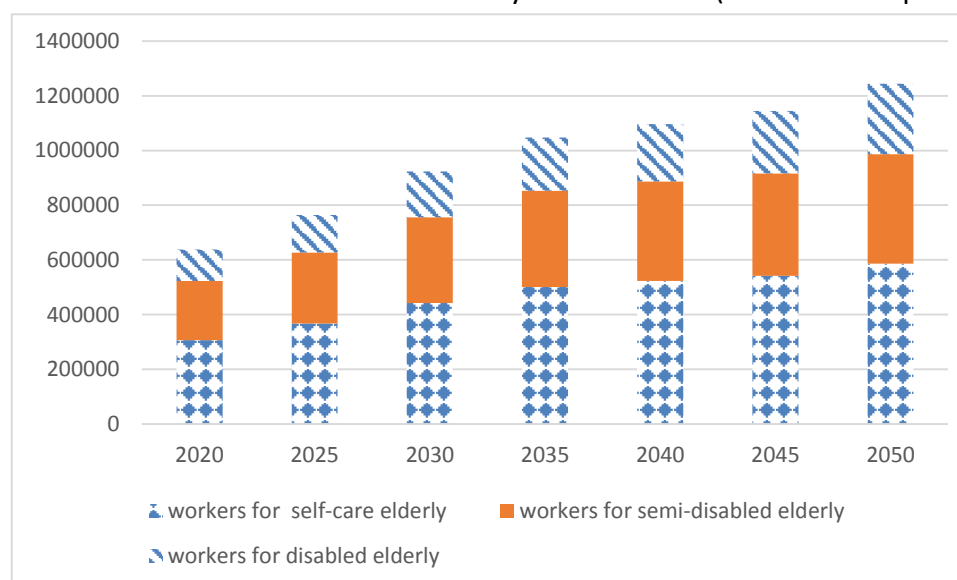
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<sup>20</sup>In the 2015 national survey sampling of 1% the population, a survey was conducted on the health and self-care capabilities of the elderly aged 60 or older across the country. They were classified as “healthy”, “substantially healthy”, “unhealthy, but able to take care of themselves” and “unable to look after themselves”. This article regards the “healthy” and “substantially healthy” old people as someone who are able to look after themselves, and the “unhealthy, but able to take care of themselves” old people as semi-disabled elderly people, while considering the “unable to look after themselves” old people as disabled elderly people.

the ratio of the elderly care workers to semi-disabled elderly people is 1:10; and the ratio of the elderly care workers to disabled elderly people is less than 1:4.<sup>21</sup>

The calculation results show that in 2020 China needs about 640,000 elderly care workers, of whom 110,000 are needed for beds provided for the disabled elderly, 220,000 for beds provided for the semi-disabled elderly and 310,000 for beds provided for those able to look after themselves, and by 2050 China will need about 1.24 million elderly care workers, which is almost double that of 2020. Among them, the number of nursing staff required for beds provided for the disabled elderly is 260,000, 400,000 for beds provided for the semi-disabled elderly, and 580,000 for beds provided for those able to look after themselves. Among all the elderly care workers needed, more are required to have the ability to serve the disabled and semi-disabled elderly.

**Figure 1:** Forecast of the demand for elderly care workers. (Low-demand plan)



*Method Two:* a high-demand plan, which estimate the needs of elderly care workers by measuring the needs of the disabled and semi-disabled elderly people.

This method predicts the number of disabled and semi-disabled elderly people in different years, referring to “the ratio of the elderly care workers to semi-disabled elderly people should not be less than 1:10; and the ratio of the elderly care workers to disabled elderly people should not be less than 1:4”, and measuring the needs of elderly care workers for the disabled

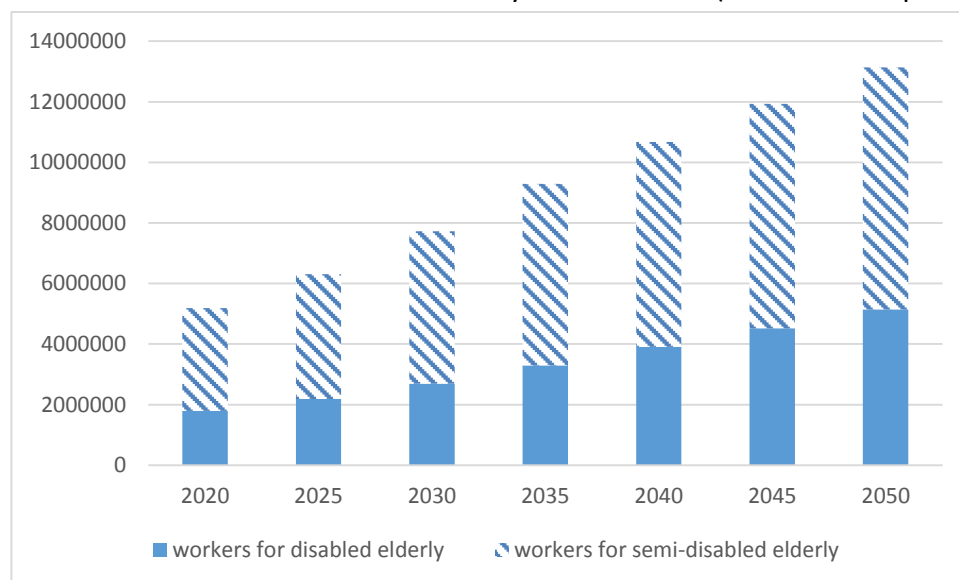
<sup>21</sup>According to the requirements of *the Standards for Life Care Services for Senior-care Institutions* that are now soliciting opinions from the society, the elderly care workers should meet the needs of life care services. The ratio of the elderly care workers to senior citizens able to take care of themselves should not be less than 1:20; the ratio of the elderly care workers to senior citizens able to take care of themselves on certain occasions should not be less than 1:10; and the ratio of the elderly care workers to senior citizens not able to take care of themselves should not be less than 1:4.



and semi-disabled elderly people, regardless of whether they adopt home-based care, community-based care or family-based care, and whether they live in urban or rural areas. For the elderly people able to look after themselves, it is assumed that their lives do not require the care of others or only need general life care service, and therefore do not measure the needs of elderly care workers for them. And it is assumed that the health status of the elderly in each age group by 2050 is consistent with that in 2015.

The calculation results show that in 2020, about 5.2 million elderly care workers are needed in China, of which 1.8 million are required for the disabled elderly and 3.4 million are required for beds provided for the semi-disabled elderly. By 2050, China will need about 13.14 million elderly care workers, which is about 2.5 times that in 2020. Among them, there are 8 million required for beds provided for the disabled elderly and 5.14 million required for bed provided for the semi-disabled elderly.

**Figure 2:** Forecast of the demand for elderly care workers. (Low-demand plan)



### **Broaden the supply channels for elderly care workers**

The calculation results show that the gap between supply and demand for elderly care workers will become increasingly prominent. This gap is first manifested in the insufficient number of service teams. At present, the difficulty in recruiting people and keeping them has become the main challenges faced by senior-care institutions, and the nannies who are directly employed by families are also in short supply. With the increase in demand for elderly care workers, this contradiction will become more prominent.

### *Supportive strategies to skilled care-workers*

Both the care workers and their employers are less motivated to carry out training. From

institutions point of view, the high mobility of elderly care workers has seriously affected the enthusiasm of institutions for on-job training. The mechanism of employee's wages increasing with the service years is not efficiently applied. From the perspective of workers, the large number of low-educated older workers themselves has low learning ability and willingness to learn. The improvement of skills cannot directly bring wage rising. Workers themselves do not regard the care job as a career with long-term prospects, so it is easy to leave due to personal or family reasons. Also, the vocational skills appraisal exam is more focused on theory and written knowledge, and is difficult for them.

So more supportive strategies should be brought for skilled elderly care workers, including in education and training, social security, social honor, etc., improve the social status and income level of skilled care-workers and making them have higher career- development prospects, change the impression that jobs in the senior-care service industry are all low-end and low-income.

#### *New technologies brings opportunities to alleviate the shortfall of elderly care workers*

Making full use of new technical means such as various assistive devices and smart devices can effectively improve the quality of life of the elderly, and greatly save the workload of elderly care workers and improve the working environment. Assistive devices can reduce and alleviate the inconveniences of disability for people with disabilities and the elderly. There are also assistive devices that can help prevent the development of disability. These products can help the elderly to eat, dress, bathe, and go to the toilet, and even allow the elderly to independently complete some housework and travel independently. Those new technologies will help the elderly to improve their autonomy and social inclusion level and then change the task and content of the elderly care work. Smart devices mainly refer to the next-generation information technology products such as the Internet of Things, cloud computing, big data, and intelligent hardware. Smart devices can be applied in many areas such as disease and health management, life care, etc. At present, there are products in wireless positioning, stumble-and-fall monitoring, remote care, elderly behavioral intelligence analysis, chronic disease management, catering and entertainment.

#### **South-South Cooperation: Attracting ASEAN skilled care-workers**

China will also need to attract overseas skilled care-workers to meet the increasing care needs of elderly people, which also brings job opportunities to ASEAN countries. To encourage the mobility of care workers, more efforts should be taken.

First, a system on recognition of professional qualifications for overseas workers will be an urgent need. The newly revised National Standards for Occupational Skills for Elderly Care Workers (2011) clearly defines the requirements of elderly care workers, which might be a criteria for the international certification. But the examination system for certificate needs to be reformed. Now the examinations are held locally; standards of local appraisal centers are not consistent. Also, many institutions and workers think the examinations are too theoretical, not closely related to their daily work. So a well-designed recognition system with an international standard is needed to connect China's care-work market to the international labour market.

Second, comprehensive training program will also be needed. There are many good experiences from international society on elderly care training. Introducing advanced overseas training courses and gradually open the training market for elderly care professionals will be important on improving the qualities of care workers. Also, training on language and cultural are indispensable parts in the whole training for foreign care workers. Care work is highly emotion-related, expression and communication skills, intercultural understanding are also important for care workers, which brings more challenges on foreign workers.

Third, protecting the rights of labour migrants to promote decent work for care workers is imperative. Elderly care worker has a high proportion of informal employment and turnover rate. Care jobs are more likely to be temporary jobs than some other jobs. There are a large proportion of employers who are individuals or families, making it even more difficult for labor protection laws and regulations to play a role. So how to promote decent work for care workers will become big challenges on attracting foreign care workers. Regulations on wages, vacation, labor safety and health, insurance and welfare etc, should meet the need of care worker. Also, the practicability of current mediation and arbitration system of labor disputes for foreign care workers will also need to be assessed.

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